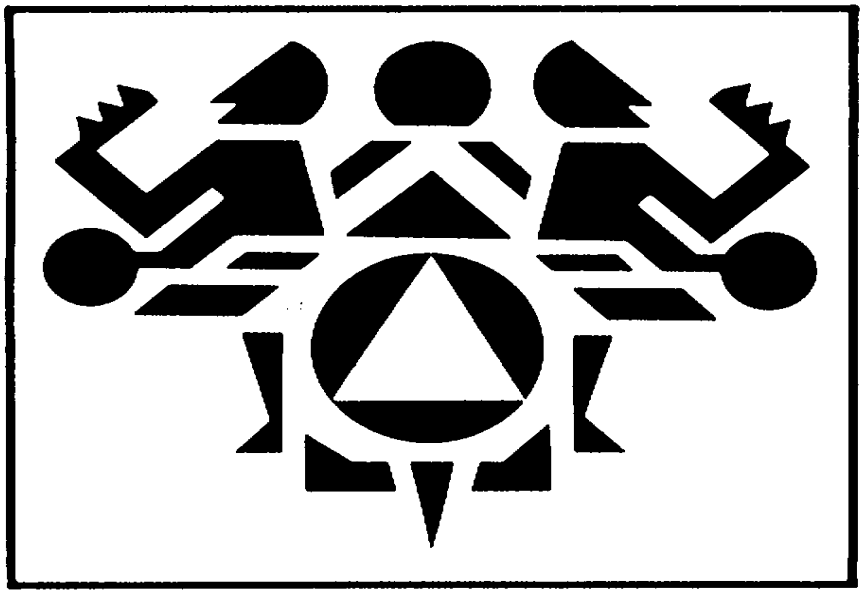
SUMMARY OF MINUTES



QUARTERLY BOARD MEETING

OCTOBER 18-20, 2016

CLEARWATER CASINO & RESORT

SUQUAMISH, WA

Northwest Portland Area Indian Health Board
October 2016 Quarterly Board Meeting
Clearwater Casino Resort, Suquamish, WA
October 18-20, 2016
Summary of Minutes

Issue	Summary	Action	Follow-Up
Tuesday October 18, 2016			
Indian Health Service, Mary Smith Principal Deputy Director Indian Health Service	See attached transcription		
Area Director Report Dean Seyler, Area Director	❖ **New Staff:** ❖ LCDR Kathi Murray, MS, RDN, CDE – Area Diabetes Consultant ❖ Kathi.murray@ihs.gov ❖ 503-414-5555 ❖ **FY18 Budget Formulation (Area Meeting)** ❖ Date – November 29th ❖ Location – Portland ❖ CAPT Ann Arnett, Executive Officer ❖ Andy Joseph and Steve Kutz – Tribal Reps to National Meeting ❖ **Mandatory Seasonal Influenza Immunizations for Civilian Health Care Personnel** ❖ Policy applies to all Civil Service employees, contract staff, temporary employees, students and volunteers whose duties and responsibilities require them to work permanently, temporarily or occasionally in an IHS health care facility (hospital, clinic or health station) regardless of their job category or level of patient contact (definition of Health Care Personnel [HCP]) ❖ Must provide acceptable documentation substantiating influenza vaccine receipt or request for exemption by October 31 ❖ Two forms of exemption considered: 1) Medical 2) Religious ❖ Portland Area Recognized for Achievement in Adolescent Immunizations ❖ Received at the National Immunization Conference, September, 2016		

- Tdap/Td 95.1%
- Meningococcal 91.4%
- 1 dose Human Papilloma Virus (HPV) 81%
- 85.4% (Females) 77.0% (Males)

- New Adult Immunizations Measure for GPRA
  - Testing and validation conducted by NWTEC with IHS and Tribal sites in Portland Area and two other IHS Areas
  - Developmental measure for 2016-2017
  - Will be implemented in 2017-2018
- **FY16 CHEF Balance – $13,177,538***
  - 1.6 million submitted for Portland Area
  - $1.3 million approved and returned
- **PRC Area Risk Pool Conference Call**
  - November 8, 2016
  - 10AM
  - Email sent to six Tribal Health Directors
- **Maximum Supportable Space (MSS)**
  - Approved IHS Program Space is Used to Determine the Share of Maintenance & Improvement (M&I) and Equipment (EQ) Funds.
  - Each Program Has an Established Maximum – MSS
  - PAO Division of Health Facilities Engineering (DHFE) Has Identified an Approach that May Increase the Established MSS, Potentially Increasing the Share of M&I and EQ Distributed to Programs Currently Over Their MSS.
  - In FY 2017, PAO/DHFE Plans To:
    - Analyze Current Space Records for All Tribal Health Programs with Retained Shares.
    - Notify Programs that May Benefit From This Process to Increase MSS.
    - Work with the Identified Programs to Increase Their MSS.

	In FY 2018, Subject to Workload and Resource Availability, There May Be Buy-Back Opportunities for Tribes Who Have Taken Their Shares to Follow This Process
	
	❖ **Government Performance and Results Act (GPRA)**
	❖ **GY 2016- 24 measures**
	❖ **Four new measures:**
	  ❖ Statin Therapy to Reduce CVD Risk with Diabetes
	  ❖ Influenza Vaccination Rates Among Children (6 mo-17 yrs)
	  ❖ Influenza Vaccination Rates Among Adults (18 and older)
	  ❖ HIV Screening Ever (13-64 years old)
	❖ **Two revised indicators:**
	  ❖ FAS Prevention (alcohol screening)- Age range expanded to females 14-46 years.
	  ❖ DV/IPV Screening- Age range expanded to females14-46 years.
	❖ **Government Performance and Results Act (GPRA)**
	❖ **GY 2016 Results (24 measures)**
	  ❖ National- Results pending
	  ❖ **Portland (Federal & Tribal)- Met 15 measures**
	❖ **Government Performance and Results Act (GPRA)**
	❖ **Portland Area GPRA Reporting Sites**
	  ❖ Federal- Colville, Ft. Hall, Warm Springs, Wellpinit, Western Oregon, Yakama
	  ❖ Urban- NARA, Spokane NATIVE
	❖ Confederated Tribe of the Chehalis Reservation
	❖ Confederated Tribes of the Colville Reservation (Inchelium Clinic)
	❖ Cow Creek Band of Umpqua Tribe of Indians
	❖ Cowlitz Indian Tribe
	❖ Lower Elwha Klallam Tribe
	❖ Lummi Nation
	❖ Makah Tribe (Sophie Trettevick Clinic)		

- Muckleshoot Indian Tribe
- Nez Perce Tribe (Nimiipuu Clinic)
- Nooksack Indian Tribe
- Quinault Indian Nation (Roger Saux Clinic)
- Shoalwater Bay Indian Tribe
- Skokomish Indian Tribe
- Snoqualmie Tribe
- Squaxin island Tribe
- Swinomish Indian Tribal Community
- Tulalip Tribes
- Confederated Tribes of the Umatilla Indian Reservation (Yellowhawk Clinic)
- **Government Performance and Results Act (GPRA)**
  - **GY 2016 Results (24 measures)**
    - National- Pending
    - Portland (Federal & Tribal)- Met 15 measures
    - **Portland (Federal Only)- Met 19 measures**
      - **Western Oregon- 5th year in a row**
      - **Warm Springs & Colville- Met 23 of 24 measures**
- **Fall 2016 Portland Area Clinical Director's Meeting**
  - **October 27-28, 2016**
  - **Warwick Hotel, Seattle, WA**
  - **Topics:**
    - CDC Opiate Prescribing Guidelines
    - Addressing Childhood Obesity
    - Salish Integrative Oncology Center
    - VA-IHS Collaboratives
    - Integrating Environmental Health into Clinical Practice
    - Use of an ECHO Model for Hepatitis C Case Management

Summary of Minutes

Executive Director Update Joe Finkbonner	**Personnel** • **New Hires:** – Oceana Henderson, On-Call Office Assistant • **Promotions:** – David Stephens, HCV RN Project Manager – Jessica Leston, HIV/HCV/STI Clinical Services Project Director – Candice Jimenez, Research Coordinator • **Interns:** – Jana Hodgins, PRT Volunteer **Events** **August** – PHAB Accreditation Committee **September** – National Tribal Forum for Excellence, Spokane, WA – Nike Native Fitness (didn't attend) Nike HQ – WEAVE Annual Gathering, Portland, OR **October** – NCAI, Phoenix, AZ **11th Annual Indian Day Celebration** **Hood to Coast** **Upcoming** **November** • Vacation • Oregon Health Insurance Marketplace, Portland, OR • Public Health Leader/Mentor Panel, UW		

	December • WDSF Board meeting • PHAB Board of Directors • NWIC Foundation Board meeting • NPAIHB Annual Holiday Party (Dec. 9th)		
Region X Update Susan Johnson, HHS Regional Director	See transcription		
	Committee Meetings (working lunch)		
We R Native Update, Stephanie Craig-Rushing, Suicide Prevention & PRT Project Director	See attached PPT		
SAMHSA Update David Dickinson, MA, Regional Administrator Substance Abuse & Mental Health Services Administration - U.S. Department of Health & Human Services	See attached PPT		
Opioid Guidelines/Policy, CAPT Thomas Weiser, MD, MPH, Medical Epidemiologist	See attached PPT		
	Executive Session		

Summary of Minutes

WEDNESDAY OCTOBER 19, 2016			
Cancer Project & Tobacco Update Kerri Lopez WTDP & NTCCP Project Director	See attached PPT		
Zika Virus Update CAPT Thomas Weiser, MD, MPH, Medical Epidemiologist	See attached PPT		
Committee Reports	• Elder's Committee, Dan Gleason **(A copy of the report is attached)** • Public Health, Victoria Warren-Mears **(A copy of the report is attached)** • Behavioral Health, Marilyn Scott **(A copy of the report is attached)** • Personnel Report, Cassie Sellards-Reck **(A copy of the report is attached)** • Legislative Report, Laura Platero **(A copy of the report is attached)** • Youth Report, Leland Bill **(A copy of the report is attached)**		
Legislative Update **Laura Platero, Government Affairs/Policy Director**	**Report Overview** 1.Status of FY 2017 IHS Budget 2.Contract Support Costs 3.Veteran's Administration 4.Community Health Aide Program (CHAP) Expansion 5.Tribal Premium Sponsorship 6.Catastrophic Health Emergency Fund 7.Other Policy Updates 8.STAC Meeting Update 9.MMPC CMS TTAG Update 10.Litigation Impacting Indian Health 11.Legislative Issues 114th Congress		

	12.Important Dates **Status of FY 2017 IHS Budget** •Congress enacted a continuing resolution through December 9, 2016 – funding pro rated and at FY 2016 level. •Senate and House Committees' Interior, Environment and Related Agencies appropriation bills reflect differences (detailed on next slide)- to be negotiated. •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 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 and discussed during the September 15-16, 2016 CSC Workgroup meeting. –IHS will finalize by the end of October. **Veteran's Administration**		

	•On September 12, 2016, the Veteran's Administration issued a Dear Tribal Leader Letter (DTLL) •In October, 2015, VA submitted a Plan to Congress to Consolidate Programs of the Department of Veterans Affairs and conducted Tribal Consultations. •As part of implementation of this Plan, tribal consultation is being sought on tribal health programs participation in the core provider network and potentially transitioning from the current reimbursement agreement structure to a model under which tribal health programs deliver care to all those eligible for services. •In person consultation: –September 28, 2016 at 9:00am-11:00am at the Smithsonian National Museum of the American Indian (NMAI) •Written comments are due on November 5, 2016 and can be sent to: tribalgovernmentconsultation@va.gov **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 are 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 •Comments are due on October 31. **Other Policies** •IHS Re-alignment of IHS Headquarters –All Tribes Call on 9/29/16 and in person discussion at NCAI on October 9. –Comments due November 5 •SAMSHA's Draft Tribal Behavioral Health Agenda (TBHA) –Sets forth a framework, priorities and strategies to address behavioral health issues in Indian country. –Comments due on October 31. •CMS MACRA MIPS & APM		

	–Final Rule issued on October 14. CMS Medicare Expansion of Diabetes Prevention Program Proposed Rule –Proposed to expand the Medicare Diabetes Prevention Program beginning 1/1/2018. –Tribal consultation has been requested before final rule issued. •CMS Managed Care Final Rules –All Tribes Call on 10/5/17. –CMS will provide an overview of Indian specific provisions and comments on an Indian health addendum –Effective 7/1/17; CHIP provisions effective 7/1/18 **•CMS 100% FMAP -- CMS issued a letter to State Health Officials on 2/26/16 re-interpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:** –CMS to issue a FAQ on new policy – still pending. **STAC Meeting Update** •Last meeting was September 13-14; next meeting is December 7-8 •Tribal leaders have made several requests to Secretary Burwell, including: –Quality of Care Issues at the Indian Health Service –Tribal Budget Formulation Workgroup's Recommendations for the FY 2018 IHS Budget –Office for AI/AN Programs at the Office of Management and Budget –Advocacy on the Veterans' Administration Memorandum of Understanding –Senior Level HHS Position Dedicated to Coordinating Tribal Policies at ACF –Indian Child Welfare Act Implementation –1115 Waiver Approval –Transition Plan for the Next Administration **MMPC & CMS TTAG Update** •Medicare, Medicaid and Health Reform Policy Committee (MMPC) next face-to-face meeting		

on November 2.

–Priority List

•CMS TTAG conference call and face-to-face meetings on October 12 and November 3-4, respectively.

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 in favor of Manilaaq.

–IHS did not appeal the Final Order.

Indian Legislative Issues 114th Congress

•Employer Mandate Bills (S. 1771 & H.R. 3080)

•Indian Health Service Reform Bills (S. 2953 & H.R. 5406)

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 Committee; House bill passed Ways and Means Committee.

	•Senate and House Bills Reforming the Indian Health Service in response to issues in the Great Plains region. –S. 2953 -- The Indian Health Service Accountability Act of 2016 was introduced by Sen. Barrasso (R-WY) on 5/19/16. –H.R. 5406 – The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare Act was introduced by Rep. Kristi Noem (R-SD) on 6/8/16. –Senate bill referred to Finance; House bill reported favorably out of House Ways and Mean on 6/15/16. –Both bills were amended and then approved in their respective committees on 9/21/16. Other pending legislation: •Advance Appropriations (H.R. 395) •Tribal Programs Exemption from Sequestration (S. 1497/H.R. 3063) •Department of Interior Tribal Self-Governance Act of 2015 (2. 286) •Family Stability and Family Kinship Act of 2015 (S. 1964) •Native American Suicide Prevention Act of 2015 (H.R. 3166) •Correct Inconsistencies in the ACA/IHCIA (S. 2114) **Important Dates** •Several comments are due in the next 3 weeks. •Portland Area Budget Formulation Meeting – November 29, 2016. –Location: Portland, OR •NCAI Transition Plan Submissions –Due: Wednesday, October 19, 2016 –Submit to: Nicole Hallingstad, Director of Operations, NCAI, nhallingstad@ncai.org		
	BREAK		
Native STAND Update	See attached PPT		

Stephanie Craig-Rushing, Suicide Prevention & PRT Project Director			
	LUNCH		
Tribal Update	1. Kalispel 2. Kootenai 3. Lower Elwha Klallam Tribe		
Data Repository/Data Movement Victoria Warren-Mears, PhD, RDN, FAND; Director, Northwest Tribal Epidemiology Center	See attached PPT		
Quality of Care and Business Practice and the ACA Laura Herbison, CEO, **Western Oregon Service** Unit & Jay Sampson, CEO, Yakama Service Unit	See attached PPT		
Public Health Update Clark Halvorson, Assistant Secretary, Environmental Public Health, State of WA			
Thursday, October 20, 2016			

Summary of Minutes

Chairman's Report Andy Joseph, Jr.	See attached PPT		
TLDC Update			
FINANCE REPORT – Eugene Mostofi			
	MOTION: BY GREG ABRAHAMSON, SPOKANE, 2ND Sam Penny, Nez Perce Tribe	**MOTION**	**PASSED**
MINUTES	Skipped will review in January	**REVIEW IN JANUARY**	
Resolutions:			
	17-01-01 Supporting Standing Rock Sioux Tribe and Opposition to Dakota Access Pipeline Ratified, motion by Cassie Sellards-Reck, Cowlitz Tribe; Seconded by Marilyn Scott, Upper Skagit Tribe. MOTION PASSED	**MOTION**	**PASSED**
	17-01-02 Support of Community Health Aide Program (CHAP) National Expansion Motion by Andy Joseph, Colville Tribe; Seconded by Brent Simcosky, Jamestown Tribe. MOTION PASSED	**MOTION**	**PASSED**
	17-01-03 Support Engagement of Youth and Development of Youth Track Motion by Cassie Sellards-Reck, Cowlitz Tribe, Seconded by Leland Bill, Yakama Nation. MOTION PASSED	**MOTION**	**PASSED**
ADJOURN at 10:07 a.m.			

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

OCTOBER 2016 QUARTERLY BOARD MEETING

Clearwater Casino & Resort, Suquamish, WA

October 18-20, 2016

MINUTES

Tuesday, October 18, 2016

Call to Order: Andy Joseph, Chairman,

Invocation: Janice Clements

Posting of Flags: Suquamish Warriors Veterans posted the flags.

Welcome: Suquamish Tribal Chairman, Leonard Forsman

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 – **Present**
Umatilla Tribe – **Present**	Quinault Nation – **Absent**
Warm Springs Tribe – **Present**	Samish Nation – **Absent**
Coos, Lower Umpqua & Siuslaw Tribes – **Absent**	Sauk Suiattle Tribe – **Absent**
Coquille Tribe – **Absent**	Shoalwater Bay Tribe – **Present**
Cow Creek Tribe – **Present**	Shoshone-Bannock Tribe – **Present**
Cowlitz Tribe – **Present**	Skokomish Tribe – **Absent**
Hoh Tribe – **Absent**	Snoqualmie Tribe – **Present**
Jamestown S'Klallam Tribe – **Present**	Spokane Tribe – **Present**
Kalispel Tribe – **Absent**	Squaxin Island Tribe – **Absent**
Klamath Tribe – **Absent**	Stillaguamish Tribe – **Present**
Kootenai Tribe – **Absent**	Suquamish Tribe – **Present**
Lower Elwha Tribe – **Present**	Swinomish Tribe – **Present**
Lummi Nation – **Absent**	Tulalip Tribe – **Present**
Makah Tribe – **Present**	Upper Skagit Tribe – **Present**
Muckleshoot Tribe – **Present**	Yakama Nation – **Present**
Nez Perce Tribe – **Absent**	

There were 25 delegates present, a quorum is established.

MINUTES

Andy Joseph: (Session started) introductions of our Tribes so you know who you're speaking to.

Sheryl Kennedy: Good morning Mary Smith, I'm Sheryl Kennedy. I'm the Vice Chair of the Northwest Portland Area Indian Health Board also the Vice Chair of the Confederate Grand Ronde.

Greg Abrahamson: Good morning. I'm Greg Abrahamson from Spokane Tribal Council and Health Board

Shawna Gavin: Good morning. I'm Shawna Gavin Treasurer of the Health Board and Health Commission Chair, Umatilla Tribe.

Kevin Collins: Good morning. I'm Kevin Collins and I'm the director of Health Services for the Stillaguimash.

Marilyn Scott: Good morning, Mary Smith. My name is Marilyn Scott and my family given name is Lithuitsa (phonetic) and I represent the Upper Skagit Tribe.

Jolene George: Good morning, Mary Smith. My name is Jolene George and I'm the Health Director for the Snoqualmie Tribe.

Dylan Dressler: Good morning. My name is Dylan Dressler. I'm the Health Services Director for the Lower Elwha Tribe.

John Stevens: Good morning Mary Smith. This is John Stevens. I'm Program Administrator for the Swinomish Tribal Community.

Tracy Rascon: Good morning. This is Tracy Rascon, Makah Tribe. I'm the Tribal Clinic Administrative Officer and Internal Health Worker.

Bob de los Angles: Good morning. My name is Bob de los Angles. I work with the Snoqualmie Tribe.

Brett Simcosky Good morning. My name is Brett Simcosky. I'm the Director of Health Services for the Jamestown S'Klallam Tribe

Janice Clements: Good morning. My name is Janice Clements, Warm Springs Tribe.

Leland Bill: Good morning, Mary, My name is Leland Bill, I'm from the Yakama Tribal Council.

Dan Gleason: Dan Gleason Chehalis Tribal Council.

Tino Batt: Good morning. I'm Tino Matt. I'm Shoshone Bannock Tribe Business Council.

Cassandra Sellards-Reck: Good morning. My name is Cassandra Sellards-Reck from the Cowlitz Tribal Council in Washington.

Jim Steinruck Hello, Mary Smith. My name is Jim Steinruck. I'm the health administer for the Tulalip Tribes.

Female: _____ for the Quileute Tribe Council.

Sam Penny: Good morning. My name is Sam Penny, Nez Perce Tribe.

Don Brandon: Good morning, Mary Smith. Don Brandon First Confederate Tribe Siletz Indians.

Sharon Stanphill: Sharon Stanphill Cow Creek Health and Wellness Center. I'm a Health Operations Officer.

Kim Zillyet-Harris: Good morning. Kim Zillyet-Harris, Shaolwater Bay Wellness Center Health, Health Director

Leslie Wosnig: Good morning. Leslie Wosnig from the Suquamish Tribal Health and Policy Administrator.

There were 24 delegates present, a quorum is established.

Andy Joseph: Okay, that's all over board that's present today. So I just want to lay it out again. We're glad to hear your voice and hopefully you'll make it back this way some time before this administration. I guess if you have a report with you, we can listen to that now.

May Smith: Okay, thanks everyone. Again, I'm really disappointed. I really wanted to be out there with you in person. And I'm glad that you all were able to do it. The weather was pretty scary for a while. I know there were high winds and things; I really debated until the last moment to see if it was still possible. It didn't seem like it was going to work out. So I apologize but I do want to be up there sooner rather than later. I wish I could be there in person today but thanks to all of you. I'm really excited to be joining your meeting and looking forward to taking the ferry out there. I want to thank Joe Finkbonner and Chair Joseph from the Northwest Portland area of Indian Health Work Staff and everyone. I want to thank Dean Seyler, IHS Portland area Director and all of the IHS staff for all of their contributions. I know through these sessions you're working on strengthening our government to government relationships and excited to be calling in. I understand this is like the Southern area of working sessions. The last one was on March 31 and I guess you guys talked about over 20 topics. I'll just speak briefly because I want to hear from all of you. And just to give you all a little update about some of the things that we've been working on. We have five priorities that we're working on including the _____ and care, improving how we deliver services, addressing Behavioral Health issues, which unfortunately is always big issue in Indian country, strengthening management, bringing more quality and expertise to IHS and engaging with all of you of course with all of your priorities. We have some new staff announcements that I wanted to let you know. Many of you may have met her Emerald Janis _____ our FHA Clinical Officer. She _____ and then the other thing was I know many of you may have known him for many years, Richie Bernal. He worked at IHS for over 30 years and he recently retired from the agency. So we wish him

luck. And Emerald _____ is actually still is the Oklahoma area director but she has also graciously agreed to be the acting deputy team community director for the _____ taking over ____ Bernal's role. I'm sure you all may know him already. I look forward to you all are working with him. ____we want to deliver high quality car and we're taking a very close look at it. This is a short-hand way to say business. We need to be transparent and look at things and I always say if we're not talking about things then we're not looking to address them. _____ we find them, we fix them, one of the things, when we started with the monitoring of all our 26 hospitals. I know there's not one in the Portland area but I want to make sure that you are always in my thoughts very important and I know you all have one update that's really exciting as you all obtained an Oregon dental pilot project and I guess it was approved in February 2016 making it the first dental pilot project approved by the State of Oregon. This is really exciting. I applaud all of you. I have met with a lot of you either separately or maybe in a small group and I always recognize the innovation that's going on in the Portland area. It's always very exciting for me to meet with all the Tribes in the Portland area. One of the other things we're working on is improving how we deliver services and we did announce on September 20th expanding child health and we have a new contract in the Great Plains. But to me, I had a talk with some of you about this. I think child health here is one of the one of the major priorities for all of the Indian Health Service. It's a way to get specialty care to our patients and I know that all of you think about this as well. One of the exciting new announcements, and I think are the first to hear that we've been working on trying to expand child health in the Portland area as well, and one way we're trying to do that is link up the VA facilities with IHS facilities and we, I think have reached the point where that's operational, and Dean, you can correct me if I'm wrong but I would like to do more of that for all of our IHS but you are all trailblazers in that. I don't know, Dean If you guys want to talk a little bit about that.

Dean Seyler: Yes, we had a Western Oregon Service Center. We've been working with… down in Chemewa but the agreement with the VA and having a tela-Behavioral Health for American Alaskan Native Vets who have that service-connected disability. We've already done some test connections. Those that work fluctuate. That is depending on the data stream going on at the time of the network but we are definitely excited that this up and running and we're working on things and this will be the template that will be used for the rest of the Portland area. And definitely I'll share with Tribes if they're interested. And also, the template will be shared by the rest of the _____ throughout the other area.

Mary Smith: Thanks, Dean. That's very exciting for you all are leading _____ Portland area and this took many hours of work. It was probably harder than you would think that it was but getting exciting. I'd like to see more of this collaboration with the Department Of Veteran's Affairs because we're providing health care to the Native Americans. It's important to us particularly also I know many of you are veterans as well and Chair Joseph is and it's important to us to have those collaborations with the Department of Veteran's Affairs so that we can provide the services to American Indian veterans. Another thing that I'm working on is these Medicare and Medicaid pilots. And we did them at hospitals but actually we're doing pilots to try and sign up American Indian and Alaskan Native American for Medicare and Medicaid, and I've been traveling around and just last week I was at Phoenix Indian Medical Center and we did a great event. It was the first Indian market of the season. We're trying to get the message out that everyone should sign up for everything they're entitled to. I know people of Indian country they say well I'm eligible for IHS, why should I sign up for Medicare and Medicaid? And I say yeah, well, you may be entitled to IHS but you may also be entitled to Medicare and Medicaid and I

think that Native Americans should sign up for everything they're entitled to. The stories are really powerful for claims that IHS might not be able to provide. We had a mother who was with us out at PIMC of course she signed up for Medicaid. The father of her children had an accident with his hand that required surgery, which cost over $25,000 and then she had six children and actually for 8 years they were trying to pay off that debt for that surgery. Recently, the folks at PIMC said to her you and all your kids may actually be entitled to Medicaid and as it turned out they were, the entire family. So they were able to sign up and then shortly thereafter, the mother herself she had some issues with her thyroid. She needed ultrasound and then one of her daughters had a traumatic event that required some medical assistance as well and Medicaid paid for all of that. They're really powerful stories. The result of all these pilots we're going to be using for best practices and roll them out in all the areas and I want to congratulate the Portland area because you all exceeded your targets for FY15 third party revenue and were able to collect over $28 million in third party revenue and work with. The impact was that the area was able to hire 277 staff in six of the Service units. Also, implemented _____ Internet protocol system to improve power of communication with the patients. In addition to the greater care that our patients can get, it really helped directly in your area. One of the other things where I mentioned in Behavioral Health and I do want to mention, and I know you are all are at the forefront living in the Portland area open for comments, Community Health Aide Program and I know that Chairman Cloosby of the Swinomish Tribe. I know they're implementing that in Alaska. And the comment period ends next week October 27th, I hope you all can get your comments in because again, I think this was a way for people to get a greater access to health care and then in addition the one thing about this program is that it is community based. A lot of the community health aides, I know the dental aides have gotten a lot of publicity but it includes the dental therapists and obviously the dental services are extremely important, particularly for the young care and I'll quote our Chief Dental Officer ____ tells me that a little work for them is too little too late. If you bring your kids in at the age of 2, you should have been doing that earlier for dental care. The community health aides also include Behavioral Health aid, primary care, maternal care, and the way this program has been implemented in other areas. If these community health aides are… the word community is there for a reason. They do come from the community. They are ready for people to be inducted in locations that they serve. The way that it is implemented in Alaska is done on an area basis. I think the way this could… if we do our work at IHS, I think that each area can customize the program to whatever works for you all. It's also, a way to create training programs for people in the community, establish programs with community Tribal colleges, or universities as well. I'm hoping that I get some excellent comments from the people who I know have a lot of knowledge in the Portland area, like I said the comment period closes next week. Also, I want to mention a few things that are in our budget and just to stop for a moment and let you know that currently we're operating under a continuing resolution as is the entire federal government. That continuing resolution goes through early December and at that time, we're hoping that there will be ominous bill and we're hoping at that time that you'll get fully funded for our budget. In our FY17 project that we hope will be considered in December, we've asked for $402 million increase for IHS and there's a lot of key initiatives in there including investments in our IT system, $20 million integrating the Behavioral Health into our Primary Care, other IT investments. We also have several Behavioral Health initiatives and a couple I'd like to point is one is a new very exciting thing. It's a $15 million to create a new Tribal crisis fund and this will be mandatory funding. This is not a grant program. This would be to include Behavioral Health crisis in your community and that could be a number of things. That could be opioid or prescription drug abuse that could be suicide, whatever it is, a Tribe would be able to declare it

and essentially a Behavioral Health crisis in their community and then be eligible for these funds to provide resources or staff and other resources. If I really _____potent new initiative, one thing we all know is that grant programs don't always wind up as to when the assistance is needed. The timing might not work out and then this allows more possibilities because it is not a grant program. I know that you all are working on a second rebuild youth treatment center in Portland. _____ in Spokane and I know consultation was done over a two-year period and that's exciting to move forward on that. We're also working to strengthen management. We're working on a number of HR issues. I know some of you participated and you actually went before NCAI started. We actually did what was called a World Café and that was an intense listening session. Both short-term and long-term were important issues. We had a lot of great travel participation as well as NCAI and NIHB and others. We will be putting out your report of the ideas that were generated by these Tribes and the one thing that session I intend to say it was so energizing because is that the only way things can work with IHS. We cannot do it alone. We can only do it with you all side by side with us working together and it truly was a day of partnership with our Tribal partners and IHS generating these ideas. Be on the look out for that report coming in the beginning of November and it should be exciting and I do want to recognize, Management and Operations of the Portland area, I know your Portland area Immunization Program received an award for vaccination coverage from the CDC and it was an award for updating progress for helping people 20/20 goals in adolescence age 13 to 17 years. Congratulations, that's exciting news.

We're also working to bring more quality to IHS one thing I want to point out we do have direct quality framework out for Tribal comments, which closed two weeks ago. I hope that you all put in some good comments. We did do some improvement consultations. We did one in NIHB and we'll be looking forward to giving a report on that as well. Then finally, I mentioned efforts on Self-Governance and I want to thank Chair Joseph he's Chair of our Contract Support Working group and I am really excited to announce that we have and will be putting out very shortly a new Contract Support Cost Policy the first policy in in ten years. Again, the only reason this works is because it was IHS and the Tribes working together Chair Joseph can attest from those meetings was difficult but again, we have to address the difficult issues and work through them and I think that we did. I think the policy is a significant improvement. It's not to say that they aren't more things to work on but I'm excited about the new policy but the groups… that there's more work to do and they actually set a date next February to meet again. Be on the look out for the new policy. We're going to do some training sessions on it as well. Again, our fiscal 2017 budget also fully finds Contract Support Cost to make that mandatory starting in that FY 18 budget. And I just want to close by giving special recognition to Andy Joseph. He served on the Contract Support Cost work group and the IHS Budget Formulation work group and his leadership and partnership has really helped me personally. And all of the goals at IHS and really raised the level of services we can provide for our patients including the veterans, I want to thank him so much and thanks to all of you in the Portland area. So thank you.

Andy Joseph: Thank you, Mary. We probably have several people that would like to ask questions. I do have a few questions that I would ask to on behalf of our area. On the budget the Portland area, we don't have any hospitals and the Senate side they're recommended not to give an increase in Purchase in Referred Care and to me that means doing more work with less resources because the cost of providing services goes up every year. So when they flat line a budget line item that a Portland area always makes a lot of funding in that line item. When it gets flat lined to me that cost our people they

end up having to live in pain longer than they should. Sometimes, they need these procedures that keep them alive. To me, I really am interested in the community health aide. Of course, I believe that Tribes are all equal and that Direct Services Tribe should have the equal access to those programs like are all equal. Direct Service Tribes should have equal access to those programs like DHAT. My Tribe and my neighboring Tribe one time ago, declared states of emergency on suicides. So I can see where mental health aide therapist would come in really good because they would be more like on the ground providers that could go out and do more prevention work. I really like that idea. In addition, I know there's a lot of funding sources that are… And additional staff being deployed to the Great Plains and we're wondering where the funding source for that is if it's taken from any of our area… What we have. Let's say we have your similar issues… The Portland area is always pretty well run. We have those needs as well being funded with such a low rate compared to any other federally funded program. We're all impacted one way or the other. One other question is if any of the Area Shares are being impacted by the IHS realignment efforts. I know it did have a brief meeting at NCAI on realigning IHS Headquarters my ____ to me, I think just looking at the re-org Chart sometimes it's really good to realign and I did mention that when I was at that consultation or meeting. One more thing is the information on the CMS contract, the Health Insight. We understand the contract will support best health care health practices in other another operational improvement for Indian Health Service, I just think the government operated hospital that participated in Medicare program have… I know our board probably has better questions as well.

Mary Smith: Thank you. Chair Joseph you had a number of things _____ being offered. First, I want to say in terms of resources to the Great Plains, the one thing I do want to say not in terms of funding per se _____ taken from other areas, or one type of resources that were used were people and we did deploy people from other areas. I know a number of people were deployed from the Portland area and I'm sure there were many people that I know that Johnathan Merrell was, Marcius Martinez there, and so I'm sure that Dean I'm missing others you know many of the others _____ I thank every single person who did that the personal sacrifice and it was much needed. I do want to thank all the Tribes in the Portland area for allowing us to "borrow" some of your key people for a critical need and I do appreciate it. I recognize it as is puts a strain. We were always committed to giving those people back as soon as possible and I guess the one thing, I always say is that we are all one system if the Portland Area needed help, we would then help too. There was no other budgetary impact on that. So I wanted to be clear on that. I think the other comment was regarding the realignment. We did do a call on September 29th and we did put proposed realignment at IHS and the reason for this is as, you all know, we number of challenges at IHS, in fact, over a week ago, we had two more Officer Inspector Generals reports of quality or care issues at IHS. One of the things they talked about was oversight and accountability and actually providing support to each of the IHS areas so that they can deliver high-quality care. In response to that, we wanted to create greater lines of authority at Headquarters to do that. One of the most significant changes is that if you look at our current Org chart and all these things are up on IHS website and if you're not able to find it there, I'm sure Dean can point you in the right direction or give you the materials. A current organizational chart has all the senior team. I did what we're calling the Big Box and we can't be more part of or organization or responsible for it. To me, every member of the senior team is responsible for a portion of the organization and amongst us all; we're responsible for the entire thing. We wanted the organizational chart to reflect that. In addition, the one thing, the reason we have the World Café was need. We're basically in a crisis and this is not just in

the Great Plains. This is everywhere on Recruitment and Retention of people at IHS. One of the things we did present at the World Café is we did a presentation on our vacancy rate throughout IHS and we did every area so Portland was on there. I don't think I have it front of me but suffice it to say that there were more than we would like vacancies in terms of permanent staff positions. We do fill those with contractors but I think our goal is we want permanent people there in all of those positions and _____ there's not enough medical staff. IHS operating in rural areas and Tribal communities, they took those challenges and they also have challenges with our nonmedical staff. One of the other changes in the realignment is to create long-term workforce development position and that person would really look to bolster really improve our scholarship and repayment program. Work to establish partnership with Tribal colleges and universities. It would include nonmedical staff like maybe helping with finding a pipeline IT people or other management staff. Those are some of the things, it's the one thing that I _____ question Chair Joseph was if this was going to be impacting Tribal Shares. No, it's not impacting Tribal shares at all. In fact, I think our intent is that this would be seamless to Tribes, this is more of an internal organizational to provide greater accountability and oversight for IHS staff and the intent of is not to have any impact to Tribes at all. We have it up for comment and we've gotten some requests so we can be totally transparent for a longer comment period. We got a letter yesterday, just to let all of you know, because I like to be transparent, we got a letter signed by pretty much almost everyone. We got… NHB signed the letter Self-Governance Advisory Committee, Direct Service Advisory Committee, USET and I might be missing another group and asking for an additional 60 days for the comment period. But again, it's not and impact on Tribal share. Again with one other thing Chair Joseph asked about was PRC, yes, would love to have a real discussion with Tribes about the PRC program. I would like it to serve more people. I know one of the ways we can do that without even altering the program itself is by signing people up for Medicare and Medicaid because that then frees up PRC dollars for other things. I do recognize that you all in the Portland area, especially for the last several years that you do not feel that the allocation there does not meet your needs. It would be helpful not only for the PRC working group to have a real discussion about that because to me, Indian Health Service as a whole needs to have a focus where prevention and preventing conditions and promoting healthy lifestyles and I don't think that the message we're sending the way of PRC system is set up now. I'm glad you raised that Chair Joseph I would be more than happy to have a discussion with all of you. We've been actually thinking internally about PRC from some of the things we've just even added around internally. We have these CHESDA service area and in some ways they're somewhat arbitrary. It would be interesting to see what we could do with regional model that would require more funding but again, I'm open to brainstorming and thinking about outside the box because the goal for me, and I think everyone that IHS is that we want to provide the best care and access and improve access to care for all our patients. I think I hit upon most of your points Chair Joseph and thanks again for asking.

Andy Joseph: Thank you. We're open to questions.

Cheryle Kennedy: Good morning. This is Cheryle Kennedy. I appreciate your being available to respond to questions and to offer your update on what's happening with the Indian Health Service. I appreciate that you mentioned the aggressive collection rate that the Portland area has.

Mary Smith: I'm still here.

Cheryle Kennedy: I appreciate your acknowledging the Portland area's aggressive collection rate for alternate resources. But if you work for other areas, or really in the position of the Portland area, you know that we're the PRC dependent area. And in doing so, we would not be able to achieve and to meet many of the needs of our patients, if we didn't do that. I think that if you look at the other areas, they are perhaps not as aggressive as collecting as we are because their needs are met through a greater degree than ours are. I like the idea then you just said that perhaps by region we can take on a pilot project. I feel that's a good effort. I would really like to encourage you to work on that model so that the demonstration of what it really takes for this area and others who dependent on patient PRC to be served at the same level. I believe that really is truly addressing the access to quality care issue that we have. I just wanted to comment that on the Plains Tribes, I believe that all Tribes should be funded at no less than others. According to the agreed-upon Tribal shares formula, I believe everyone should be at least at that level. But more so when I think about the responsibility and the Trust Responsibility that the federal government Indian Health Service has towards its people, I don't hear that said a lot when I hear the Indian Health Service officials speak. I think it's really the Trust Responsibility to aggressively pursue all funding at our level at every level and other agencies to make sure that we get what is owed to us. It's been a while since I've heard what the level of need funded across the United States for Indian patients is but I'm sure it's still very low because I can feel the strain in our Tribal clinics and with our patients who still get and go on a waiting lists in many of the areas in the Portland area. It's something that we just can't ignore and say well, we'll do better next year or maybe there's another model that will be better. We know all of this takes funds. The funding needs to start at the top. I believe and I know many other Tribes have said this as well, that we need a Tribal liaison who is established to work with ONB, to look at all the marks that are coming in, and to aggressively earmark those dollars that we need to be fully funded. I think you only have to look at Medicare and Medicaid through our entitlement programs and to see that big glaring gap between what they're funded and what we're funded. I don't think anyone could feel good after looking at that to say that we're doing the best that we can. I'm not demeaning you or your work. I know you stepped into position that has carried this legacy since the 1950s. We have to learn how to get out of that entrenchment and to address things in a different way. I do believe that there needs to be flexibility in funding to the areas. I know that Self-Governance we're able to do that, before all the Indian Health Service units need to have the same requirement. I think that the line item approach doesn't meet the needs and I'd like to see Tribes take a look at that and to provide their recommendations. I don't want to take up too much of your time but again, I appreciate your paying attention to the Northwest Portland area and listening to our comments and providing responses.

Mary Smith: No, thank you very much. I totally agree with you. I agree with everything you said. You look at our per capita funding is like $3200 per capita, which is much lower than federal prisoners, certainly much less than Medicare and Medicaid and the VA frankly, and I think people estimate it like at the 35% title of need. The other thing too is that I encourage all of you to read the OIG report because again I'm all about transparency and discussing the hard issues but one particular item that stood out to me one of the report send to me. It said that over a 15-year period, the population that IHS serves had increased by 70%. The Native-American population is one of the largest fastest growing population in the country where our population increased by 70%, the overall, US populations during that same time period increased by only 32%. It is a challenge. I hope that we can all work together to address those issues because believe me, I want every single one of our patients to get the care that they're entitled to

and the government has responsibility for. I know that there's a lot of great stories out there. I know there's a lot of innovative things being done in Portland but I'd like to see more. Thank you for your comments. I totally agree with everything you said.

Cheryle Kennedy: You're welcome.

Brett Simcosky: This is Brett Simcosky with the Jamestown S'Klallam Tribe. I'd like to echo what Andy said and as that we're really very supportive about the Community Health Aide Program. I was actually in Alaska for a few years and we implemented that program. It really does provide additional services and wrap around services that are not being provided by other health professionals. While I think it works everywhere, it really works in rural areas. It really, really helps in rural areas. One of the things, as you probably know that they did in Alaska is they _____ the professionals or innovating _____ certified and trained properly, they made health service trained and certified local professionals in the State of Alaska be accepted that certification. I know that… I don't know how fast the Indian Health Services is able to work on this but I hope maybe we could add some flexibility in the area offices. The State of Washington just had their 1113 Waiver approved and they're starting to work on their State plan for 2017. I know they're trying to place in that State plan a number of different levels of community health aides. One of the things that's coming up is how we serve Tribal health aides and how do we train them and do it all properly. I would hope they would be some flexibility that possibly in the area office that can be involved in these conversations. How do we have certification that make certain that we have had what we have trained and certified staff but also that the states accepts those certifications?

Mary Smith: Thank you so much for your time and we're hoping the we'll get all the comments and _____ because _____to each area to implement it, whatever meets their needs and I'm glad you pointed out that the program is certified according to the needs in Alaska. I think what I've heard from the Alaska people is basically _____ quick way of basically working for us, don't change what we're doing. That's not the intent but the intent would allow each community to decide either what would work for them but a baseline and standard. Thanks for your comments on that.

Tracy Rascon: Hi, this is Tracy Rason with the Makah Tribe. I wanted just to mention… I don't really have a question. It's just more of a comment. We've gone into that where we'll get everyone on Medicaid and Medicare being back in 2008, 9, 10, and we're really good at getting people on. Their problem is though that we can't find anyone that will take them when we need to send them out. So then we end up just paying retail for it and using PRC because no one will take our Medicaid patients. We've even had to buy them insurance for the exchange just because they… We can't even take our patients. It generates revenue for us and that's all good and well but… We struggle with that. That's all I have to say.

Mary Smith: Thank you for raising that. I'm happy to follow up on that. I'm sure that Dean is as well.

Cassandra Sellards-Recks: Hi, this is Cassandra Sellards-Reck. I appreciate your comments, Mary. You were on the phone with us a couple of meetings ago when you talked about Indian Health Services

Hospitals and losing their Medicare and Medicaid certification. I just wanted to share. I'm a nurse by trade. I work in the ER in Portland, a big hospital in Portland. I take care of some Tribal members, not in my own Tribe but in other many non-Native Tribal members. Many of them are from the VA. When they can't get into the VA because the VA is not accepting ambulances anymore, they come to our hospital. We see lots of them. The consistent message that I hear is they're grateful to my hospital because the VA isn't nice to them. I have really concerns. First of all, I have concern with telehealth I know that there can be some positives. But I really feel that's _____ on a bigger problem and they our Native people deserve physicians. They deserve practitioners. They deserve the health care that they were promised in the treaties. They deserve those things. We need to put a screen and a stand and stick it in front of an elder or somebody who's been to war and from the VA saying that this is the Behavioral Health solution in your area. It's really not a solution. It's abandoning a temporary problem. I'm hoping it's not a permanent solution to a problem. If you're going to have telehealth at a system that's already tasked that doesn't serve its members in the VA, they have long waits. They have long issues and there own veterans aren't getting assistance. It was many meetings ago when we heard that the VA had issues and weren't meeting the needs of the veterans. I don't know how to share the enthusiasm about having the telemedicine, if you aren't providing additional resources to the VA but just asking them or getting them to agree to another thing for them to do. I guess I would be interested to hear about those resources and how they're going to get additional health so that now that they can serve the Native population. I just don't feel like that that's the solution. The solution is bigger than that. Another thing I guess it would be important to get an update on how the hospitals in Indian health is in the whole. When it comes to those hospitals that are closing down back East because I'd be interested to know what the cost associated with all of that is. What are all the people in those places going to do for a job and then also that's adding to the burden of purchase and referred care. Because all those people who used to go to the Indian Health Hospital are now going to go into the system and the government is not going add money for purchased and referred care. Now we have lots of Native people who are not getting health care, or they're going to be getting their health care at somewhat of a cost and that increases a burden for the whole system. Then again, it's even more stressed than it ever was. I guess that's an important piece for legislators who are approving our Budgets to understand if that burden does happen. I think as a whole, I think it's wonderful that you had a World café and looked at some of those things. I think there are solutions around you and you should look at some of the top performing hospitals and health care units that are performing who have excellent standards. Who have customer service, that's one thing that I think that's really important is that we forget… that IHS forget that Indian people are customers and if they're treated like that, they're treated with that respect and that dignity that then that will help them change. They will be able to incorporate that into the care that they receive and that can change people's lives. That's the fundamental thing I feel like as a nurse when I interact with people is to treat them with dignity and respect and I can be the one person that maybe can help them in their lives and maybe that can be life changing for them. Especially when they come in and are so down and out and I feel like the VA system can improve in that and I'm not sure that I'm comfortable with my Native people going into a system that's already tasked. Those are the concerns I have. I thank you for being on the phone. I was excited to be able to see you in person but maybe another time. Thank you.

Mary Smith: Thank you for comments and I really appreciate your comments and I thank you for pointing out an important thing that we do have had a lot of challenges and I have to say a lot of

challenges and we have are not just at IHS. There's shortages, of medical personnel in rural America and generally and we see that acutely as well. I wish there was one stable answer, one magic bullet that would solve all of our problems and there's not. And so I think when I say telehealth, when I say accessing additional services at the VA or two things to think about but they're not the total solution. Unfortunately, we have to have a number of things that we're working on and we are. Not everything's been built for everyone as you point out. Not everyone's going to really feel comfortable with telehealth and that's perfectly fine. Because like you said, the patients are the customers. For people who we can provide additional services _____, it really makes a difference and even _____ IHS _____only 16,000 consultations on Behavioral Health or child health so it has already provided a lot of help. Like I said, we're going to use a number of strategies. Not any one strategy is going to be the perfect solution or fix everything. We have to throw everything on the table and keep our mind open and be creative. But I appreciate all your comments and all of service that you have in your background as a nurse. Thanks so much.

Marilyn Scott: Good morning, Mary Smith. This is Marilyn Scott and I'm a Council member of the Upper Skagit Tribe in Washington State. Thank you for joining us this morning. I have a couple of comments and one is I'm encouraged to hear that Indian Health Service is prioritizing and recognizing the need within Behavioral Health within the communities and the recognition of their services that we have not always been able to address in our communities is Behavioral Health and the focus is always primarily with the budget. We're very under funded as it comes to helping our people that have Behavioral Health issues. I'm hoping to hear a bit more about in the future, the near future the new initiative that you shared with us with the Tribal crisis response fund and then what is not working with the grant program because many of our specialty programs that we in health service get funded with becomes a grant program. Then it's not sustainable. It may be available as it relates to crisis with suicides or other issues. But it's not able to be maintained. It's short-lived. The other comment that I have is around the potential expansion of Community Health programs and Behavioral Health is an area within that expansion that we really need to consider as the Behavioral Health agenda moves forward. We are all facing crisis within our communities with the opioid and heroin addiction issues and without having the Behavioral Health and the culturally appropriate specialists that actually are community members helping our people utilize the cultural strengths that they may have and the connections where their traditional cultural traditions. In some sense, many of the Behavioral Health providers, the credential and licensed providers in the outside Tribal communities just do not understand the way the people need to be able to utilize their own spiritual and internal cultural strengths. And having those specialty Behavioral Health community specialists to help our people get better and recognize that there are strengths that they have and that can help them move forward with that. I really am encouraged that Indian Health Services recognizing and acknowledging the area of concern and Behavioral Health and potential for expansion. We have been successful here in the State of Washington working with the State with Medicaid and because we do not have hospitals in the Portland area, many of our Tribal members when they deliver our babies, they are seeking their care through the Maternity Support Services with Medicaid Eligibility in many cases. But we have been able to successfully been able to give the community health representatives recognized and be able to get reimbursement for maternity support services for our CHRs the Tribe's staff within our state. It's taken a long time to get that recognition with the State and the waiver and the State plan that the State has. But the Tribes have been successful in that area. And also able to get our chemical dependency professionals recognized as

an eligible team member that in some cases make those referrals when we have a high-risk mom that has need for Behavioral Health services and able to get those individuals into the care that we need. It takes some work but I really hope that the recognition also for Indian Health Services for the innovation of Tribes in the various areas for the Tribes types of facilities, BPL Tribe has opened their oncology center. They have traditional healing as part of that program and it's an opportunity that we can utilize the benefit. And addressing the long-term care needs of our area, the Colville Tribe having the long-term care center but struggles with the ability to keep the doors open and meet the needs of our elder and disabled population in our community so any support in Indian Health Service can provide to recognize the innovation of the types of facilities that meet the needs of our Tribes in our community and the Community Health programs and to serve the patients that we need to get our caregivers in our communities to be able to get the reimbursement. Thank you.

Andy Joseph: This is Andy again. This kind of ties in with what Marilyn was talking about in her traditional practices. I also am a delegate to the Healing Lodge of the 7 Nations it's a Youth Treatment Center and I know California should be coming on line soon. I'm hoping that you can help. You could probably strong arm Kitty Marx to the CMS office to look at doing an inpatient encounter rate for those youth treatment centers. When Pam Hide was in charge of the SAMSHA she state that the Healing Lodge of the 7 Nations was like the role model, youth treatment center in the whole nation. The success rate there is really high compared to than any other youth center out there. I would just say that's because of our traditional practices and the music and the different ways of healing. It's more of a therapeutic model. It really impacts the children that are there. We had a deal with the 16-bed issue and there's more beds there. And then we also had to deal sometimes with the State and instead of dealing with the State, I would recommend if you could help us out and do an inpatient encounter rate through IHS because it is an IHS facility that would not only help the Healing Lodge but it would help California. If we get another treatment center here if it's for children or adults, I think that it would be a step in the right direction to our traditional practices that would be used. I guess it would save the government a heck of a lot more money… To be a successful treatment center versus going to one where they don't have any of our culture. I also on the about long-term care, we worked pretty hard at that into the Indian Health Care Improvement Act we'd really like your support and help and try to do like the Crow Tribe did. They went in with State and they got an inpatient encounter rate with their long-term care facility. I think that it needs to be an IHS encounter rate not something that the State would recommend to the Tribes because the IHS encounter rate to me would be at a higher rate. Plus it would protect the Tribes with the current Administration that come with the federal encounter rates. It's really important that we try to do something before the end of this administration. Right now, the Puyallup Tribe is actually working with the State on an encounter rate for our rest home. Thank you.

Mary Smith: Thank you so much. I just want to say that if Dean you're already working on this but if not right now Dean to follow up you mention Chair Joseph, Kitty Marx at CMS encounter rate with CMS and follow up on that.

Dean Seyler: Yes, I think that Dean will follow-up.

Mary Smith: Okay.

Andy Joseph: I'm not seeing anymore hands go up. There's one way back in the corner there.

Tim Gilbert: Good morning. It's Tim Gilbert, Umatilla Tribes. It turns out that's all I have an easy question for you. Has the Indian Health Service rescheduled their National Awards Ceremony?

Mary Smith: Yes, we have. I actually I don't know we rescheduled to December. I don't know if _____ actually knows because I don't have an exact date in front of me.

Male: [Unintelligible].

Andy Joseph: Okay, I'm not seeing any hands now. We really want to thank you Mary for taking the time to interact with us and I really want to thank you for stepping up in the role that you're doing and it's been really… I guess more aggressive and in the right direction for all of our people, your help in saving lives and that's what we're all here for. Thank you.

Mary Smith: Thank you for the kind words. Chair Joseph and thank you for your service. Thanks to everyone in the Portland area. Thanks for allowing me to attending your agenda. I know you all have very important work for the people that you serve and I next time out. I want to be in there in person. I want say thanks again to all of you. Thank you, Dean. Thank you.

Dean Seyler: Thank you, bye.

IHS Area Director Report, Dean Seyler

Dean Seyler: Thank you. We'll really go through this fast. We're supposed to be on break right now. So I'll share the slide that Ms. Mary Smith mentioned about the recognition for the achievement of adolescent immunizations. Dr. Weiser is more familiar with this than I am but he did attend the recent National Immunization Conference where he picked up that award and that is a testament to the work that the Tribes are doing here in the Northwest, the local Tribal facilities and the federal sites. I don't know if there's anything that need to be mentioned, special about that Dr. Weiser. And then of course, we've got the new adult immunizations measures for GPRA and that's going to establish the base.
The CHEF balance this year 2016, what I wanted to share was that there's still some money sitting there at headquarters with us, which was the third year in a row. There's been a CHEF balance. But I can tell you that the staff there in the Portland area office have been diligent in their work and meeting deadlines and making sure the packets are as complete as possible. As you can see, we have had $1.6 million of claims that include not only the two federal sites of PRC but also the Tribes, and now at 1.6 million, 1.3 million has been recovered and returned back to the Northwest Tribes. More funds to address health care issues.
The PRC area Risk Pool set up and that's the last time was when Doni Wilder had established a risk pool because CHEF it's an area CHEF area pool. It has not been tapped into for the last two years. We had about $450,000, which should be back out to those Tribes who were part of that risk pool. Not everyone was part of that but for those who were in there. Somebody check and talk with those Tribes and get their comments and thoughts about these _____. If you want to continuing with that, or

would like to do that but that's just funds. That's not in their initial pot of the funds that come out at the of the end the year.
The Maximum Supportable Space that is something is being right there by our facility staff and I think in the interest of time because Richard's here today if any of you have questions please see him. I'm not going to go a lot into the GPRA that's coming up. This is more informational and I was actually, as you know, I try to get Dr. Rudd more involved with my presentations so you hear from him directly. This is all pretty much informational for you. If you have any questions, please feel free to see me after the break. Anything you'll see where are the charts talks about both about the federal sites and then the federal sites and travel site and how we did with GPRA. There is a fall Portland Area Clinical Director's meeting coming up. There's a lot of Tribal clinical directors that do attend that. So I highly encourage you to work with your clinical directors. The meeting will in be Seattle. Does anyone have any questions or comments?

Cassie Sellards-Reck: I just want to make a comment that there have been trainings for IPC that are really important for the Tribes who want to move forward with more efficient care and the Tribes rely on those trainings or the ability to connect and learn about how to do it a different way and those aren't happening. Have they been on a schedule, and where are those going to happen? It seems like a really important thing to improve patient quality and efficiency.

Dean Seyler: Are you talking about in the Area or National?

Cassie Sellards-Reck: Here at the Portland area.

Dean Seyler: So partly it has to do with Jonathan was deployed to the Rosebud Service Unit for 120 days. We're getting back on track. And I'm sorry, do you have any enter dates set up already Jonathan, or? Okay. You should expect to see an e-mail coming now either from myself or Jonathan. Lots of new dates coming up soon.

Sharon Stanphill: Did I miss when this Mrs. Murray is going to be starting?

Dean Seyler: No, you didn't miss it because I didn't say it.

Sharon Stanphill: Okay.

Dean Seyler: Actually, is I don't have a date yet. They're trying to negotiate or release the date from the Tucson area. As soon as I have that, I will get an e-mail out. Any others? Thank you for your time.

BREAK

Executive Director Update, Joe Finkbonner, NPAIHB Executive Director

Joe Finkbonner: Good morning, everyone. ____ so I'll just go through in the same format that I have. It should be a really short this time, as we've only had eight weeks between our last meeting here. New hires: Oceana Anderson is our new on-call assistant. She comes in here and either serves when our

projects are getting ready for big events or have had a lot of mail outs or if somebody needs additional help or even help at the front desk. Promotions, David Stevens, has been promoted to our Hepatitis C project manager and in the same project Jessica Leston has been promoted to the Clinical Services Project Director and Candice who has been with us only a few years has been promoted to the Research Coordinator. Congratulations to them. We have an intern, Jana Hodgins, PRT and is a volunteer _____. A little about meetings I've been to and give you a little highlight of each of these. At the quarter we had to go to our PHAB, Public Health Coordination Board Accreditation Committee. That's some of the subcommittees we had accreditation for and we actually reviewed the applications of what ____ health jurisdictions state and Tribal. I say that with emphasis now because we now have the first Tribe that's been public health accredited in the nation and that's Cherokee. Cherokee has done an amazing amount of work to get to this place and we all should congratulate them and whenever we have the opportunity to see them or have the chance to interact with them either electronically or telephonically, please send them congratulations because that's no small task to achieve a public health accreditation and they worked incredibly hard to get to this point. They deserve all the kudos that they received. In that same line, the National Tribal forum for excellence in Spokane, it was really an opportunity that National Networks for Public Health Institutes and CDC had convened for many State and local jurisdictions sections to answer questions about public health accreditation and those that are in pursuit of it. What was missing is that they haven't done that for Tribes. We approached them and said you need to have something Tribal specifically because Tribes have different questions and different issues surrounding public health accreditation than would states and locals. They took us up on the offer and Bridget Caniff worked with Red Star International and put on an amazing conference for 2-1/2 days in Spokane. There were great assembly _____ we had speakers including Kay Banner the Executive Directive for the public health accreditation board and my personal highlight is I got to reach out and interact with Dr. Michael Trujillo. Some of you may remember Dr. Trujillo. We invited him out because it was also the 20th anniversary for the Tribal EpiCenter. I thought it was appropriate for Dr. Trujillo to be able to make comments about that luncheon celebration again because it was his watch in when the Tribal EpiCenters were first established 20 years ago. We brought him out. I also, used that as opportunity to express my thanks and thanks from the Board for his service as the IHS director and we presented him with a cedar hat at that time as well. He is doing well. He misses the Northwest. He had a chance to connect with some folks while he was in Spokane and he looks forward to coming up and visiting more. For the Tribes that are looking for an MPH student. His daughter _____ for Dr. Trujillo. His daughter is MPH soon so she is focusing on international health so if you might have a cool summer project for an MPH student focusing on international health, she would love to talk with you about it. Native Fitness Health success again, we brought out the Tribal newsletter, you'll see some pictures in the back and it was very well attended. I wasn't there because I was at the Public Health Forum in Spokane. It was success as usual; rate attendance and everybody left there reinvigorated about approaching their diabetes programs and health education. In Portland, we had our WEAVE Annual Gathering. Many of you in the room have a project with our WEAVE and staff and you probably _____anything from returning back to your natural indigenous plants and foods or everything to QI processes within your clinic. It was about health improvement and uses the resources there to really focus on addressing chronic or improving patient care. I had the chance to go there and look at the boards and posters that were put out from all the products that were funded from mini grants from WEAVE. It's quite impressive. If you all have a program that's funded by WEAVE staff, I would encourage you to catch up with them and find out what they're doing because every bit of it was very

interesting and I thought very successful as well. Lastly, I was at the NCAI. I went on Sunday for all the consultations that was going on. I didn't make it Sunday. I lost an entire day of consultation on IHS issues and you'll hear more about that when Laura does her legislative report but the one that I will comment on is the CHAP program. But the CHAP Program consultation, if you were in the room, you saw that there was probably about 15 people in the room and of all but about two of them were from the Portland area. Obviously it's an issue that the Portland area Tribe are taking very seriously but also see the opportunity to create some extenders to their system using mid-levels and other high powered paraprofessionals to really extend their services they provide to their Tribal populations. I know that the Indian Health Services will have definitely have perspective in the Portland area not only from that consultation session but also I think many of you have written letters giving your opinions and input on how that program should be implemented when it comes to the Lower 48. I appreciate that. One thing I did leave off from here is also Washington Dental Services Foundation had its Annual retreat, which was the same day as our Indian Day Gathering in the square in Portland. I want to bring it up because it's a transformative meeting is the best way to describe it. We have… Brian Cloosby was there and Mel Tonasket was there and there were in the morning session panel along with Rachel Hogan. Dr. Hogan from the Swinomish they were in the morning panel. They really talked about _____ talked about how they're using the dental therapists in the Swinomish community and Dr. Hogan talked about the technical parts about how it helped, how they're being used in the clinic to really expand and really achieve top performance of all the staff that they're there because they have the dental therapist that's there to take care of the less complicated procedures and also to get into the schools and start talking with the kids about prevention and how important that was is a big part of the program as the actual drill and fill. That was really eye-opening to a lot of the folks that were on the foundation board because they think of this primarily as a person who is maybe out of high school that was going to drill and fill and provide substandard care and the comments around the table from a couple of folks were… Let me put it this way, a bit paternalistic. Also, they seemed like they were all saying that Tribes were willing to accept lower quality care. We had about an hour and a half discussion the following morning about that about that. It really was eye opening to them when we brought back comments from Brian about the importance of Tribes being able to address their own problems. And Tribes being able to develop a solution for their own problems, and that Tribes want what's best for the communities not just to leave untreated dental caries in our community. We talked about the quality of the system that doesn't address dental caries. That being the worst offender that anything they can make about the technical ability about the dental therapists who happen to do amazing work. Their fears were unfounded. They're paternalism was a bit offensive. They were really unaware of it. I specifically told them you are being paternalistic and _____ because they talked about it and they said yeah, we are trying to dictate to you how you should provide care to your community. That's not what their role should be. Their role should be to help gather resources and help share resources so that we can address this backlog. I think it was really worthwhile. I know that John phone's is probably been reading a bunch since that time because the dental services foundation is eager to do more work with Swinomish and learn more about how the dental caries program is working. I know that as… looking around and say these statements but, one of the things that's going on in Washington State is that CMS… Or I should say Medicaid Office is looking at to having a single provider by having managed care of oral health in Washington State and there will be a single person that's contracted to really be the insurance portion of that the manager for that. And Delta Dental is really is interested in that process. They're doing the numbers to see if financially it makes sense for them and they need the Dental Association to step in and be a strong

advocate for them if they choose to pursue that contract for the State. Here's the tightrope that their walking on. The tightrope that they're walking is according to the Dental Association in order to get that bid the Oregon State _____ but what they're forgetting about is that the Tribes also have a say so in that bid through Medicaid waivers and I had a chance to work with the State on its government basis and also through CMS at the Federal level to say we have some issues. The Delta Dental needs to walk this tightrope according to both the Tribes and the Dental Association because this works well for them. I had a conversation with John about this but I think now if the Tribes are really interested in getting dental therapy as a part of a provider's system that will be reimbursed, now is the time to start putting pressure on the appropriate folks that the Delta Dentals of the world that have influence with the Dental Association. Even Dental Association members that might be supportive, which there are some out there, there are some of the old guard that really is controlling the purse strings and supporting political candidates that are anti-dental therapy. I think this is the time for trying to really push that something that's important to you. It's really to identify those folks who are pro dental therapy and pro-Tribal sovereignty and put the pressure on them to step forward and start speaking out against the Dental Association and its opposition to dental therapy.

I would like to congratulate our Hood to Coast Team that they did the 199 miles from the mountain to the beach. They were projected to do it in 32 hours and some odd change and they did it in 31 and… Close to 32 but it was definitely better than their projections. It was a very good process for all of them because it gave them a summer of getting in shape and focusing on their health. I think that they are better off for it not only for individually but collectively as a team, they really came together and you can tell had a lot of fun doing it. Having said that, I think next year's Hood to Coast the applications had to go in the box by October 5th. The race is fairly over now. Just make your application for next year. In recent _____ their application again for Hood to Coast. We also submitted one for the Portland to Coast, which is a walking version of it, instead of the running version. Our team for the Portland to Coast was accepted. We have seven members now that are on the team but we need over 12. Any of you who are interested in joining a team from walking to Portland to the Coast contact us and we'll be happy to have you part of the team.

The upcoming meetings, I'm taking some time off at the end of October to go on vacation. Whether I deserve it or not, I'm going to go, October 29th to November 5th, my wife and I are heading to Cancun with a friend, which some of you may remember, Dr. Jeff Hagen. He has a place in Cancun and has invited… He and his wife have invited us to join them in Cancun so we decided we would do that. I still am on the Oregon Health Insurance Market Place Advisory Committee and the next meeting is in Portland. It's coming up in a couple of weeks and I've been invited every year at the Public Health Leadership Institute for North and South Public Health Practice to sit on the panel. It's really kind of fun panel because what they do on this panel is the students that are part of the _____ Institute get to ask questions with the different perspectives that are up on the panel and it can be anything. So I never know what it's going to be. I think they appreciate having ____ foremost leaders that Tribes the future public health leaders. The Tribes are in their neighborhood and they ____ work with the Tribes and I think that's one reason why they have asked me to be on there. Also, the Tribes have very sophisticated systems. There are a lot of things that Tribes are able to do and have the flexibility to do that many of their local health jurisdictions are not able to do. I think they find that appealing they definitely learn from their panels that are out there. I feel that they all have a chance to be… Have a staff go to this leadership institute because it's well run. So it's usually done pretty good by the Northwest Center. Bud Nolan used to head it up all the time. He is still doing a Northwest center of public health practice but

he's retired since CDC MDMPH. So it's worthwhile they do a good job. I will be at our December annual meeting for the Washington Dental Assistants Foundation and the Board of Director's meeting for the Public Health Accreditation Board in December which will be in D.C. and I also Northwest Indian College Foundation. Those will all be meeting in December. We are having our holiday party on December 9th at the office so if you all are around in Portland, please stop by and share with us. One other thing I want to bring up. With all this talk about quality and quality improvement, I'm bringing in a national speaker from Florida State University. He's a colleague of mine, on the Public Health Accreditation Board and he's going to talk to our staff about implementing the culture and quality improvement. We're doing that largely to sort the Tribes that will be going through the Public Health Accreditation. If you decide to pursue that, we know that we will be pulled in to some degree or another as some support for you. Whether it be epidemiology, or some of our health HPDP programs or workforce training programs that at some way or another we will be pulled in to that conversation that would help in your efforts towards Public Health Accreditation. We want to put our best foot forward by making sure that we have that culture of QI within our organization and we represent you well if they come asking us questions about what we do. You know that that's going on. Any questions?

Female: No questions but we have one more comment.

Joe Finkbonner: Yes, question.

Cassie Sellards-Recks: We talked to you the last meeting, having an update on CHAP and understating it more _____. We don't see it on the agenda. Will there be time for that? Some of us don't have time or attend NCAI and don't have the update and still have questions.

Joe Finkbonner: Sure, we have time at the end of today. We can definitely make time during the Executive session talk more about it and answer questions.

Cassie Sellards-Reck: That would be great.

Joe Finkbonner: Yeah. I also have one other I forgot our EIS officer has stationed with us for the next two years and that's Sarah Hatcher. Sarah, do you want to say hi to everybody?

Sarah Hatcher: Hello.

Joe Finkbonner: And the last time up in August, I gave Victoria her plaque for her 10 year but I have not given her blanket. So Victoria, can you come up, please? ____.

Victoria: Thank you.

Joe Finkbonner: Any other questions? Thank you.

Female: I have one.

Joe Finkbonner: Yes.

Marilyn Scott: Not a question but a comment that is _____ in the Public Health Institute and the effort that the Tribes of Washington have been doing with the Department of Health, Secretary Wiesman and Tribal Public Health and the emphasis that we have made has made a difference. But one of the things that I just wanted to share with you is that having Victoria with the Epidemiology Center because one of the things that the Tribes of Washington have been emphasizing is the lack of American Indian, Alaskan Native data within the statewide data systems and how can we integrate if the data that the Epidemiology Center has for our Tribes and incorporate that into what the State is looking at and prioritizing the state funding that they receive from the federal government. I just wanted to comment also that the effort of Washington State Tribes and leadership with Secretary Wiesman's support for recognizing, we have been able to get more Tribal programs in presenting at the statewide Public Health Association Conferences held in October. This year, we had six sessions that we were able to get included and we had the president of the State Public Health Association acknowledge the sovereignty and the Tribes of Washington at the statewide conference in the welcome address and the recognition of the Tribes being sovereign and the jurisdiction was included in the closing remarks that Secretary Wiesman had. It's taken a long road of effort to get that recognition but I think we're on the road of being able to improve information for the American Indian Alaskan Natives with what the State is doing.

Joe Finkbonner: I agree. It's been a long process. We may remember when we first started the American Indian Health Commission, one of the first things we worked on was the definition of Tribal health jurisdiction with Bruce Miahara (phonetic) when he was the Secretary of Health and trying to get that put into code and we followed Mel's wisdom and _____ put into code because then that would have implied that Tribal health jurisdictions would have been subservient to the State. It would fall into that whole dialogue and that chain. Instead we just used a working definition of our Tribal health jurisdiction and didn't codify it but it definitely has become more commonplace for leadership not only within the State but public health associations as well to recognize the Tribes in their unique role. Yes, it's been a long battle. Thank you.

Dean Seyler: Just real fast before we switch. I'd have information I've forgotten to share with everybody as it talks about money. As you mentioned we are the CR. There are 13 Title 5 Tribes that on the calendar year or fiscal year and we've distributed to 5 Tribes. When we get the balance _____ of the money we hand over the rest. It's for all the Title 1 contracts _____ end of this week. You should see a prorated amount through December 15th. Is that what it is Ann? Tthe CRs December 15th?

Male: 9th.

Dean Seyler: Thank you, 9th. So from October 1st to December 9th that dollar amount will be shown up into your guy's accounts probably by early next week, when treasury pushes it out in your bank and accepted. I just want to make sure and get that out there to let you guys know. Money's on the way. Thank you.

Joe Finkbonner: I just hope that I didn't skip over the slide was up there for Indian Day and I want to just say a few words. This is our Eleventh Annual Indian Day Celebration that we have in Pioneer Square. It really is just a mini Pow-wow and allows our organizations as well as other Tribal

organizations, Indian organizations and Portland does set up their wares and tell them what they do for the Tribal communities or the Urban population. Shawna and brother showed up and I want to thank Sean for being there. I'm sorry I wasn't able to be there because I was at the Washington Dental Services Foundation Retreat and I complained loudly that the next year so they're not going to have their retreat on the day of our Indian Day Celebration. I will be there next year and I welcome you all to come and I'll make sure we have plenty of others. It's the fourth Friday of September every year. Thank you.

Andy Joseph: Thank you, Joe. Our next presenter, we're going to have Susan Johnson HHS Regional Director for Region 10.

Region 10 Update, Susan Johnson HHS Regional Director for Region 10

Susan Johnson: Hi everybody. Thanks so much for allowing me joining you. I was last with you folks I think in Springdale in January. I just wanted to give you a brief update as to where I've been and what I've been doing in the last several months. What is before us, which is kind of like abyss for me, there are only about 10 weeks left in this administration so I want to start with my exit line, which is to say if there's anything I can do to assist with issues that are still ongoing, while we still have the Obama Administration until January 19th, catch me. Because I can get to the Secretary and try to use some last minute assists with issues that we could try to settle before we go into the post-Obama Administration, whoever that may be. Don't get me started on that. I'm awake at 3 am. I can just tell you that. But since last January, I have been able to visit with the Muckleshoot, Shoshone Tribe In March, Mr. Tino Batt were in Idaho in April, Spokane Tribe last July and several trips to Alaska visiting with many Tribal villages up there and it most notably at the end of the summer with Deputy Secretary Mary Wakefield, who took an entire week to travel up to Barrow and Fairbanks and out to Circle to a clinic that has no running water and then back to Kenai just to see some of the great new health activities going on in the peninsula. There's been quite a bit of travel back to D.C. several times just two weeks ago meeting with the Secretary and all the Regional Directors to help with the last push our issues key to this administration, notably is the opioid crisis that I know we're all aware of and several of the issues of funding that still need to be addressed with Congress. Congress did pass a nice bill that but there was no funding attached to it. So that's an ongoing fault in our effort to deal with that crisis in many of your locations. I mention a couple of things from our last consultation and as you know we worked in the meantime between each consultation to followup on the issues raised. So if it's not like Groundhog Day the same issues come up again and nothing seems to happen. We make every effort to move some of these issues ahead in ways small and sometimes large since they cross the country and are not just our region as issues. Notably continuing unfinished business still is what was referenced earlier, the IMD Rule that there seemed too many to be updated and speaking of the opioid crisis hithers additional treatment opportunities as we deal with that crisis. I brought that directly to the Secretary who brought it directly to the _____ in CMS when I was there. They are looking at whether CMS does have the opportunity and the ability and the authority to deal with that issue without congressional approval. As you can imagine that could be a _____ back there. At least 19 US Senators including our own Patty Murray and the Alaska Senators have written to CMS encouraging them to bring that rule into the 21st Century and deal with it under their ability to act and citing authority that allows them to do that. That remains before us as a piece of unfinished business. I would be interested in hearing from some of you

as I stay throughout a bit of this afternoon then I have to head back. One of the main issues of our consultation was about consultation and what is meaningful consultation, what is not a check the box activity with CMS, especially on waivers as states pursue different kinds of waivers and we've had a lot of activity in that discovery process in Washington State. And we're all looking at Marilyn who's been dogging and moving that ahead and also in Idaho and I'm looking at Tino and the efforts to lurch forward towards meaningful consultation and improve that in Idaho. I'm hopeful that we kept up the pressure. I will be in at an all day meeting on Monday up here in Washington and Dorothy will be there and others from the Health Authority. You can catch me there if there's anything I need to underscore and support that continues to be less than what we need it to be in Washington. I hope to be at one at Idaho as well before we reach the end of this administration on January 19th. I'm hopeful that things have gotten better but we know that words are just words unless actions follow. We need to be monitoring not just the consultation but also the ability to look for the ACHs to pursue real meaningful membership on board to those ACHs and I know that was raised. That's a continuing effort I think throughout the region especially, as I mentioned, Washington and Idaho. One of the things that I was most pleased about during my tenure with you the last seven years has been CMS, which we know is often not one of the more flexible organizations to move forward taking their new guidance with 100% FMAP that came out several months ago. I know that folks in Oregon perhaps have been working with Dr. Bruce Goldberg to move that ahead in a way to benefit Tribes in the state. Alaska certainly has been going through lots of activity there. I'm hopeful that will provide Tribes with a new avenue of activity and flexibility with CMS. That will be something I'll continue to monitor. We will have, as I mentioned, the Quarterly calls coming out in the next couple of weeks, I salute again the Swinomish Tribe for your DHAT Program. I think I'd love to see the headline that 10 additional Tribes have started their own programs in Washington and Oregon and throughout this region. I think it's just so emblematic to have such demonstration of Tribal sovereignty and I commend you for that and look forward hearing about that progress. In a similar way, the CHAP Program as Mary Smith mentioned earlier today having that expand to the Lower 48 and provide in different avenues for ways in which it can be amplified to provide services in all of our communities I think will be very exciting to see. I'm less hopeful than I was a year ago that Idaho will expand Medicaid expansion. I think there seems to be a lack of leadership on that issue despite the polls that show 60% of Idahoans want to do something to close that gap. But that will be a piece of unfinished business, I fear as I leave. In closing, I want to say that it's really been an incredibly personal joy and privilege to have served in this capacity for seven years with this administration. I think that the Obama Administration has been good to its word as it has pledged to work with you throughout the past two terms. I look forward to hearing that IHS has been removed from sequestration going forward with the next administration and that some of the other pieces of unfinished business can be finished. But we all have regional representatives to resign or retire as of January 19th. If there is a better Democratic administration that follows, it's possible I can be reappointed. We'll see. I would certainly love to come back and continue to work with you. I have been inspired by all of you and leave my visits with much more than I'm ever able to bring to you. I just wanted to say hello today and also goodbye. I hope that I might see you but I'll certainly be around if not in this capacity, and will always have you in my heart. Thank you so much.

Andy Joseph: Thank you, Susan. I know you came to Colville and one of our issues that was really pushing on our Tribe really hard at the time was staffing and you probably heard me talk about staffing. There is a standing resolution with Portland Area out of our Tribe's builder of our facilities and every one

of our Tribes I would say had been waiting and waiting and waiting for that priority list to have a federal government builder our facilities. Some of us couldn't wait and at the current rate, that's been on staffing from building the village, Portland won't see any facilities for over 30 years. So we continued having to wait for any kind of staffing and there is a resolution that we passed must have been 10 years ago and somehow working on getting staffing for our Tribes built, our facilities. Colville has built three of them. We're going to build another one soon and if we would have had joint venture if we would got picked, our largest district we would have got 115 new staff that would have staffed that facility right now. There's only 13. I think employees there. They're kind of borrowed from _____ service unit and _____. We helped write the Indian Health Care Improvement Act and there's so much opportunities for Tribes to be able to build more but I always say if we only have a limited amount of qualified, certified providers that could actually build, then you're really limited. I guess if… I'm hoping that we get a new democrat in there and maybe they'll follow what Obama did and have a stimulus program but I would hope that if there's a stimulus program that they would look at staffing all the Tribes to what their potential would be because we all want to be able to take advantage of those bills. If we can again, in our treatment center and a long-term care if you can help in any way in getting us an IHS encounter rate for providing inpatient care services, to me I think that would be a real victory for our Portland area Tribes and the Region 10. I think we should be taking the lead on that long-term care. The Crow already beat us to that but it would be good to get a really good deal for providing those kinds of services that provide a cultural way of taking care of our people. I want to thank you for taking your time to visit so many of our Tribes and I know it's been a real honor to have you representing our people. Thank you.

Susan: Thank you, Andy. Thank you very much.

Marilyn Scott: Susan, I just wanted to thank you for the support and the effort that you have done with Washington State and the Tribe's concerns with the changes that have happened within Washington… The Health Care Washington Initiative. But one of the things that you mentioned about the importance of consultation, I know that nationally the Tribal Technical Advisory Committee has worked on getting more involvement and oversight with the CMS innovation division and because Washington State is one of the states that has received the $64 million, 5-year innovation grant that is the foundation of the healthier Washington initiative and the establishment of the Accountable Communities of Health. But there is still lack of coordination between the 1115 Waiver and the opportunities that we have, the Tribes have and what is included in that 1115 Waiver that we know about 1915 B Waiver that has been integration of the Behavioral Health and into 2020 and the coordination of the agencies responsible for moving that forward and the directive that the state legislator has made. It still has left the Tribes out of the priority of funding and the press release that was recently, over a week ago that the State has been approved for the 1115 Waiver. But as the waiver was being developed, the Tribes are still not clear on how we're going to be able to be benefit from the new opportunities that are included in that waiver. So I just wanted to raise that so that your office can be assisting the Tribes of Washington as these waivers and as the implementation of the agencies appointed responsibility for moving this forward. I hope to see you at the Monday Healthier Washington Symposium. Thank you.

Susan Johnson: I think I'm between you and lunch.

Cheryle Kennedy: I appreciate the work that you've done through the years. I believe it's made a difference. I know that most Tribes struggle with the money that's there as their primary reason for allowing us to move forward with plans and you've helped tremendously so I want to thank you for your efforts and what you've done for the State of Oregon. I don't know if you… I know you came to Grand Ronde we had one of our consultation meetings there. It's been a few years ago but it seems like we continue to struggle in Oregon and you're right, Dr. Goldberg has, since he's been acting as a consultant and not in the position he had previously with Oregon, there's been some headway that's been made. I don't know what all the restrictions were within the State of Oregon that prevented him from making these moves while he was in the position. But we are making some headway now. It just seems to me that there is a real struggle with consultation and if the States would come forward with that with whatever time you have left, it would be very important to do so. The Oregon experience is really that… The Health Authority is doing their best to consult and there are meetings that are set up. But what we experience is that the real meat of how we move forward with delivering health care is left out. So we continue to have those struggles. I think the few that are here today from Oregon can witness that. We're still not where we want to be. If there's anything that you can do in your remaining weeks, we would appreciate that. I know that there is a meeting that will occur I'm not sure if what case that is I see Carolyn back there with Sharon but there will be a date for –

Sharon Stanphill: The 27th.

Cheryle Kennedy: Yes. Of October when we will get together so if you have any time, we certainly would invite you to come and listen in and help in that process. I know that many, many different ideas have been given to the new director but things don't seem to run like it should. We understand that in Oregon our numbers aren't up to the degree that Native Americans are in Washington and so it seems like that gives the Executive Director permission to de-prioritize our needs so. Anyhow, that's what we face. So I do appreciate you work and getting to know you throughout the years.

Susan Johnson: ____ but I'm happy to call and to check with you ____. Thank you. _____ I'm speaking in Tacoma (phonetic) but I'm happy to call and to check with you _____.

Committee Meetings & Working Lunch

We R Native Update, Stephanie Craig-Rushing, Suicide Prevention & PRT Project Director

Healthy Native Youth, A one-stop-shop for educators who want to expand learning opportunities for AI/AN youth

Workgroup Goal

- Gain insights and connections to support the dissemination of culturally-appropriate sexual health programs to AI/AN youth.

Website Goals

- Provide tribal health educators and teachers with a one-stop-shop to access to age-appropriate, culturally tailored sex education resources for AI/AN youth.
- Prepare tribal health educators and teachers to deliver this content.
- Measure the reach and impact of our efforts.

Several graphs please review PowerPoint for further information

Effectiveness study: by the numbers

- ❑ **2** study arms: Native IYG and Control
- ❑ **25** Tribal Sites randomized
- ❑ **3** regions: AK, NW, AZ
- ❑ **574** middle school aged youth enrolled
- ❑ **3** surveys: Pre, Post, 12-month follow-up

Youth who took Native IYG reported:

- ☐ More reasons not to have sex
- ☐ Increased STI knowledge
- ☐ Increased condom knowledge
- ☐ More confidence obtaining condoms
- ☐ More confidence about using condoms

Native VOICES Toolkit

- ☐ Native VOICES video (23 minutes)
- ☐ A condom demonstration video (1:40 minutes)
- ☐ A dental dam demonstration video (1:08 minutes)
- ☐ A selection of condoms and dental dams
- ☐ A users' guide

SITV Evaluation

- September 2014 – December 2015
- 5 new communities in southwestern and northwestern Alaska (n= 105) with youth ages 15-19 years old
- Implemented facilitated Safe in the Village workshops in schools and community settings
- Participants filled out surveys before and immediately after the workshop and an online follow up survey 6 months after
- Data analysis is ongoing

***Several graphs please review PowerPoint for further information*

<u>SAMSHA Update, David Dickinson, Regional Administrator</u>

"We continue to address the impacts of alcohol and other drugs, youth suicides, domestic violence and the list continues. However, now is the time to address the source of these symptoms—historical and intergenerational trauma."

—Tribal leader, White House Tribal Nations Conference, 2014

The Drivers

- Tribal leaders gave impetus to the National TBHA
  - SAMHSA's Tribal Technical Advisory Committee discussions led to concept for TBHA
  - Broader tribal leader call for coordination and collaboration to break silos and "work differently"
- High rates of behavioral health problems among American Indian and Alaska Native people

- Behavioral health issues are not isolated—there are correlations with physical health and social and economic conditions that require a more collective/collaborative approach

The Messages

- Traumatic events have long-term impacts
  - *Need to heal from historical, intergenerational, and other traumas*
- Solutions must match the problem
  - *Use a socioecological approach*
- Prevention is the Priority
  - *Elevate prevention and support recovery*
- Infrastructure and delivery systems
  - *Systems and services must be fixed*
- Lack of information and stigma are in the way
  - *Raise awareness and educate tribal communities and partners*

Prescription Drugs - Great Lakes Inter Tribal Council

- 30.9% of youth, 27.7% of minor adults and 24.9% of adults intentionally misused prescription medication
- 7.6% of youth think there is no risk to misusing prescription drugs; another 5.9% think there is only a slight risk
- 15.6% of youth, 34% of minor adults, and 28.1% of adults indicate it would be very easy to obtain non-prescribed prescription drugs if they wanted to

Prescription Drugs – Northwest Portland Area Indian Health Board

- From 2006-2012, there were 10,565 AI/AN deaths and 584,070 deaths among non-Hispanic whites (NHW) in ID, OR, and WA
- Drug overdoses accounted for 4.3% of all AI/AN deaths and 1.7% of all NHW deaths
- Majority of drug overdose deaths among AI/ANs (65.3%) and NHW (69.3%) were from prescription drugs

Words of Wisdom

"Our children are taking their lives, our families are being torn apart, our culture is disappearing because of substance abuse, suicide and violence, it is time to act by committing our time, ideas and resources to stop this destruction." "These words come straight out of my heart, my tears and my prayers."

What the TBHA is

- A document that provides a clear, national statement about the extent and need for prioritizing behavioral health problems
- A tool for improving collaboration on common issues across different entities/sectors
- A blueprint that harmonizes efforts and creates a collaborative approach for program and policy activities—no single entity can change outcomes alone

What the TBHA is Not

- Not a silver bullet—will not fix problems, compounded over decades, overnight
- Not a strategic plan—nor a replacement for existing strategic plans (existing plans have a purpose and legal and/or policy directives)

Not a list of prescribed actions that tribal, federal, state, and local governments or other stakeholders must take

The TBHA Framework

- AI/AN Cultural Wisdom Declaration

- Six cross-cutting considerations
  - Youth, Culture, Identity, Individual Self-Sufficiency, Data, Tribal Leadership
- Five foundational elements upon which priorities and strategies were built
  - Historical and Intergenerational Trauma
  - Socio-Ecological Approach
  - Prevention and Recovery Support
  - Behavioral Health Systems and Support
  - National Awareness and Visibility
- Priorities and Strategies

American and Alaska Native Cultural Wisdom Declaration

- Developed by tribal representatives
- Elevates importance of tribal identities, culture, spiritual beliefs, and practices as essential for improving well-being
- Ensures cultural wisdom and traditional practices are taken into account and supported as fundamental elements of programs, policies, and activities for improving behavioral health

Historical & Intergenerational Trauma

- Focus

Support priorities and strategies that support healing

- Priorities
  - Ensure appropriate support systems are in place to support healing
  - Invest in community connectedness
  - Promote healing to break the cycle of trauma

Social-Ecological Approach

- Focus

Support priorities and strategies that capture the larger context within which AI/AN behavioral health issues are rooted and interventions to more effectively address them

- Priorities
  - Sustain environmental resources
  - Invest in necessary and reliable infrastructure
  - Support healthy families and kinship

Prevention and Recovery Support

- Focus

Support priorities and strategies to address issues that inhibit opportunities to intervene early and that are required to sustain positive emotional health

- Priorities
  - Develop programming that meets community needs
  - Mobilize and engage communities

Behavioral Health Services/Systems

- Focus: support priorities and strategies to improve coordination, linkages, and access to behavioral health and related services
  - Target workforce development, recruitment, retention
  - Support flexible and more realistic funding
  - Support tribally directed programs
  - Support youth-based programming

  - Expand scope of current programming

Coordinate with law enforcement programs

National Awareness and Visibility

- Focus

Support priorities and strategies to improve understanding of AI/AN behavioral health disparities and their consequent impacts on physical health and well-being

- Priorities
  - Build tribal capacity
  - Build tribal partner capacity

Support tribally directed communication strategies

Next Steps

- Tribal comment period ends October 30, 2016
- National Rollout
- Implementation activities in collaboration with NIHB, NCAI, and NCUIH

The Power of the TBHA

- Based on tribal voices and priorities
- Opportunity to shape policies and programs
  - Supports wisdom of cultural and traditional practices alongside western approaches
  - Garners appropriate attention to priorities that address outstanding challenges
  - Mobilizes collaborators to act together
- Uses existing platforms (i.e., strategic plans, etc.) to "work differently"

SAMHSA Region X Suicide Rates 2014

Rank	State [Division / Region]	Deaths	Rate
2	Alaska [P / West]	167	22.7
8	Oregon [P / West]	782	19.7
9	Idaho [M / West]	320	19.6
21	Washington [P / West]	1,119	15.9
	Nation	**42,773**	**13.4**

Source: Obtained 18 December 2015 from CDC/NCHS's *Mortality in the United States: 2014* Public Use File and Web Tables (released and accessed 18 December 2015; Table 19)

Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant Program

This program supports states and tribes (including Alaska Villages and urban Indian organizations) in **developing and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration**. Such efforts involve public/private collaboration among youth-serving institutions and agencies and include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child- and youth-supporting organizations. A cross-site evaluation is conducted under a contract in the Division of Prevention, Traumatic Stress, and Special Programs.

Current GLS Tribal Grantees (1)

- Crow Creek Sioux Tribe
- Oglala Sioux Tribe

- Chippewa Cree Tribe
- Rosebud Sioux Tribe
- Shingle Springs Band of Miwok Indians
- Indian Center, Inc.
- **Association of Village Council Presidents (AK)**
- Northern Cheyenne Tribe
- **Confederated Tribes of Colville Reservation (WA)**
- California Rural Indian Health Board
- American Indian Health & Family Services of SE MI, Inc.
- Native Americans for Community Action, Inc.
- **Southcentral Foundation (AK)**
- Pueblo of San Felipe

Current GLS Tribal Grantees (2)

- United Indian Health Services, Inc.
- **Northwest Portland Area Indian Health Board (OR)**
- **Yellowhawk Tribal Health Center (OR)**
- Confederated Salish and Kootenai Tribes
- **Dena' Nena' Henash dba Tanana Chiefs (AK)**
- Muscogee (Creek) Nation
- **Native American Rehabilitation Assoc. (NARA) (OR)**
- Wichita and Affiliated Tribes
- Choctaw Nation of Oklahoma
- **Kawerak, Inc. (AK)**
- **Fairbanks Native Association (AK)**
- Native American Health Center, Inc
- **Tribes & Bands of the Yakama Nation (WA)**

Circles of Care History

- After years of advocacy and tribal consultation, Circles of Care was funded in 1998 by SAMHSA as a 3 year planning grant for AI/AN communities with financial and other support from BIA, IHS, OJJDP and NIMH
- Additional cohorts were funded in 2001 and 2005 by SAMHSA with small interagency agreements with IHS and NIMH to support technical assistance contracts
- In 2008 SAMHSA funded the fourth cohort and fifth cohort in 2011
- In 2014 SAMHSA not only funded, but expanded the sixth cohort both in number of grants and funds available for award

Impact of the Circles of Care Program

- 49 AI/AN Communities have been awarded COC grants since 1998:
  - 32 Tribes or Tribal organizations
  - 15 Urban Indian Organizations
  - 2 Tribal Universities
- 20 of 38 “graduated” COC grantees have received Systems of Care grants either directly, or in partnership with another organization to implement their model
- Most of the other 18 have implemented their model through different strategies

Circles of Care VI Grantees (2014-2017 Projects)

1. **Tanana Chiefs Conference - AK**
2. Native Americans for Com. Action (Flagstaff) AZ
3. Indian Hlth Ctr of Santa Clara Valley (San Jose)- CA
4. Quartz Valley Indian Reservation - CA
5. Ute Mountain Ute Tribe - UT
6. Osage Nation - OK
7. Lower Brule Sioux Tribe - SD
8. **Hoh Tribe - WA**
9. **Makah Indian Tribe - WA**
10. **Seattle Indian Health Board - WA**
11. Red Cliff Band of Lake Sup. Chippewa -WI

Circles of Care VI Goals

- …to plan and design a holistic, community-based, coordinated system of care approach to support mental health and wellness for children, youth, and families.
- …increase the capacity and effectiveness of mental health systems
- …focus on the need to reduce the gap between the need for mental health services and the availability and coordination of mental health, substance use, and co-occurring disorders in AI/AN communities for children, youth, and young adults from birth through age 25 and their families.
- …draws on the system of care philosophy and principles…
- …a system of care is defined as a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with mental health needs and their families.
- …families and youth work in partnership with public and private organizations to design mental health services and supports that build on the strengths of individuals and address each person's cultural and linguistic needs.

SAMHSA Native Connection
Purpose

- …to prevent and reduce suicidal behavior and substance abuse among American Indian/Alaska Native young people up to and including age 24.
- …reduce the impact of substance abuse, mental illness and trauma on AI/AN communities through a public health approach
- …allow AI/AN communities to support youth and young adults as they transition into adulthood by facilitating collaboration among agencies.

Background Note: Native Connections Principles

- *Community Involvement and Feedback*
- *Strengths-Based*
- *Grounded in Community Readiness*
- *Identify the Gaps, Pilot Solutions*
- *Lead Coordination Across the Agencies*
- *Foster Relationships*
- *Innovation in Serving AI/AN Youth*
- *Supported by AI/AN Technical Assistance*
- *Evaluated for Effectiveness in Saving Lives*

New Native Connections Awards

10 new grants to Washington Tribes and Tribal Organizations
2 new grants to Oregon Tribes
26 total new Native Connections Grants in Region X (includes grant awards to Alaska Native Tribal Organizations)

SAMHSA Funding Opportunities

- Visit the SAMHSA website: http://www.samhsa.gov/
- Click on the "Grants" tab at top of homepage.
- Then click on "Fiscal Year 2016 Grant Announcements
- View individual announcements

Changes in Application Process

- IMPORTANT: SAMHSA is transitioning to the National Institutes of Health (NIH)'s electronic Research Administration (eRA) grants system. Due to this transition, SAMHSA has made changes to the application registration, submission, and formatting requirements for all FOAs. All applicants must register with NIH's eRA Commons in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).
- Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process six (6) weeks in advance of the application due date.

Collaboration: Foundation for Success

Center for Substance Abuse Prevention
Center for Mental Health Services
Center for Substance Abuse Treatment
Center for Behavioral Health Statistics and Quality

For additional information, please contact: otap@samhsa.hhs.gov

Region X Contact Information: David Dickinson
SAMHSA Regional Administrator
david.dickinson@samhsa.hhs.gov
206-615-3893

Opioid Guidelines/Policy, Thomas Weiser, MD, MPH, Medical Epidemiologist

Background

- Opioid prescriptions have risen dramatically over the past 15-20 years
  - 1 in 4 receiving long-term opioid therapy, in primary care settings, struggle with opioid addiction
  - 300% increase in prescription sales since 1999- without overall change in reported pain
  - 259,000,000 prescriptions for opioids were written in 2012- enough for every adult in America to have a bottle of pills
- Annual incidence of opioid overdose and deaths has also risen:
  - Overdoses: In 2011, over 420,000 emergency room visits were related to misuse or abuse of prescription opioids, including intentional and unintentional overdose
  - Deaths: from 1999-2014, more than 165,000 people died from prescription opioid overdose

- Increased research has led to greater understanding of the dangers of long-term opioid prescribing and the lack of benefit

Federal Steps

- Indian Health Service Indian Health Manual, Chapter 30 (2014) "Chronic Non-Cancer Pain Management" and Chapter 32 (2016)- "State Prescription Drug Monitoring Programs"
- CDC released new opioid prescribing guidelines in 2016
- Surgeon General: "Turn the Tide" campaign, 2016

IHS

- Chapter 30: Chronic Non-Cancer Pain Management
  - Pain assessment, management
  - Patient education, rights and responsibilities
  - Provider responsibilities- assessment, treatment, education and re-assessment
  - Treatment guidelines- opioid and non-opioid regimens
- Chapter 32: State Prescription Drug Monitoring Programs (PDMPs)
  - Area-State MOU
  - Prescribers, pharmacists may access
  - Requires providers to check PDMP before prescribing opioid medications

CDC

- Compiling data from State health departments and vital statistics
- Produced opioid prescribing guideline and other publications
- Produced provider and public educational materials

https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf

Office of the Surgeon General

- Initiated Turn the Tide Campaign http://turnthetiderx.org/#
- Visited tribal leaders in OK, visited Bethel, AK and an Alaska Native village.
- Sent letters to all physicians across the country
- Encouraged providers to take the pledge:

As HEALTH CARE PROFESSIONALS, we believe we have the unique power to end the opioid crisis. We pledge to:

1. Educate ourselves to treat pain safely and effectively.
2. Screen our patients for opioid use disorder and provide or connect them with evidence-based treatment.
3. Talk about and treat addiction as a chronic illness, not a moral failing.

State Steps- Idaho

- Idaho Board of Medicine Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain (Sept, 2013)
- Office of Drug Policy- "Prevention Idaho" administers the Substance Abuse Prevention Block Grant and the Strategic Prevention Framework State Incentive Grant

https://prevention.odp.idaho.gov/index.html

- Public Campaign:
  - Betheparents.org
  - Lock Your Meds
  - Naloxone
- No ongoing campaign to address prescription opioid abuse

State Steps- Oregon

- Convened a Task Force to draft opioid prescribing guidelines for providers in OR, based on 2016 CDC guidelines https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/index.aspx
    - Included IHS/NWTEC representation (Dr. Weiser)
    - 4 subgroup areas- Implementation, Communication, Marijuana and Substantive Issues
    - Oregon Guideline follows the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain
    - Emphasizes limiting strength and duration of opioid prescriptions, use of naloxone to prevent overdose deaths, improving data, use of the prescription Drug Monitoring Program to identify potential misuse or abuse.

State Steps- Washington

- First issued opioid prescribing guidelines for providers in WA in 2007.
    - Updated in 2010 and 2015, ahead of CDC guidelines
- The 2016 WA State Interagency Opioid Working Plan includes four priority goals:

1. Prevent opioid misuse and abuse.
2. Treat opioid abuse and dependence.
3. Prevent deaths from overdose.
4. Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

Available at: http://stopoverdose.org/

Oregon Resolution

"The Oregon Opioid Prescribing Guidelines Task Force adopts the *CDC Guideline for Prescribing Opioids for Chronic Pain* as the foundation for opioid prescribing for Oregon. The Task Force further encourages more discussion at state, regional and organizational levels regarding how the guidelines will be disseminated, communicated to patients and providers, and implemented."

Approved June 3, 2016

Next steps

- Request NPAIHB consider a resolution to endorse the efforts of Oregon and Washington States and IHS to address the prescription opioid overdose epidemic
- Consider further actions that NPAIHB can take to assist Tribes dealing with the prescription opioid epidemic

Executive Session

RECESS

MINUTES

WEDNESDAY OCTOBER 19, 2016

Call to Order, Cheryle Kennedy, Vice Chairwoman

Cancer Project & Tobacco Update, Kerri Lopez, WEDP &NTCCP Project Director

NTCCP Trainings/Activities

- Clinical Cancer Update
  - 29 participants (2016)
  - CEU accreditation
- Tribal Tobacco Summit
  - 50 participants (2016)
- Tobacco Cessation
  - Basic Tobacco Intervention Skills for AI/AN
  - 18 participants (2015)
- Tribal BRFSS
- Inflatable Colon "Kiki"
  - Supporting NW Tribal CRC Education Activities
- Tribal Cancer Plan Implementation Funding
- Tribal site visits

  Cancer 101

  Development tribal action plan

  Participation in tribal prevention, screening and education activity
    - Technical assistance
    - Dissemination of resources

Tribal BRFSS– 6 tribes

Complete

- Two Oregon
  1. Randomized phone
  2. Census phone
- Two Washington
  1. Door to door

In progress

- One Oregon
  - Census phone
- One Oregon
  - Tribal resolution
  - Development of survey materials and IRB application

Tobacco Cessation

- Basic Tobacco Intervention Skills Training (BTIST) for Native Communities
- 5A's model
- 6 Modules topics

Tribal Implementation

Clinic Integration

- From train - trainers
- 3 month time
- 50 clinic/admin staff were trained in the 5A's BTIST
- Of 50 staff participants 31 staff formed 4 teams
    - With the goal to increase referrals

Results

- 41 web-base referrals to the quit-line, 366% increase
- 51 commercial tobacco users agreed to stop smoking
- 26 clinical staff members level of knowledge increased

Other Implementation

- 1 on 1 cessation counseling
- Group classes
- Referrals to another resource for tobacco cessation
- All clinic staff training (from receptionist to the IT person)

NTCCP Coalition Meeting Navigation and Communication

- Topics
- Communication with patients
- Resources for Survivors
- Tobacco Cessation
- Lung cancer screening
- Other resources:
    - Housing
    - Financial assistance
    - Transportation
    - Resource Fair:
    - Organizations sharing information with tribes (6)

Youth tobacco training

- Tobacco Facts
- Tobacco 101 presentation
- Tobacco vs. Candy
- Environmental Scan Tool
- Group discussion

Rates AI/AN Women

- **32.5%** of AI/AN women smoke
- **18%** of AI/AN women smoke during pregnancy nationally. **** 2003 data
- **26%** of AI/AN women smoke during their last 3 months of pregnancy.
- **22.3%** of AI/AN women in Oregon smoke during pregnancy, in the last 3 months of pregnancy 16.2%

Colorectal Cancer Disparities

CRC Screening 2012 (ID, OR, WA)[1]

- AI/AN 36.0% (50-75 yo)

CRC Distant Staging 2003-2007 (ID, OR, WA)[2]

- AI/AN 23.9%
- NHW 18.1%

CRC 5 yr Survival 1998-2007 (ID, OR, WA)[3]

- AI/AN 0.4727 (0.4190, 0.5338)
- NHW 0.5627 (0.5627, 0.5825

E-cigarettes

Myths

- Safe than conventional cigarettes
- Healthy alternative
- Does not cause death
- E-cigarette aerosol is harmless "water vapor" and is as safe as clean air
- No second hand smoke
- Little to no nicotine in e-liquid
- Fun, Cool, Sexy
- Cannot overdose on nicotine from e-liquids

Facts

- No FDA approved
- Currently no sufficient evidence to conclude that e-cigarettes are an effective smoking cessation tool.
- E-cigarette aerosol can contain heavy metals and cancer causing agents
- E-liquid contains insufficient amount of nicotine levels
- Most adults who use e-cigarettes also smoke conventional cigarettes, referred as "dual use"
- Marketing to youth using Big Tobacco tactics and fun flavors
- Gateway to smoking or using other tobacco products

Current Policy Work in Tribal Communities

- Tribal Admin-Community Campus
- Health Clinic
- Education
- Gathering Space
- Events & Gatherings
- Tribally Run Businesses
- Tribal Housing
- External Partners

Cancer Challenges – Multifaceted

- High need for Cancer Resources in AI/AN communities
    - Geographic Isolation
    - Independent Healthcare Systems
    - Low Health Literacy
    - Patient — Provider Communication
- Screening – referrals
- Screening rates for paps and mams going down
- After care for cancer survivors in tribal community
- Economic Impact

NTCCP Tools and Resources

- Twenty Year Northwest Tribal Comprehensive Cancer Control Plan
- Northwest Tribal Cancer Resource Guide

- Cancer 101
- Cancer Fact Sheets
- Appointment Companion
- Tribal Cancer Action Planning
- Tribal Tobacco Policy Workbook
- Northwest Tribal Colorectal Cancer Screening Toolkit
- Second Wind Curriculum
- NPAIHB Tribal Profiles
    - State level
- Multiple Presentations
    - E-Cigarettes, Pregnancy & smoking, Cancer Resources, Cancer Survivor support group support and Cancer Action Planning
- Multiple factsheets
    - HPV, Tobacco, SHS, E-cigarettes, Smoke-free Homes, etc.

NTCCP Staff

- Kerri Lopez;
    - NTCCP Project Director
- Eric Vinson;
    - NCCP Coordinator
- Antoinette Aguirre;
    - Cancer Prevention Coordinator
- Ryan Sealy;
    - WEAVE NW Tobacco Specialist
    -

Zika Virus Update, CAPT Thomas Weiser, MD, MPH Medical Epidemiologist

Background

- What is Zika virus? How is it transmitted?
- What are the health effects of Zika virus infection?
- What precautions should we take in the Pacific Northwest?

What is Zika Virus?

- Flavivirus- similar to dengue, yellow fever and West Nile virus
- Vector-borne disease- *Aedes egypti* and *Aedes albopictus* mosquitos are the primary vectors

Non-Mosquito Transmission of Zika Virus

- Mother to fetus
- Sexual transmission- more information is being learned about sexual transmission of the virus
    - Transmission primarily from men to women or other men
    - 1 documented case of transmission from woman to man
    - The virus was cultured from semen as long as 90 days after infection
    - The virus has also been found in vaginal mucous in primates
- Other body fluids- blood, urine, amniotic fluid, cerebrospinal fluid

Health Effects of Zika Virus Infection

- Acute Zika virus infection: fever, rash, joint pain, or conjunctivitis; less common: muscle pain, headache

- Guillain-Barré Syndrome: post-infectious autoimmune disorder characterized by bilateral flaccid limb weakness attributable to peripheral nerve damage
- Congenital Zika Syndrome: microcephaly, intracranial calcifications or other brain anomalies, or eye anomalies

Prevention Steps

- Mosquito transmission of Zika virus has not been documented in the Pacific Northwest. The following prevention recommendations are only **for those who travel to areas with known Zika virus transmission or those who have contact with someone who has traveled in these areas:**
- Prevent exposure to mosquitos
    - CDC recommends the use of window screens, bed nets and EPA-registered mosquito repellents
    - Mosquito larvacide to treat standing water and reduce mosquito burden near homes
    - Permethrin spray to treat bed nets, clothing
- Prevent exposure through sexual contact
    - Condoms to prevent exposure
- Prevent pregnancy if exposed
    - Long-acting reversible contraception to prevent pregnancy if exposure is likely to occur or have already occurred

Recommendations

- CDC recommends Zika virus testing for potentially exposed persons with signs or symptoms consistent with Zika virus disease, and recommends that health care providers offer testing to asymptomatic pregnant women within 12 weeks of exposure.
- For couples planning to conceive who do not live in areas with active Zika virus transmission:
    - Couples in which the female partner may have been exposed to Zika virus should wait at least 8 weeks before trying to conceive
    - Couples in which the male partner may have been exposed to Zika virus should wait at least 6 months before trying to conceive

Committee Reports

- Elder's Committee, Dan Gleason (A copy of the report is attached)
- Public Health, Victoria Warren-Mears (A copy of the report is attached)
- Behavioral Health, Marilyn Scott (A copy of the report is attached)
- Personnel Report, Cassie Sellers-Reck (A copy of the report is attached)
- Legislative Report, Laura Platero (A copy of the report is attached)
- Youth Report, Leland Bill (A copy of the report is attached)

Legislative Update, Laura Platero, Government Affairs/Policy Director

MINUTES

Report Overview

1.Status of FY 2017 IHS Budget
2.Contract Support Costs
3.Veteran's Administration
4.Community Health Aide Program (CHAP) Expansion
5.Tribal Premium Sponsorship
6.Catastrophic Health Emergency Fund
7.Other Policy Updates
8.STAC Meeting Update
9.MMPC CMS TTAG Update
10.Litigation Impacting Indian Health
11.Legislative Issues 114th Congress
12.Important Dates

Status of FY 2017 IHS Budget

•Congress enacted a continuing resolution through December 9, 2016 – funding pro rated and at FY 2016 level.

•Senate and House Committees' Interior, Environment and Related Agencies appropriation bills reflect differences (detailed on next slide)- to be negotiated.

•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 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 and discussed during the September 15-16, 2016 CSC Workgroup meeting.

–IHS will finalize by the end of October.

Veteran's Administration

•On September 12, 2016, the Veteran's Administration issued a Dear Tribal Leader Letter (DTLL)

•In October, 2015, VA submitted a Plan to Congress to Consolidate Programs of the Department of Veterans Affairs and conducted Tribal Consultations.

•As part of implementation of this Plan, tribal consultation is being sought on tribal health programs participation in the core provider network and potentially transitioning from the current reimbursement agreement structure to a model under which tribal health programs deliver care to all those eligible for services.

•In person consultation:
–September 28, 2016 at 9:00am-11:00am at the Smithsonian National Museum of the American Indian (NMAI)
•Written comments are due on November 5, 2016 and can be sent to: tribalgovernmentconsultation@va.gov

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 are 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
•Comments are due on October 31.

Other Policies

•IHS Re-alignment of IHS Headquarters
–All Tribes Call on 9/29/16 and in person discussion at NCAI on October 9.
–Comments due November 5
•SAMSHA's Draft Tribal Behavioral Health Agenda (TBHA)
–Sets forth a framework, priorities and strategies to address behavioral health issues in Indian country.
–Comments due on October 31.
•CMS MACRA MIPS & APM
–Final Rule issued on October 14.
CMS Medicare Expansion of Diabetes Prevention Program Proposed Rule
–Proposed to expand the Medicare Diabetes Prevention Program beginning 1/1/2018.
–Tribal consultation has been requested before final rule issued.
•CMS Managed Care Final Rules
–All Tribes Call on 10/5/17.
–CMS will provide an overview of Indian specific provisions and comments on an Indian health addendum
–Effective 7/1/17; CHIP provisions effective 7/1/18
•CMS 100% FMAP -- CMS issued a letter to State Health Officials on 2/26/16 re-interpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:
–CMS to issue a FAQ on new policy – still pending.

STAC Meeting Update

•Last meeting was September 13-14; next meeting is December 7-8
•Tribal leaders have made several requests to Secretary Burwell, including:
–Quality of Care Issues at the Indian Health Service
–Tribal Budget Formulation Workgroup's Recommendations for the FY 2018 IHS Budget
–Office for AI/AN Programs at the Office of Management and Budget
–Advocacy on the Veterans' Administration Memorandum of Understanding
–Senior Level HHS Position Dedicated to Coordinating Tribal Policies at ACF
–Indian Child Welfare Act Implementation
–1115 Waiver Approval
–Transition Plan for the Next Administration

MMPC & CMS TTAG Update

•Medicare, Medicaid and Health Reform Policy Committee (MMPC) next face-to-face meeting on November 2.
–Priority List
•CMS TTAG conference call and face-to-face meetings on October 12 and November 3-4, respectively.

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 in favor of Manilaaq.

–IHS did not appeal the Final Order.

Indian Legislative Issues 114th Congress

•Employer Mandate Bills (S. 1771 & H.R. 3080)

•Indian Health Service Reform Bills (S. 2953 & H.R. 5406)

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 Committee; House bill passed Ways and Means Committee.

•Senate and House Bills Reforming the Indian Health Service in response to issues in the Great Plains region.

–S. 2953 -- The Indian Health Service Accountability Act of 2016 was introduced by Sen. Barrasso (R-WY) on 5/19/16.

–H.R. 5406 – The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare Act was introduced by Rep. Kristi Noem (R-SD) on 6/8/16.

–Senate bill referred to Finance; House bill reported favorably out of House Ways and Mean on 6/15/16.

–Both bills were amended and then approved in their respective committees on 9/21/16.

Other pending legislation:

•Advance Appropriations (H.R. 395)

•Tribal Programs Exemption from Sequestration (S. 1497/H.R. 3063)

•Department of Interior Tribal Self-Governance Act of 2015 (2. 286)

•Family Stability and Family Kinship Act of 2015 (S. 1964)

•Native American Suicide Prevention Act of 2015 (H.R. 3166)

•Correct Inconsistencies in the ACA/IHCIA (S. 2114)

Important Dates

•Several comments are due in the next 3 weeks.

•Portland Area Budget Formulation Meeting – November 29, 2016.

–Location: Portland, OR

•NCAI Transition Plan Submissions

–Due: Wednesday, October 19, 2016

–Submit to: Nicole Hallingstad, Director of Operations, NCAI, nhallingstad@ncai.org

BREAK

Native STAND Update, Stephanie Craig-Rushing, Suicide Prevention & PRT Project Director

NATIVE STAND

- ❑ In Indian Country, tribal and community leaders are keenly aware of the challenges faced by their teens.
- ❑ Our challenge, in terms of community readiness is:
  - ❑ to move community leaders beyond recognition of the problem.
  - ❑ to commitment of resources to evidence-based interventions.

From STAND to Native STAND Background

- STAND created by Mike Smith, Mercer University SOM, was the developer of the STAND curriculum.
- Reps. of National Coalition of STD Directors/I.H.S./CDC developed a work group.
- Native Work Group adapted the original STAND.
- Reviewed by Native Youth & Professionals.
- Validated in 4 BIE schools & 1 reservation community.

Native STAND Program

The Curriculum

1. **Facilitator's Manual**
2. **Peer Educator Manual**
3. **Resource Manual**

- *29 ~ 90 min. sessions*
  - ❖ *Culture and Tradition*
  - ❖ *Honoring diversity / respecting traditions*
  - ❖ *Healthy relationships*
  - ❖ *Negotiation and refusal skills*
  - ❖ *Decision making*
  - ❖ *Being a peer educator*

Core Elements

- Uses active learning
- Uses primary prevention techniques
  - ➢ ***Non-judgmental attitudes***
  - ➢ ***Information sharing***
  - ➢ ***Advocating specific behaviors***
  - ➢ ***Positive role modeling***
  - ➢ ***Promoting personal commitment***
- Healthy, positive sexual expression in relationships

Culturally Tailored program & Curriculum

- ➢ **Culturally Relevant**
  - Stories/activities from various tribes
  - Urban and Reservation
  - Inter-Tribal

- **Expanded**
  - Healthy Relationships
  - Reproductive Health
  - STIs/HIV/AIDS Prevention
  - Early Pregnancy/Parenting
- **Created <u>flexible</u> format**
  - 90 minute segments
  - For use in boarding schools, after school programs, in-school, etc.

The Program

Training
Hands-on Learning
Implementation Action Plan
Native STAND Activities
Teens Become Peer Educators

What happened in select native settings?

1. Students demonstrated significant improvements in knowledge of:
   1. STD/HIV/AIDS Prevention
   2. Reproductive Health
   3. Healthy Relationships
2. Tribal youth reported providing 1-on-1 peer education and referrals.
3. Adult facilitators learned how to better communicate & teach about sensitive topics.
4. Program was well received; recognition in addressing critical gaps in sexual health education**.**

Native STAND Project Core TEAM

Oregon PRC
Bill Lambert
Michelle Singer
Kavita Rajani
Tom Becker
Caitlin Donald
Brittany Morgan

NPAIHB
Stephanie Craig Rushing
Jessica Leston
**Adolescent Tribal Health*
**NW Tribal Epi Center*

Outreach & research

Program is action oriented and empowers communities.
Project will measure & evaluate the adoption and impact in communities.
It is community driven!

PROJECT SIGNIFICANCE: raising healthy native youth

- 50+ educators and AI/AN organizations trained.
- Train-the-Trainer opportunities.
- Snowball Effect: Add new youth & allies over time.
- Pre- and post- questionnaire data on key indicators:
  - (+/-) Changes in Youth
  - Community Awareness & Engagement

- ❖ Capacity Building
- ❖ Leverage of Resources
- ❖ Culturally relevant health education

Project commitment

"Natives Helping Natives"

- Build the capacities of tribal communities to engage in research.
- Allow individual communities to better access and understand data that would benefit their communities toward eliminating health disparities.

PROJECT PARTICIPANT BENEFITS

- 1-week of hands-on free training with curriculum materials.
- 2-year implementation funding ($5K each year)
- Technical assistance with Core Team, Coaches, Peers.
- Data on your youth, for your community, owned by your community!

Project update --Indian Country & Native STAND Year 1 & 2 cohorts into action!

30 Program Participants in 14 States, including Alaska!

- Tribes and AI/AN organizations
- Reservation/Rural Based & Urban/Metro Areas
- Mostly No Existing Adolescent Health Program
- Potential Implementation Host Sites Varies
- Projected Student Group Size Baselines: (10-19) and (20+)
- Diverse Educator Professional & Life Experiences

Join the Movement – Year 3 Recruitment Opportunity

Last chance!! Native STAND 2017!

The Center for Healthy Communities is partnering with the NPAIHB to recruit 25 Tribes and American Indian/Alaska Native organizations!

a) If selected, 25 participants will receive the Native STAND Educator Training on the delivery of the Native STAND program; and,
b) If selected, a part of the Native STAND Project as the Year 3 Cohort and the collective effort.

Educator summer Training Objectives

1. Provide an overview of the Native STAND Dissemination and Implementation Project, including it's goals and objectives.
2. Prepare educators to teach an adolescent sexual health curriculum, with hands-on training using the Native STAND curriculum & program.
3. Prepare educators to recruit participants and implement the Native STAND curriculum in your community.

Summer Training Program Opportunity - June 26 to June 30, 2017

- o 1 week in Portland – travel and lodging paid for.
- o Native STAND curriculum materials provided.
- o Hands-on Practice at THRIVE with youth.
- o Human subjects protection training.
- o Technical Assistance, recruitment and teaching tips.
- o Evaluation, data collection and planning resources.
- o Graduate and depart with action plans for home communities.

Who should apply?

- Tribes and AI/AN organizations that serve high school age Native youth (grades 9-12, ages 14-18 years) are encouraged to apply.
- Examples of previous participants include Tribes, urban Indian organizations, Indian education departments, school districts and prevention programs.
- This training program is appropriate for educators and prevention specialists in the area of health, human/social services, education and juvenile justice.

What are the Requirements for Educators and host site?

- Identify an individual to serve as the Educator and to receive the Certified Training.
- The identified individual must provide assurance that they are able to attend the summer training.
- Have access to a setting to deliver the Native STAND Program.
- Provide support letters from your Tribe and/or organization.

How DO I Apply?

- ✓ It is recommended that interested individuals and organizations submit their application online.
- ✓ However, paper applications will also be accepted.

APPLY ONLINE at www.oregonprc.org

Questions or to learn more? View the website

www.oregonprc.org

1. **About Native STAND**
2. **Application for Educator Training Program & Project**
3. **Learn about the Certification as Native STAND Educator Training Program**
4. **Frequently Asked Questions (FAQs)**
5. **Resources**
   - I Presentations
   - II Data Collection & Evaluation 101
   - III Publications & Resource Articles
   - IV Evaluation Reports
   - V Native STAND Curriculum (3 Manuals)

Important Dates in 2016-17

NOW! Applications Available
Nov. 17: Informational Recruitment Webinar
March 1: Application Deadline
April 1: Site Selection & Notifications
June 26-June 30: Certified Educator Training in Portland
LAST CALL FOR 25 FOR OUR FINAL YEAR! www.oregonprc.org

LUNCH

MINUTES

Tribal Update

1. Kalispel
2. Kootenai
3. Lower Elwha Klallam Tribe

Data Repository/Data Movement, Victoria Warren-Mears, PhD, RDN, FAND; Director, Northwest Tribal Epidemiology Center

Overview

- How does data flow to IHS?
- NWTEC Access
  - EpiData Mart
  - Linkage Projects
  - Research Projects
- Data Repository Progress
  - Data Stewardship

Several graphs please review PowerPoint for further information

Visioning the Future

- Finish Data Repository
  - Data stewardship of data developed and collected at the NWTEC
  - Data stewardship for other data
- Develop data portal for access by tribal leaders
  - Web based with unique tribal passcodes and protections

Quality of Care and Business Practice and the ACA, Laura Herbison, CEO, Western Oregon Service Unit & Jay Sampson, CEO, Yakama Service Unit

NPAIHB – Report Yakama Service Unit

Quality Improvement Timelime

- Affordable Care Act (ACA)
- .....Enrollment of Patients
- ……Budget impact
- ……Address Needs to Improve Care
- .....Planning Activities

Enrolling patients

Laura Kluever… she was named the "Top Tribal Assister" in the State of Washington for her work in enrolling patients using the Healthplanfinder and paper. The business office was aggressive in their efforts to enroll patients. This was contagious to other departments that quickly learned to refer patients to our benefit coordinators: Medical, Dental, PHN, Pharmacy, and PRC.

Business office processes

Here are a few shots of the staff that help to deliver the work from registering a patient, enrolling a patient, and finishing the revenue process.

83% of Active Patients have healthcare coverage.
Reimbursement revenue has exceeded $10 million

PEDIATRIC SPECIFIC POSITIONS
Pediatrician
Pediatric Dentist
Special Needs Public Health Nurse

Other Staff Changes
- Pharmacy Technician (Point of Sale)
- Patient Registration
- Coder
- Custodian

Initial plan for working within current facility.

Other Change
- Equipment
- Facility

GC Analyzer
CD, Lab Director, Lab Supervisor, Lab Technologists. Brings this form of testing in-house as we are currently a moderate complex lab. Analyzer will enable quicker results to providers and lead to cost savings. Projection is a cost savings of approximately $40k annually. Estimated payback period is roughly 2 years. We are also updating our Siemens Chemistry analyzer. A replacement and not an addition.

Facility Changes
Improve the area for patient registration…for the patients and the employees of the main entryway to the clinic. Solution is by systems furniture.
A consultative finding of a AAAHC survey. Installation is to be initiated in November 2016.
Provide 6 additional exam rooms: increase ratio of exam rooms to PCP Team, and add another Medical Team.

Change for Improvement
- Provide (6) additional exam rooms.
- Provide capability for bariatric equipment needs and an isolation area in event of an outbreak or other need.
- Improve the patient panel size for each medical team.
- Increase access for patients to primary care services.

Planning
Goal: Continue to improve access for services.

Dental Facility: separate, larger, more efficient layout.
New facility makes available space in clinic to evaluate:

- Optometry Department expansion,
- Renovate space for increasing nurses for medical teams,
- Renovate space to address referral needs.
- Work with Tribal programs on possible alternate building location.

Western Oregon Service Unit, CAPT Laura Herbison, CEO

Chemawa Indian Health Center

This year, 2016, Western Oregon Service Unit (Chemawa Indian Health Center) celebrates 37 years of comprehensive outpatient services to federally recognized American Indian and Alaska Native people and their descendants living in or visiting the service area. Located in Salem, Oregon, Chemawa Indian Health Center has grown to provide health care to over 6,000 patients that represent 299 tribes from all areas in Oregon and SW Washington. The clinic continues to work closely with Chemawa Indian School and Bureau of Indian Education to coordinate all aspects of patient care to the over 400 high school students living on campus.

Renew and Strengthen Partnerships with Tribes and Urban Programs

- Governing Board attendance by Grand Ronde Executive Director, Kelly Rowe
- Governing Board attendance by CIS Superintendent, Lora Braucher
    - Care Coordination Improvement team between CIS and WOSU
- NARA site visit, POS training, provider shadowing
- Site Visit by the U.S. Secretary of Veterans Affair, Robert A. McDonald
    - 267 registered Native American Veterans representing 78 tribes

Ensure Work Is Transparent, Accountable, Fair, and Inclusive

- GPRA
- Quarterly Director's Priorities Reports
- Governing Board charter to include data dashboard, policy/AAAHC crosswalk
- Quarterly budget reviews with Budget Analyst
    - Daily and weekly obligations / collections finance reports
- Monthly department reports
- QI projects – public drive – department and workgroup folders

Improve the I.H.S

- Modernization
    - Project Schedule: 25% complete with construction
        - ADA compliance throughout with new canopy entrance
        - Increase exam rooms, addition of 4th care team
        - Improved operational efficiency
        - Additional group mental health counseling rooms
    - Construction Complete: July 24, 2017

Chemawa Indian Health Center

PROGRAM SERVICES

Scheduled and Same Day Ambulatory Appointments
Women's Health, Family Planning, Well Child Exams
Pharmacy including mail order prescriptions

Dental, Optometry, and Lab
Mental Health Support
Alcohol and Substance Prevention
Public Health Nursing
Benefits Coordination in support of ACA
Group Diabetes Education and Self-Management Courses

Public Health Update, Clark Halvorson, Assistant Secretary, Environmental Public Health, State of WA

RECESS

Thursday, October 20, 2016

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

Invocation: Dan Gleason

Chairman's Report – See attached report

TLDC Update, Cassie Sellards-Reck and Sharon Stanphill

Minutes – skipped will do in January 2017

Finance Report, Eugen Mostofi

Motion by Greg Abrahamson, Spokane Tribe; seconded by Sam Penney, Nez Perce Tribe to approve the Finance Report. MOTION PASSED

Resolution:

17-01-01 Supporting Standing Rock Sioux Tribe and Opposition to Dakota Access Pipeline
Ratified, motion by Cassie Sellards-Reck, Cowlitz Tribe; Seconded by Marilyn Scott, Upper Skagit Tribe. MOTION PASSED

17-01-02 Support of Community Health Aide Program (CHAP) National Expansion
Motion by Andy Joseph, Colville Tribe; Seconded by Brent Simcosky, Jamestown Tribe. MOTION PASSED

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

MINUTES

Motion by Cassie Sellards-Reck, Cowlitz Tribe, Seconded by Leland Bill, Yakama Nation. MOTION PASSED

Motion to Adjourn

ADJOURN at 10:07 a.m.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

OCTOBER 2016 QUARTERLY BOARD MEETING

Clearwater Casino & Resort, Suquamish, WA

October 18-20, 2016

MINUTES

_____ _____

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

_____ _____

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

_____ _____

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

QUARTERLY BOARD MEETING
Suquamish Clearwater Casino Resort
Suquamish, WA
October 18-20, 2016

AGENDA

MONDAY, OCTOBER 17, 2016

2:00 PM	Tribal Health Directors	Kitsap Hall (in the Lodge)
TUESDAY, OCTOBER 18, 2016 – SALMON HALL		
7:30 AM	**Executive Committee Meeting**	
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call	Andy Joseph, Chairman Suquamish Chairman, Leonard Forsman Suquamish Warriors Shawna Gavin, Treasurer
9:15 AM	Indian Health Services	Mary Smith, Principal Deputy Director Indian Health Service
10:00 AM	Area Director Report **(1)**	Dean Seyler, Area Director
10:30 AM	**Break**	
10:45 AM	Executive Director Report **(2)**	Joe Finkbonner, Executive Director
11:15	Region X Update	Susan Johnson, HHS Regional Director
12:30 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: Stephanie Craig Staff: Andra Wagner Staff: Laura Platero Staff:
1:45 PM	We R Native Update	Stephanie Craig-Rushing, Suicide Prevention & PRT Project Director

2:15 PM	SAMHSA Update **(3)**	David Dickinson, MA, Regional Administrator Substance Abuse & Mental Health Services Administration - U.S. Department of Health & Human Services
3:15 PM	**BREAK**	
3:30 PM	Opioid Guidelines/Policy **(4)**	CAPT Thomas Weiser, MD, MPH Medical Epidemiologist
4:30 PM	Executive Session	
6:00 PM	***Cultural Dinner***	***House of Awakened Culture***

WEDNESDAY OCTOBER 19, 2016- SALMON HALL

9:00 AM	Call to Order Invocation	Cheryle Kennedy, Vice-Chairman
9:15 AM	Cancer Project & Tobacco Update **(5)**	Kerri Lopez WTDP & NTCCP Project Director
10:00 AM	Zika Virus Update **(6)**	CAPT Thomas Weiser, MD, MPH Medical Epidemiologist
10:15 AM	Legislative Update **(7)**	Laura Platero, Government Affairs/Policy Director
	BREAK	
11:00 AM	Native STAND Update **(8)**	Michelle Singer (Navajo) Project Manager, Native STAND (Students Together Against Negative Decisions) Oregon Prevention Research Center – The Center for Healthy Communities OHSU-PSU School of Public Health
12:00 PM	**LUNCH**	
1:30 PM	Tribal Update 1. Kalispel 2. Kootenai 3. Lower Elwha Klallam Tribe	
2:15 PM	Data Repository **(9)**	Victoria Warren-Mears, PhD, RDN, FAND Director, Northwest Tribal Epidemiology Center
2:45 PM	Quality of Care and Business Practice and the ACA **(10)**	Laura Herbison, CEO, Western Oregon Service Unit & Jay Sampson, CEO, Yakama Service Unit

3:30 PM	**BREAK**	
3:45 PM	Suquamish Community Health Program **(11)**	Barbara Hoffman, DNP and Fran Miller, Nutritionist
4:15 PM	Public Health Update **(12)**	Clark Halvorson, Assistant Secretary, Environmental Public Health, State of WA

THURSDAY, OCTOBER 20, 2016- SALMON HALL

8:30 AM	Call to Order Invocation	Andy Joseph, Chairman
8:45 AM	Chair's Report	Andy Joseph, Chairman
9:00 AM	Committee Reports: 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution 7. Youth	
9:30 AM	Unfinished/New Business 1. Approval of Minutes 2. Resolutions 3. Future Board Meeting Sites: • *January 17-19, 2017 – Great Wolf Lodge (Chehalis)* • *April 2017 – Tentatively Yakama* • *July 2017 Joint Meeting w/ CRIHB – Canyonville, OR (Cow Creek)* • *October 2017 - TBD*	
10:00 PM	Adjourn	

INDIAN HEALTH SERVICE PORTLAND AREA DIRECTOR'S UPDATE

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

Indian Health Service Portland Area

- **New Staff:**
  - LCDR Kathi Murray, MS, RDN, CDE – Area Diabetes Consultant
    - Kathi.murray@ihs.gov
    - 503-414-5555

FY18 Budget Formulation (Area Meeting)
- Date – November 29th
- Location – Portland
- CAPT Ann Arnett, Executive Officer
- Andy Joseph and Steve Kutz – Tribal Reps to National Meeting

Indian Health Service Portland Area

- **Mandatory Seasonal Influenza Immunizations for Civilian Health Care Personnel**
  - **Policy applies to all Civil Service employees, contract staff, temporary employees, students and volunteers whose duties and responsibilities require them to work permanently, temporarily or occasionally in an IHS health care facility (hospital, clinic or health station) regardless of their job category or level of patient contact (definition of Health Care Personnel [HCP])**
  - **Must provide acceptable documentation substantiating influenza vaccine receipt or request for exemption by October 31**
  - **Two forms of exemption considered: 1) Medical 2) Religious**

Indian Health Service Portland Area

	UP FY15	Share of PA Total	UP FY16 *3rd Draft*	Share of PA Total
Burns Paiute	164	0.15%	155	0.14%
Chehalis - *	1,097	1.00%	1,121	1.02%
Coeur d' Alene - *	4,984	4.53%	4,592	4.17%
Colville - *	8,079	7.33%	8,012	7.27%
Coos/Lower Umpqua/Siuslaw - *	762	0.64%	947	0.86%
Coquille - *	901	0.82%	779	0.71%
Cow Creek - *	2,472	2.24%	2,443	2.22%
Cowlitz - *	3,947	3.58%	4,301	3.90%
Grand Ronde - *	4,229	3.84%	4,746	4.31%
Hoh - *	21	0.02%	11	0.01%
Jamestown S'Klallam - *	570	0.52%	250	0.23%
Kalispel - *	597	0.54%	2,105	1.91%
Klamath - *	3,178	2.88%	3,053	2.77%
Kootenai - *	173	0.16%	180	0.16%
Lower Elwha - *	958	0.87%	923	0.84%
Lummi - *	4,369	3.96%	4,446	4.03%
Makah - *	2,386	2.16%	2,505	2.27%
Muckleshoot - *	4,927	4.47%	6,220	5.64%
Nez Perce - *	4,006	3.63%	4,064	3.69%
Nisqually - *	1,725	1.56%	1,613	1.46%
Nooksack - *	1,288	1.17%	1,210	1.10%
NW Band Shoshoni - *	96	0.09%	96	0.09%
Port Gamble - *	1598	1.45%	867	0.79%
Puyallup - *	5,322	5.74%	5,489	4.91%
Quileute - *	631	0.57%	585	0.53%
Quinault - *	2,614	2.37%	2,604	2.36%
Samish - *	615	0.56%	611	0.55%
Sauk-Suiattle	73	0.07%	71	0.06%
Shoalwater Bay - *	408	0.37%	408	0.37%
Shoshone Bannock - *	6,216	5.63%	6,142	5.57%
Siletz - *	4,508	4.09%	3,071	2.79%
Skokomish - *	797	0.72%	824	0.75%
Snoqualmie - *	924	0.84%	741	0.67%
Spokane - *	1,753	1.59%	1,734	1.57%
Squaxin Island - *	854	0.77%	859	0.78%
Stillaguamish - *	91	0.08%	83	0.08%
Suquamish - *	781	0.71%	1,384	1.26%
Swinomish - *	1,484	1.35%	1,551	1.41%
Tulalip - *	5,313	4.82%	5,401	4.90%
Umatilla - *	3,342	3.03%	3,271	2.97%
Upper Skagit - *	429	0.39%	324	0.29%
Warm Springs - *	5,806	5.27%	6,038	5.48%
Western Oregon SU - *	2,344	2.13%	2,172	1.97%
Yakama - *	13,511	11.35%	12,352	11.19%
TOTAL	**110,225**		**110,192 - ***	

Indian Health Service Portland Area

- **Portland Area Recognized for Achievement in Adolescent Immunizations**
  - Received at the National Immunization Conference, September, 2016
    - Tdap/Td 95.1%
    - Meningococcal 91.4%
    - 1 dose Human Papilloma Virus (HPV) 81%
      - 85.4% (Females) 77.0% (Males)
- **New Adult Immunizations Measure for GPRA**
  - Testing and validation conducted by NWTEC with IHS and Tribal sites in Portland Area and two other IHS Areas
  - Developmental measure for 2016-2017
  - Will be implemented in 2017-2018

Indian Health Service Portland Area

- **FY16 CHEF Balance – $13,177,538***
  - **1.6 million submitted for Portland Area**
  - **$1.3 million approved and returned**
- **PRC Area Risk Pool Conference Call**
  - **November 8, 2016**
  - **10AM**
  - **Email sent to six Tribal Health Directors**

* As of September 30th

Indian Health Service Portland Area

- **Maximum Supportable Space (MSS)**
  - Approved IHS Program Space is Used to Determine the Share of Maintenance & Improvement (M&I) and Equipment (EQ) Funds.
  - Each Program Has an Established Maximum – MSS
  - PAO Division of Health Facilities Engineering (DHFE) Has Identified an Approach that May Increase the Established MSS, Potentially Increasing the Share of M&I and EQ Distributed to Programs Currently Over Their MSS.
  - In FY 2017, PAO/DHFE Plans To:
    - Analyze Current Space Records for All Tribal Health Programs with Retained Shares.
    - Notify Programs that May Benefit From This Process to Increase MSS.
    - Work with the Identified Programs to Increase Their MSS.
  - In FY 2018, Subject to Workload and Resource Availability, There May Be Buy-Back Opportunities for Tribes Who Have Taken Their Shares to Follow This Process.

Indian Health Service Portland Area

- **Government Performance and Results Act (GPRA)**
  - **GY 2016- 24 measures**
  - **Four new measures:**
    - Statin Therapy to Reduce CVD Risk with Diabetes
    - Influenza Vaccination Rates Among Children (6 mo-17 yrs)
    - Influenza Vaccination Rates Among Adults (18 and older)
    - HIV Screening Ever (13-64 years old)
  - **Two revised indicators:**
    - FAS Prevention (alcohol screening)- Age range expanded to females 14-46 years.
    - DV/IPV Screening- Age range expanded to females14-46 years.

Indian Health Service Portland Area

- **Government Performance and Results Act (GPRA)**
  - **GY 2016 Results (24 measures)**
    - National- Results pending
    - **Portland (Federal & Tribal)- Met 15 measures**

Indian Health Service Portland Area

- **Government Performance and Results Act (GPRA)**
- **Portland Area GPRA Reporting Sites**
  - Federal- Colville, Ft. Hall, Warm Springs, Wellpinit, Western Oregon, Yakama
  - Urban- NARA, Spokane NATIVE

- Confederated Tribe of the Chehalis Reservation
- Confederated Tribes of the Colville Reservation (Inchelium Clinic)
- Cow Creek Band of Umpqua Tribe of Indians
- Cowlitz Indian Tribe
- Lower Elwha Klallam Tribe
- Lummi Nation
- Makah Tribe (Sophie Trettevick Clinic)
- Muckleshoot Indian Tribe
- Nez Perce Tribe (Nimiipuu Clinic)
- Nooksack Indian Tribe
- Quinault Indian Nation (Roger Saux Clinic)
- Shoalwater Bay Indian Tribe
- Skokomish Indian Tribe
- Snoqualmie Tribe
- Squaxin island Tribe
- Swinomish Indian Tribal Community
- Tulalip Tribes
- Confederated Tribes of the Umatilla Indian Reservation (Yellowhawk Clinic)

Indian Health Service Portland Area

AREA AGGREGATE Dashboard Report - Portland Area Federal/Tribal IHS sites

	National 2016 Target	Numerator	Denominator	2016	# Needed to Achieve Target
Good Glycemic Control <8	49.5	2930	5871	49.7%	MET
Controlled BP <140/90	65	4226	5973	70.8%	MET
Statin Therapy	Baseline	2617	4195	62.4%	N/A
Nephropathy Assessed	61.1	3652	5973	66.2%	MET
Retinopathy Assessed	61.6	3118	5968	52.2%	559
Dental Access General	29.3	25043	73975	33.9%	MET
Sealants	14.8	2914	17517	16.6%	MET
Topical Fluoride	28.3	6531	18547	35.2%	MET
Influenza 6 mo- 17 yr	Baseline	5681	15213	37.3%	N/A
Influenza 18+	Baseline	14030	36026	38.9%	N/A
Pneumovax 65+	87.3	3542	4238	83.6%	358
Active IMM 4313*314	76.8	647	1009	64.1%	128
Pap Smear Rates 24-64	55.6	6583	13351	49.3%	841
Mammogram Rates 52-64	55.9	1880	4041	46.5%	370
Colorectal Cancer 50-75	38.7	4767	12010	39.7%	MET
Tobacco Cessation Counsel/Quit	49.1	8029	17051	47.1%	344
FAS Prevention 14-46	Baseline	8200	13706	59.8%	N/A
IPV/DV Screen 16-46	Baseline	7691	13706	56.1%	N/A
Depression Screen 18+	67.2	22021	36026	61.1%	2189
Childhood Weight Control	22.8	502	1891	26.5%	-71
Controlling High BP-MH	60.6	4963	8271	60.0%	50
CHD Comp CVD Assessment	53.3	1145	1933	59.2%	MET
HIV Screening Ever	Baseline	19234	52212	36.8%	N/A
Breastfeeding Rates	35.8	51	114	44.7%	MET

Indian Health Service Portland Area

- **Government Performance and Results Act (GPRA)**
  - **GY 2016 Results (24 measures)**
    - National- Pending
    - Portland (Federal & Tribal)- Met 15 measures
    - **Portland (Federal Only)- Met 19 measures**
      - **Western Oregon- 5th year in a row**
      - **Warm Springs & Colville- Met 23 of 24 measures**

Indian Health Service Portland Area

AREA AGGREGATE Dashboard Report - Portland Area Federal IHS sites	National 2016 Target	Numerator	Denominator	2	# Needed to Achieve Target
Good Glycemic Control <8	49.5	1577	3235	48.7%	25
Controlled BP <140/90	65	2312	3235	71.5%	MET
Statin Therapy	Baseline	1470	2291	64.2%	N/A
Nephropathy Assessed	61.1	2447	3235	75.6%	MET
Retinopathy Assessed	61.6	1916	3232	59.3%	75
Dental Access General	29.3	10526	35906	29.3%	MET
Sealants	14.8	1522	8469	18.0%	MET
Topical Fluoride	28.3	2897	8948	32.4%	MET
Influenza 6 mo- 17 yr	Baseline	3233	7370	43.9%	N/A
Influenza 18+	Baseline	8184	17906	45.7%	N/A
Pneumovax 65+	87.3	1945	2166	89.8%	MET
Active IMM 4313*314	76.8	867	887	75.4%	8
Pap Smear Rates 24-64	55.6	3873	6563	59.0%	MET
Mammogram Rates 52-64	55.9	1104	2026	54.5%	29
Colorectal Cancer 50-75	38.7	2610	6001	43.5%	MET
Tobacco Cessation Counsel/Quit	49.1	4932	8448	58.4%	MET
FAS Prevention 14-46	Baseline	4685	6851	68.4%	N/A
IPV/DV Screen 14-46	Baseline	4521	6851	66.0%	N/A
Depression Screen 18+	67.2	12798	17906	71.5%	MET
Childhood Weight Control	27.8	246	982	25.1%	-23
Controlling High BP-MH	60.6	2742	4462	61.5%	MET
CHD Comp CVD Assessment	53.3	707	998	70.8%	MET
HIV Screening Ever	Baseline	13346	25514	52.3%	N/A
Breastfeeding Rates	35.8	29	72	40.3%	MET

Indian Health Service Portland Area

- **Fall 2016 Portland Area Clinical Director's Meeting**
  - **October 27-28, 2016**
  - **Warwick Hotel, Seattle, WA**
  - **Topics:**
    - CDC Opiate Prescribing Guidelines
    - Addressing Childhood Obesity
    - Salish Integrative Oncology Center
    - VA-IHS Collaboratives
    - Integrating Environmental Health into Clinical Practice
    - Use of an ECHO Model for Hepatitis C Case Management

Questions or Comments

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

Our Goal... to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

Our Foundation... to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Executive Director Report

Suquamish Casino Resort
Suquamish, WA
October 18, 2016

Joe Finkbonner, RPh, MHA

Personnel

- **New Hires:**
  - Oceana Henderson, On-Call Office Assistant
- **Promotions:**
  - David Stephens, HCV RN Project Manager
  - Jessica Leston, HIV/HCV/STI Clinical Services Project Director
  - Candice Jimenez, Research Coordinator
- **Interns:**
  - Jana Hodgins, PRT Volunteer

Events

August
- PHAB Accreditation Committee

September
- National Tribal Forum for Excellence, Spokane, WA
- Nike Native Fitness (didn't attend) Nike HQ
- WEAVE Annual Gathering, Portland, OR

October
- NCAI, Phoenix, AZ

Northwest Portland Area Indian Health Board

11th Annual Indian Day Celebration

Chemewa Indian School joined us

Northwest Portland Area Indian Health Board

Hood To Coast

Northwest Portland Area Indian Health Board

Upcoming

November

- Vacation
- Oregon Health Insurance Marketplace, Portland, OR
- Public Health Leader/Mentor Panel, UW

December

- WDSF Board meeting
- PHAB Board of Directors
- NWIC Foundation Board meeting

NPAIHB Annual Holiday Party (Dec. 9th)

Questions…?

Northwest Tribal Epidemiology Center
(*The EpiCenter*)
July-September 2016 Quarterly Report

Northwest Tribal Epidemiology Center Projects' Reports Include:

- **Adolescent Health**
- **Epicenter Biostatistician**
- **Epicenter National Project Evaluation**
- **Immunization and IRB**
- **Injury Prevention Program (IPP)/Public Health Improvement & Training (PHIT)**
- **Maternal Child Health Projects**
- **Medical Epidemiologist**
- **Northwest Tribal Cancer Control Project**
- **Northwest Tribal Dental Support Center**
- **Northwest Tribal Registry Project-Improving Data and Enhancing Access (IDEA-NW)**
- **Wellness for Every American Indian to View and Achieve Health Equity (WEAVE)**
- **Western Tribal Diabetes Project**

Adolescent Health

Stephanie Craig Rushing, Project Director
Colbie Caughlan, THRIVE Project Manager
Jessica Leston, Project Manager
David Stephens, Multimedia Project Specialist
Tommy Ghost Dog, Project Red Talon Assistant
Celena McCray, THRIVE Project Coordinator

Contractor: Amanda Gaston, MAT, IYG Project
Students: Lauren Adrian, VOICES MPH Intern; Steven Hafner, Harvard PhD Student Intern; Katie Bauer, PSU Student Intern; Traven Joseph, UO Student Intern

Quarterly Report: July – September 2016

Technical Assistance and Training

NW Tribal Site Visits

- Seattle: Hep Education Project – Collaborative Conversations with Tribal American Indians, Urban American Indians, and Alaska Native communities on Viral Hep – July 12-14, 2016.
- Burns: *We R Native*, Burns, OR. August 15, 2016. Approximately 60 youth in attendance.
- Quileute: Social Marketing Bootcamp: Focusing on youth resilience and pride. August 23-24, 2016. Approximately 14 youth in attendance.

Out of Area Tribal Site Visits

- Cherokee, OK: PWID Project site visit and PrEP/Syphilis Training – July 5-7, 2016.
- Baltimore/DC: Baltimore Urban Clinic and IHS HQ Visit – July 25 – 27, 2016.
- Chicago Urban Clinic, Chicago, IL. August 1, 2016. National TA with UIHI.
- Milwaukee Urban Clinic, Milwaukee, WI. August 2, 2016. National TA with UIHI.

September Technical Assistance Requests

- Tribal TA Requests = 3 (Stephanie), 4 (Jessica), 2 (David & Tommy)
- Other Agency Requests = 14 (IHS, SAMHSA, HRSA, WA DOH, SD State, UT DOH, NC DOH, SMAHRT, JBS International, OHSU, ANTHC, ITCA, Potlatch Fund, #NativeGiving)

Project Red Talon / We R Native / Native VOICES

During the quarter, Project Red Talon staff participated in eight planning calls, four partner meetings, and presented at eight conferences/webinars, including:

- Booth: UNTIY National Conference: *We R Native*, Oklahoma City, OK. July 23-24, 2016. Visited by approximately 400 AI/AN youth from Tribes across the U.S.
- Call: SMAHRT Team – Concerning Post Webinar check-in, September 9, 2016.
- Call: Steven Hafner re: Violence Intervention Study, September 16, 2016.
- Host: Gen I Social Marketing Bootcamp, Olympia WA, July 11-12, 2016. Training involved 8 AI/AN youth, and 3 NW Tribes.
- Launch: www.Healthy Native Youth.org website. August 16, 2016.
- Meeting: Health Equity Convening. Hosted by Potlatch Fund. September 30, 2016.
- Meeting: We Are Healers, July 6, 2016.
- Present: HHS Teen Pregnancy Prevention Grantees Conference: *Native It's Your Game and the Healthy Native Youth Portal,* Baltimore, MD. July 19, 2016. Approximately 45 participants in attendance.

- Present: UNTIY National Conference: *We R Native*, Oklahoma City, OK. July 23-24, 2016. Workshops involved 200 AI/AN youth from Tribes across the U.S.
- Present: *Concerning Social Media Posts*, IHS Behavioral Health Conference, Portland, OR. August 11, 2016. Approximately 50 adults in attendance.
- Present: We R Native, at the *Generation Indigenous: Raising Impact with Innovation and Proven Strategies*, White House, Washington DC. Approximately 75 Gen-I advocates and philanthropists in attendance.
- Present: *We R Native*, Burns, OR. August 15, 2016. Approximately 60 youth in attendance.
- Social Marketing Bootcamp: Focusing on youth resilience and pride. Quileute Tribe. August 23-24, 2016. Approximately 14 youth in attendance.
- Webinar Presentation: We R Native & #WeNeedYouHere. Hosted by HRSA: Tribal Youth Suicide Prevention: Current Perspectives. Approximately 160 adults in attendance.
- Webinar: *Engaging Native Youth in Health Activism*, WEAVE Webinar Series. August 23, 2016. Approximately 12 tribes/attendees.
- Webinar: Two-Spirit Tuesdays: Resource Sharing, July 26, 2016.

Native It's Your Game

During the quarter, *Native It's Your Game* staff participated in seven planning calls with study partners, and supported the following trainings and events:

- Site Call: Nimiipuu Health Center, September 15, 2016
- Site Call: Shoshone-Bannock, September 2, 2016.
- Workgroup: Healthy Native Youth – Sexual Health Workgroup Call, September 28, 2016.

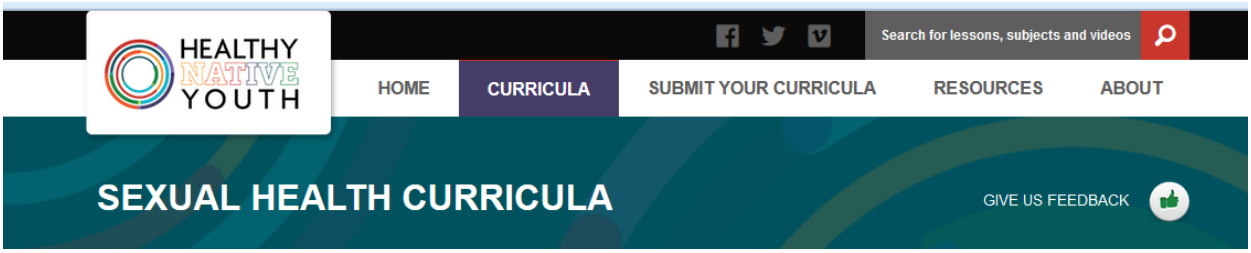
Quality Improvement

During the quarter, STD/HIV QI staff participated in eighteen planning calls and ten Adobe/Zoom meetings, including:

- Adobe: Great Plains Regional Infection Disease Session – September 1, 2016.
- Adobe: PrEP Fort Defiance – July 7, 2016
- Adobe: PrEP GIMC – July 7, 2016
- Adobe: PWID Interview Training – July 21, 2016
- Adobe: PWID Meeting with co-PI – July 6, 2016
- Meeting: Project ECHO Immersion – September 14-16, 2016.
- Zoom: ECHO HCV – August 17, 2016, August 3, 2016, July 6, 2016, September 21, 2016, September 7, 2016.

Health Promotion and Disease Prevention

Website: The Healthy Native Youth website launched on August 15, 2016: www.healthynativeyouth.org



The site contains sexual health curricula for AI/AN youth. It is designed for tribal health educators, teachers, and parents – providing the training and tools needed to access and deliver effective, age-appropriate programs.

In September, the site received:

Page views	1,651
Sessions	523
Pages per visit	3.16

Facebook page "likes" = 110: https://www.facebook.com/HealthyNativeYouth

WE R NATIVE

Website: The We R Native website launched on September 28, 2012: www.weRnative.org

In September, the site received:

Page views	7,938
Sessions	3,299
Pages per visit	2.41

- Over 360 health/wellness pages are included on the website.
- We continue to refine and improve the website, sitemap and wireframe:
  - Mobile-friendly site launched May 2016
  - Adding a Text 4 Sex Ed service – in 2016/17

Text Messages: The service currently has 4,217 active subscribers.

TEXT NATIVE TO 24587

Twitter: Followers = 3,691

YouTube: http://www.youtube.com/user/wernative#p/f

The project currently has 417 uploaded videos, has had 64,641 video views, with 115,774 estimated minutes watched.

Facebook: http://www.facebook.com/pages/We-R-Native/247261648626123

By the end of the month, the page had 40,881 Likes.

Instagram: http://instagram.com/wernative

By the end of the month, the page had 3,625 followers.

Native STAND Videos: Address Healthy Relationships • Teen Sexual Health • Condom Demonstration • Teen Pregnancy and Parenting Panel • Living with HIV/AIDS • Drug & Alcohol Youth Panel • 2 Role Plays

• 3 Public Service Announcements (PSA). Since their release, the Native STAND videos have been viewed 24,288 times.

Native VOICES Videos: 23 videos are included in the Native VOICES playlist on We R Native's YouTube Channel. Since their release, the Native VOICES videos have been viewed 2,639 times on YouTube and reached 1,860,000 people on Facebook.

- Native VOICES is the ***only*** intervention purposefully designed for AI/AN youth included in the CDC's compendium of effective HIV interventions: effectiveinterventions.cdc.gov/en/HighImpactPrevention/Interventions/VOICES.aspx

Surveillance and Research

Native It's Your Game: We continue to provide TA to 3 tribal ACF sites implementing Native IYG + parent-child components.

Healthy Native Youth Website Usability: We recruited 4 tribal sites to test the www.HealthyNativeYouth.org website and provide feedback on its use.

Concerning Social Media: The NPAIHB has partnered with the Social Media Adolescent Health Research Team at Seattle Children's Hospital to design interventions to address concerning posts on social media. We are working on an educational webinar/video and a publication.

Violence Prevention Messages: We R Native partnered with Steven Hafner to carryout formative research to design a violence prevention intervention that will be delivered to Native young men via Facebook. Interviews with young men 18-24 have been collected and are being analyzed for themes.

STD/HIV Measures Project: The project is monitoring STD/HIV GPRA measures for IHS sites throughout Indian Country. Infographics are being generated to provide visual feedback data to all 66 IHS sites, 13 Urban sites and any tribal site that provides access. PRT staff are assessing local strengths and weaknesses (administrative, staffing, clinical, and data) that influence screening.

Other Administrative Responsibilities

Publications

- Blog reference to We R Native: http://pulse.seattlechildrens.org/preventing-tragedy-by-empowering-teens-to-react-to-troubling-social-media-posts-from-peers/
- Blog reference to We R Native: https://philanthropynw.org/news/investing-health-and-prosperity-native-youth
- HEY article accepted for publication
- Working on Native VOICES Outcomes paper
- Working on *Texting 4 Sexual Health* papers (x3)
- Working on *IYG* papers (x4)
- Working on Hepatitis C papers (x2)

Reports/Grants

- NIH – NW Suicide Prevention Research Hub – NPAIHB lead
- NARCH – Native VOICES 2 – NPAIHB lead
- IRB Continuation Report – Violence Formative Research Protocol
- NPAIHB Strategic Plan

Administrative Duties

- Budget tracking and maintenance: Ongoing

- Managed Project Invoices: Ongoing
- Managed Project Subcontracts: Ongoing
- Staff oversight and annual evaluations: Ongoing

Epicenter Biostatistician

Nancy Bennett

Conference Calls:

- Planning calls weekly for the Emergency Preparedness conference
- Planning calls weekly for the National tribal forum for public health accreditation
    - Calls with speakers to finalize presentations for the national forum

NPAIHB Meetings:

- All staff meeting - monthly
- Assisted in preparation/ running of Indian day Pow Wow
    - Assembled good will bags
    - Helped set up powwow
- EP Conference planning calls
    - Began scouting locations for 2017 conference
    - Participated in planning calls

Conferences/QBMs/Out of area Meetings

- National Tribal Forum
    - Assisted in running forum

Miscellaneous

Reports:

Site Visits:

Epicenter National Project Evaluation

Birdie Wermy

Technical Assistance via telephone/email

August - September

- Ongoing communication with NPAIHB EpiCenter Director
- Ongoing communication with Tribal sites regarding project updates, information and assistance

Reporting

August

- QBM Wellness/TeamHANDS Hood To Coast Update on 8.10
- August conference call GHWIC C2 call on 8.18
- CTUIR Zoom Call CANCELED on 8.18

September

- GHWIC C2 call on 9.15 @ 11:30am
- CTUIR Zoom Call on 9.01 @ 2:30pm
- TEC Eval Call on 9.21 @ 10am

Updates

Birdie – continuing to provide evaluation TA to MSPI/DVPI service areas

- Liz Sanchez – Quileute Nation; TA on 8.05
- Beatriz Arikawa – Lower Elwha; TA (returned phone call) on 8.09
- Sent out reminder email for TA services on 9.28
  - No TA was provided to any site or programs during the month of September

Challenges/Opportunities/Milestones

- I am continuing to reach out to the programs and I receive a number of questions regarding the application renewal process as well as evaluation questions.

Meetings/Trainings

- Spirit of Giving Conference; Portland, Or. 8.02-8.04.16
- QBM; Omak, Wa. 8.10-8.11.16
- WEAVE NW Webinar on 8.23
- Indian Day Meeting 8.17
- Wellness Committee Meeting 8.18
- N7 Sports Summit; Beaverton, Or. 9.08-9.10.16
- Indian Day Meeting 9.08.16
- Wellness Committee Meeting 9.08.16

Site Visits

- Omak, Wa. 8.10-8.11.16

Upcoming Calls/Meetings/Travel

- N7 Sport Summit; Beaverton, Or. 9.08-9.10.16
- WEAVE NW Annual Gathering; Portland, Or. 9.13-.14.16
- GHWIC C2 call on 9.15
- SACNAS Conference; Long Beach, Ca. 10.12-10.15.16
- GHWIC C2 call on 10.06
- Quarterly Board Meeting; Suquamish, Wa. 10.18-10.21.16
- Wellness Committee Meeting on 10.24.16

Publications

- NONE

Immunization and IRB

Clarice Charging

Meetings:

Native Health Initiative presentation, NPAHB, July 7, 2016
NPAIHB all-staff committee meeting, July 11, 2016
NPAIHB dental conference, Clearwater Casino, Suquamish, WA, July 11, 2016
NPAIHB all-staff meeting, August 1, 2016
Tribal EP planning meeting, August 5, 2016
Indian Day committee meeting, September 8, 2016
NPAIHB all-staff meeting, September 12, 2016
Indian Day committee meeting, September 15, 2016
Indian Day, September 23, 2016

Quarterly board meetings/conferences/site visits:

NPAIHB quarterly board meeting, Twelve Tribes Resort and Casino, Omak, WA, August 9-11, 2016

Conference Calls:

Indian Health Service Immunization Coordinator's, September 22, 2016
Native Project, September 30, 2016

Portland Area (PA) Indian Health Service (IHS) Institutional Review Board (IRB):

PA IRB Meetings:

PA IHS IRB committee meeting, July 19, 2016
PRIMR webinar, September 2016

During the period of July 1 – September 30, Portland Area IRBNet program has 126 registered participants, received 1 new electronic submissions, processed 9 protocol revision approvals, 6 publications/presentations, and approved 6 annual renewals.

Provided IT and IRB regulation assistance to Primary Investigators from:

1) Cowlitz Tribes/NICWA
2) Port Gamble S'Klallam
3) NPAIHB
4) Confederated Tribes of Warm Springs
5) Oregon Health Sciences University
6) PSU/Siletz Tribe
7) Confederated Tribe of the Umatilla Indians
8) Healing Lodge of the 7 Nations

Injury Prevention Project/Public Health Improvement & Training

Bridget Canniff, Project Director
Luella Azule, Project Coordinator

Conference Calls

- 7/5,12,19,20, 26, 8/15, 25, 26 Target Forum planning committee, partner Forum update, debrief conference calls with Red Star/meetings (Bridget, Luella, Nancy Bennett)
- 7/14 TEC-CDC/NCIPC Conference call with Alex Crosby
- 8/17, 9/27, TIPCAP Administrative Calls
- 9/8, 9/29 Emergency Preparedness conference planning calls (Bridget, Luella, Nancy B)

Meetings/Conferences/Presentations

- 7/1 Attended Thrive Showcase (Luella)
- 7/8, 7/19 PHIT/IP Meetings (Bridget and Luella)
- 7/11 Attended first Elder's Day--Grand Ronde (Luella)
- 8/29-31 National Tribal Forum, Kalispel Tribe, Northern Quest, Spokane, WA (Bridget, Luella, Nancy B)
- 9/13-15 National Indian Council on Aging conference, Niagara Falls, NY – attended with elders from Chehalis and Cowlitz (Bridget)
- 9/27 NAYA Elder meeting (Luella)

Trainings/Webinars

- 7/22 Archived webinar: TIPCAP Tribal IP Successes and Challenges (Luella)
- 9/28 Red Star Webinar: Destination Accreditation: Celebrating Cherokee Nation's Journey and Achievement (Bridget)
- 9/29 Webinar: Social U – How to reach teens (Luella)

Funding

- Injury Prevention received Notice of Award for Year 2 of TIPCAP continuing grant from IHS
- Public Health Improvement and Training received Notice of Award for Year 3 continuing grant as Local Performance Site for Northwest Public Health Training Center from Northwest Center for Public Health Practice

National Tribal Forum (Bridget, Luella, Nancy)

- National Tribal Forum e-blasts/newsletter outreach to attendees
- Coordinate direct payments to NPAIHB for Forum registration
- Respond to vendor inquiries, send application, forward completed applications contacted Forum Vendors re: selection, hotel reservation and forum set up
- Created excel spreadsheet, updated, downloaded/printed speaker and hotel reservation lists to compare, and make speaker reservations, coordinated speaker room reservations with Northern Quest
- Coordinated drums, color guard, chaplain for opening/closing prayer, Tribal opening by Kalispel Vice-Chair Raymond Pierre, culture night presentation
- Print speaker handouts, NPAIHB brochures, Forum program and signage
- Typed up moderator notes, posted all presentations on NPAIHB website
- Approximately 153 Tribal, Federal, State, County, and local participants attended the National Tribal Forum for Excellence in Community Health Practice – August 30-31, 2016, Northern Quest Resort and Casino

July-Sept Core/Other (Luella)

Scan/read E- News : Friday Mailouts—grant opportunities. Tribal Resource Digest, Health News and Notes, PHHS block/grantee highlights, watch NIHB Health Care Youth Video, Registered for Webinar: Understanding and Using Injury Cost Data in your Prevention Efforts, 2016 Top Workplaces, CDC Falls, Adult Immunizations, Prescription Opioid Abuse, Dependence Cost to United States, blood pressure control, College Horizons, Guilar Muir video: Don't Crash the plane, successful meeting tools, Fake It til you make it, Stand like a Starfish

Prepare/Download/Read: Washington Firearm Tragedy Prevention Network attachment, Safekids Worldwide (The Ultimate Car Seat Guide), update travel calendar/CPST contacts, Respond to Richard Rolland—Injury Prevention Coalition Member

Forward e-mails to Tribal IP contacts, and/or CPS techs, coalition committee: Child Safety Network (prevent child drownings), Safekids worldwide: Drowning prevention, Webinar information re: Preventing Adolescent Dating Abuse, Safe sleep videos, Top Tips to keep kids safe, Washington Firearm Tragedy Prevention Network attachment, Safekids Worldwide (The Ultimate Car Seat Guide). Webinar: Understanding and Using Injury Cost Data in your Prevention Efforts, Webinar: Overdose Prevention Policy Training Academy

Travel/Site Visits

Tribe: Grand Ronde	**Tribe:** Nisqually Tribe

Date: July 11, 2016 **Purpose**: Elder's Day **Who:** Luella	**Date:** July 28-August 7, 2016 **Purpose:** Paddle to Nisqually volunteer **Who:** Luella
Tribe: Shoshone Bannock **Date:** 8/10-13, 2016 **Purpose:** Tots2Tweens Dental Screening **Who:** Tam, Luella, Nichole, Maxine	**Tribe:** Kalispel **Date:** August 29-31, 2016 **Purpose**: National Tribal Forum **Who:** Bridget, Luella, Nancy Bennett
Location: Niagara Falls, NY **Date:** September 12-16, 2016 **Purpose**: NICOA Conference **Who:** Bridget	

Maternal Child Health Projects:

Jodi Lapidus, Native CARS PI
Tam Lutz, PTOTS Project Director/Jr Investigator
Nicole Smith, MCH Biostatistician
Candice Jimenez, Research Assistant
Thomas Becker, Co-PI (TOTS to Tweens)

Native CARS Study

Background
The Native CARS study is a grant funded by the National Center on Minority Health and Health Disparities (NCMHHD), and is a partnership with the NPAIHB, University of Washington, and six Northwest tribes. This partnership aims to design and evaluate interventions to improve child safety seat use in tribal communities.

The six Northwest tribes that participated in the Northwest Tribal Safety Seat Project (under Dr. Francine Romero, Principal Investigator) in 2003 are the same tribes who participated in this study. From the 2003 observational survey, we learned that many American Indian children age 8 and under were riding either unrestrained or improperly restrained in vehicles.

In the dissemination phase of the study, all six participating tribes received community-based interventions. Three received the interventions in phase 1, and the remaining received the interventions in phase 2. We collaborated with the tribal communities to develop interventions that would meaningful and suited to each community. We evaluated child safety seat use in the community both before and after the intervention phases to see if the intervention had an impact on motor vehicle restraint use in the community.

Goal of the Intervention Phase
The goal of the Native Children Always Ride Safe (Native CARS) project was to prevent early childhood vehicle collision morbidity and mortality in American Indian Alaskan Native children through the use of community base participatory model that incorporated tribal differences in cultural beliefs, family and community structure, geographic location, law enforcement and economic factors.

Objectives/Aims of Intervention Phase

We used qualitative research methods to identify community-specific concerns and barriers, and incorporate these findings into an effective behavioral change campaign. We disseminated these results widely, and worked with tribes to design tailored community interventions based on theoretical models of health behavior change. Finally, we assisted tribes as they implemented and evaluated the interventions through a controlled community trial. During this five-year project we **specifically aimed** to:

- Determine the knowledge of AI community members about child passenger restraint systems, and determine barriers and facilitators that effect consistent and appropriate use in six tribes in the Northwestern US.
- Work with members of six Northwest tribes to determine effective methods to increase child safety seat use, developing tailored community intervention programs to address unique needs.
- Implement and evaluate the programs in the Northwest tribal communities, comparing improvement in child passenger restraint use to three comparison tribes in the Northwest through a controlled community trial.

Objective/Aims of Dissemination Phase

Because of the demonstrated success of the Native CARS Study, the study was award additional funds for a dissemination phase of the study, where the protocols, tools and intervention materials can be translated for use by other tribes both locally and nationally. These evidence-based tribal interventions will be adapted and disseminated via plans guided by a dissemination framework that leverages and expands upon tribal capacity built during the previous Native CARS cycle, by engaging the tribal participants as experts throughout this phase. Demonstrating the translation potential of Native CARS interventions into other tribal communities is an essential step toward reducing the disparity in motor vehicle injuries and fatalities experienced by American Indian and Alaska Native children in the United States.

During the current *dissemination* phase, we specifically aim to:

- Develop the Native CARS Atlas (link to http://www.nativecars.org), a toolkit to assist tribes in implementing and evaluating evidence-based interventions to improve child passenger restraint use on or near tribal lands.
- Facilitate the use of the Native CARS Atlas (link to http://www.nativecars.org) in the six tribes that participated in the original initiative, to help sustain improvements in child passenger restraint use achieved during the intervention phase and provide lessons on use of the toolkit for other tribes.
- Use the Native CARS Atlas (link to http://www.nativecars.org) to assist at least 6 new tribes in the Northwest with demonstrated readiness to implement interventions to improve child passenger restraint use in their communities

Project News & Activities

This quarter the Native CARS Study continued with the developmental work of the dissemination phase of the study. We worked with the tribal site content experts to finalize specific dissemination modules. We have worked with a new contracted web developer to complete modules in the website and edit modules we have reviewed. We have continued to work with individual sites that are testing dissemination modules at the existing sites.

TOT2Tweens Study

A staggering proportion, 3 of 4 American Indian/Alaska Native (AI/AN) children between the ages of 2-5, have experienced tooth decay, over two-thirds have untreated decay, and over half have severe tooth decay. While this may politely be referred to as a "health disparity," it could more aptly be termed a "health disaster." Many AI/AN children experience tooth decay before the age of two. Tooth decay in that age group leads to further tooth decay and other oral health problems later in childhood.

The newly funded TOTS to TWEENS is a follow up study to *The TOTS Study (Toddler Obesity and Tooth Decay) Study)* an early childhood obesity and tooth decay prevention program. The goal of this study is to survey and conduct dental screenings with the original group of toddlers to test whether interventions delivered in the TOTS will influence the prevalence tooth decay in older children. Through qualitative approaches, the study will also assess current community, environmental and familial factors that can influence oral health in children to understand any maintenance of preventive behaviors over the last ten years within the entire family.

The TOTS2Tween Study is administered through the NW NARCH program at the NPAIHB. The *TOTS2TWEENS* Study will be led by Co-Principal Investigators, Thomas Becker, MD, PhD and Tam Lutz, MPH, MHA.

Project News & Activities

The TOTS2Tweens Study continued to make preparations for additional TOTS2Tweens Dental Screening event in partner communities. This quarter TOTS2Tweens held a dental screening in the Shoshone Bannock Tribes during their Shoshone Bannock Festival and continued follow up of parent questionnaire in Shoshone Bannock. Study team also began preparing for the next screenings Makah in early fall 2016.

Another highlights of this quarter has been bringing on new Tribal Site coordinator at Makah, Kim Kummer, a recent MPH graduate from University of Washington and Makah tribal member.

For more information about the TOTS to Tweens Study, contact Tam Lutz at tlutz@npaihb.org

BOARD ACTIVITIES

Meetings - Conference Calls – Presentations – Trainings

- Meeting: All Staff Mtgs and Staff Picnic, Jul-Sep (Tam, Nicole, Candice)
- Meeting: EpiCenter Staff (Tam, Nicole, Candice)
- Meeting: Wellness Cmte Meetings, Jul-Sep (Tam, Candice)
- Indian Day Meeting, Jul-Sep (Candice,Tam)
- Meeting: Oral Health Grant Review, Sep (Tom, Jodi, Tam)
- Meeting: MCH Epi Conference poster topic and design, Sep (Tam, Nicole, Sujata)
- Event: Indian Day Event, Sep (Tam, Nicole, Candice)
- Meeting: NPAIHB MCH Meeting to discuss EpiCenter Priorities, Sep (Tam, Nicole, Candice)
- Meeting: MCH Tribal Epi Meeting in Philadelphia, PA, Sep (Tam)
- Conference: MCH City Match Conference in Philadelphia PA, Sep (Tam)
- Meeting: Partners Meeting at MCH City Match Conference, Sep (Tam)

Program Support or Technical Assistance

- Monthly Wellness tip and newsletter, Jul-Sep (Candice)

Revised Native CARS Presentation for Data Literacy Workshop and went over it with Monika to present, Jul (Nicole)

- Drafted Poster for CDC MCH Epi Conference, Aug-Sep (Nicole, Tam, Candice)

TOTS to Tweens

Meetings - Conference Calls – Presentations – Trainings

- Project Meetings, Apr-June – (Tom, Tam, Nicole, Candice,)
- Site Coordinator Phone Mtgs with Lummi, Makah, Shoshone Bannock (Tam, Nicole, Candice)
- Shoshone Bannock Dental Screenings (August) (Tam, Nicole, Luella, Maxine)
- Met with Tribal Clinical and Schools to discussion Makah recruitment (Kim)
- NARCH budget meeting, Sep (Tom, Tam and Tara)
- Met with grant writing team at OHSU, Sept (Tam, Tom, Jodi)
- Poster development for OPHA meeting, Sept (Roop, Candice, Tom, Tam, Nicole)

Program Support or Technical Assistance

- Lummi data cleaning, Jul (Nicole)
- Shoshone Bannock data collection prep, Jul (Nicole)
- Shoshone Bannock travel arrangements, Jul-Aug (Candice)
- Shoshone Bannock screening supplies prep, Jul (Candice, Tam)
- Meeting coordination, minutes and action item documentation, Jul-Sep(Candice)
- Worked on data sharing agreement and resolution, Jul (Tam, Kim)
- Shoshone-Bannock Data Collection, Aug (Tam, Nicole)
- Shoshone-Bannock Data Entry, Aug (Tam, Nicole, Candice)
- Shoshone-Bannock and Lummi Data Management, Aug-Sep (Nicole)
- Communication with Shoshone-Bannock for site set up, Aug (Tam)
- Dental Outcomes Compilation for Shoshone-Bannock Dental Clinic, Aug (Nicole)
- Makah Preparation, Aug-Sep (Tam, Nicole, Candice)
- Review of resolution, consent and data sharing agreement changes, Aug (Tam)
- Preparation and reviews of presentation to Council, Aug (Kim, Tam)
- Makah Resolution and Consent Retrieval, Aug (Kim)
- Reviewed Makah Flyer for Kim, Aug (Tam, Nicole, Candice)
- Prepared Short Description of Project for NARCH for Tanya to present, Aug (Candice)
- Preparation and Reviews of OPHA Presentation, Sept (Tam, Nicole, Candice)
- Fixed KAB Database, Sep (Nicole, Candice)
- Dental and KAB Data Entry, Sep (Oceana)
- Prepared revised budget for NARCH award, Sep (Tam, Tom)
- Revised Data Tracking sheet for Makah, Sep (Tam)
- Revised Recruitment documents for Makah, Sep (Tam)
- Submitted IRB Renewal, Sep (Tam)

Native CARS Activities

Meetings - Conference Calls – Presentations – Trainings

- Staff Meetings – each Monday, Jul-Sep (Tam, Jodi, Nicole, Candice)
- Atlas review Meeting - each Thursday, Sep (Tam, Jodi, Nicole, Candice)
- Site Coordinator Conference Monthly Call, Jul-Sep(Tam, Candice)

- Individual Site Coordinator Meetings via Phone, Jul-Sep (Tam)
- Native CARS Atlas meeting with Jeff Nye, Sep (Tam, Nicole, Candice)
- Participated in Doernbecher's Car Seat Clinic in Hillsboro as CPSTech, Sep (Tam)

Program Support or Technical Assistance

- Drafted latest CARS survey for Beta testing, tested, revised, finalized in paper format, ios, and android, Jul (Nicole)
- Reviewed latest CARS survey and provided feedback for improvement, Jul-Aug (Tam, Candice)
- Wrote instructions for downloading and using the EpiInfo app, complete with screen shots, for the Data module of the Atlas, Jul (Nicole)
- Data module revisions, Jul-Sep (Nicole)
- Prepared contracts for two observers from Klamath Tribes, Jul (Tam, Candice)
- Collected information on 50 children traveling in vehicles in Chiloquin, Jul (Nicole)
- Reviewed the data module with Kootsie, the Klamath Tribes Native CARS Site Coordinator, and received feedback, Jul (Nicole)
- Received valuable feedback on the various data collection methods from Kootsie and the two contracted observers, Jul (Nicole)
- Wrote quarterly report, Jul (Tam)
- Drafted IRB proposal, Jul (Tam)
- Meeting coordination, minutes and action item documentation, Jul-Sep (Candice)
- Revised Survey, Aug (Nicole)
- Revised Observation Video Script, Aug (Nicole)
- Communication with Jeff Nye regarding Next Revisions needed for Atlas, Aug-Sept (Candice, Tam)
- Started Analysis Plan using Excel, Aug (Nicole)
- Gathered Native CARS Atlas notes from site coordinators, Becca and Crissy, Aug (Candice)
- Sent Poster PDFs and Printed Materials to Sauk-Suiattle EpiCenter, Aug (Nicole)
- Scheduled Native CARS Atlas meeting with Jeff Nye for 9/7, Aug (Candice)
- Atlas Module Revisions, Sep (Jodi, Tam, Nicole, Candice)
- Contract Preparation for Atlas Web Development, Sep (Tam, Candice)
- Communication with Jeff Nye regarding Next Revisions needed for Atlas (Candice, Tam)
- WISQARS Tutorial for data module, Sep (Nicole)
- WISQARS Review for data module, Sep (Candice)
- Reviewed media module and created infographic, Sep(Nicole)
- Created data entry form in excel with Jenine assistance, Sep (Nicole)
- Obtained updated Patch instructions from partners for Distribution Module, Sep (Tam)
- Prepared contract for Child Passenger Safety Training in Nisqually, Sep (Tam, Candice)
- Obtained and reviewed SNAP materials from IHS for Nisqually training, Sep (Tam)
- Preparation for Doernbecher's Car Seat Clinic, Sep (Tam)
- Reviewed past priorities for MCH in preparation of MCH Tribal Epi Meeting, Sep (Tam)

Travel

Site Visits

Native CARS Observation electronic form beta testing

Klamath Tribes

July 28-29th
(Nicole)

TOTS2Tween Dental Screening
Shoshone Bannock
August 10-13th
(Tam, Luella, Nicole, Maxine)

MCH Epi Conference
Philadelphia, PA
September 13-16th
(Tam)

Project Contact Information

Jodi Lapidus, Principal Investigator
Lapidusj@ohsu.edu

Tam Lutz, Project Director, Co-Investigator, Co-PI
503-416-3271, tlutz@npaihb.org

Nicole Smith, Biostatistician
503-416-3292, nsmith@npaihb.org

Candice Jimenez, Graduate Research Assistant
503-416-3264, cjimenez@npaihb.org

Cathy Ballew, Lummi Site Coordinator

Tom Becker, Co-PI
tbecker@npaihb.org

Medical Epidemiologist

Thomas Weiser, Epidemiologist (IHS)

Projects:
*Improvement Support Team
*Adult Immunization Improvement Project
*Hepatitis C
*Immunization Program-routine immunization monitoring
*IRB
*Environmental Health
*Children with Disabilities
*EIS Supervision

Travel/Training:
*2016 Oregon Flu Summit and More-presented on work from 2 years ago to under vaccine hesitancy among NW AI/AN parents.

*2016 National Immunization Conference-presented on the Adult Composite Immunization Project.

Opportunities:
*EIS: Prepare workstation for EISO arrival. Laptop ready, SAS computer software installed.
*EIS: obtained IRB approval and near final dataset from IHS.
*Oregon Opiate Prescribing Guidelines Task Force completed its work ahead of schedule
*RN position for HCV Project hired.
*EIS Officer, Sarah Hatcher arrived at NPAIHB.

Meetings/Conference Calls:
Immunization Coordinator's call, July 18, 2016
Portland Area IRB meeting, July 19, 2016
Immunization Coordinator's call, August 15, 2016
Immunization Coordinator's call, September 19, 2016

Publications:
*Jennifer Salerno PhD, WayWay M. Hlaing PHD, **Thomas Weiser, MD, MPH**, Catherine Striley PhD, Lisa Schwartz PhD, Frederick J. Angulo DVM, PhD, Verla S. Neslund JD. Emergency response in a global health crisis: epidemiology, ethics, Ebola application Annals of Epidemiology 26 (2016) 234e237
* Carter-Pokras, O, Hutchins S, Gaudino JA, Veeranki SP, Lurie P, **Weiser T,** DeMarco M, Khan N, Cordero J. Role of Epidemiology in Informing US Childhood Immunization Policy. Submitted to CDC for clearance, to be submitted to Annals of Epidemiology

Northwest Tribal Comprehensive Cancer Control Project

Kerri Lopez, Director
Eric Vinson, Project Specialist

Special projects

- October 18th Northwest Tribal Cancer Coalition meeting
  - Presenters contacted and participant recruitment
  - WTDP & NTCCP
  - Logistics with hotel
  - Working with CDC project officer to attend
- Cancer Data availability for coordination of cancer patient care
  - Information requested from American College of Surgeons: Commission on Cancer for Salish cancer Center
- Presented poster board session at Cancer Education Conference D.C.
  - Tobacco cessation activities NPAIHB and Tribal Programs
  - Attended plenary and breakout sessions at conference
  - Attended mentoring session – discussion of writing article – poster board
  - Preparation for session – stats and updated resources
- Developed and distributed Tobacco Follow-up survey for November 2015 5As training
  - Called and emailed to follow-up to increase response rate
- Developed and distributed Oregon Tribal Tobacco Meeting survey for 2016-17
  - Called and emailed to follow-up to increase response rate – All 9 tribes have responded
- Tobacco Fact Sheets
  - Updated Second Hand Smoke fact sheet
- 2017 Northwest Tribal Clinicians' Cancer Update
  - Still waiting to decide which week in April

- Follow-up from July 27th meeting with Salish cancer Center and Legacy Cancer Insitute
    - Cancer Data availability for coordination of cancer patient care
        - Information requested from American College of Surgeons: Commission on Cancer for Salish Cancer Center
- OHSU Survivorship Program
    - Provided survivorship reimbursement information
- Annual Cancer Project report to CDC
    - Completed and Submitted
- Invited to be featured partner for NCI Research to Reality
    - Confirmation that project write-up would be appropriate
    - Clarification for CHW program development
- November National AI/AN Cancer meeting
    - Information gathered and clarification sought
- Navigation Software from GWU – addition information sought
- WEAVE Tobacco Project Collaboration
    - GPRA data and youth tobacco document presentation provided
- Insurance rates reported in SEER database for AI/AN look incorrect
    - Corresponded with NCI, CDC, and study author about SEER insurance results
- BRFSS –Tribe 5
    - Conduct BRFSS surveys
    - 185 complete
    - Final push at tribal Christmas celebration
- BRFSS Tribe 6 – resolution passed
    - Met with health committee – answer question
    - Preliminary outline for questions
    - Created timeline
    - BRFSS Incentives sent for all completed surveys
    - Update three week availability schedule for completing BRFSS surveys
    - Send weekly BRFSS updates to THD
- HPV Oregon task group
    - HPV Planning Committee Meeting - planning for October HPV conference
- HPV PRC/ACS project
    - Submitted report – invoiced for project close out
- Edits and updates on environmental scan tool for youth
- Develop Lummi youth tobacco PowerPoint
- Research materials and resources for Lummi youth tobacco training
- WEAVE Tobacco Project Assistance
    - GPRA data for preparation for Lummi Youth training
- Insurance rates reported in SEER database for AI/AN look incorrect
    - Continued to correspond with NCI, CDC, and study author about SEER insurance results

Training/Site Visits/Technical assistance

- Burns Paiute – Kiki Colon logistics
- Coquille – (2)sent wellness in the workplace; ta fixed for scheduling surveys and sending BRFSS updates
- Cow Creek –(3) assistance with email issues and cancer minigrant report; assistance with fax issues and cancer mini-grant report; FIT price information from Albuquerque
- Klamath – Kiki Colon logistics - resource
- Lummi – cancer Survivorship information for local cancer center

- NARA – Breast Cancer Resource Information
- Nez Perce – (2)Appointment Companion information for diabetes and chronic care program; TA Telehealth information, navigation information
- Puyallup – (3) Follow-up on Clinical Cancer Update CME information; TA Information for Cancer Center: Sent over Smoke free Tribal housing policy template upon request; Navigation resource information
- Shoshone Bannock – (3) Navigation resource; Appointment Companion information for diabetes and chronic care program; Needy Meds prescription drug program information
- Siletz Tribe; Collected: Revised Smoking Policy, Resolution # 2010-097
  Umatilla; Collected: Tobacco and Smoking restrictions in Government and Education Facilities
- Yakama – FIT price information from Albuquerque
- Working on comprehensive wellness in workplace policy
- Share resources with Oregon Tribal TPEP coordinators; *all month*
- CHR information to Idaho Cancer Program

Meetings/Conferences

- All Staff meeting (3)
- Project directors meeting (3)
- Staff meetings – (2 WTDP & NTCCP
- Intervention Action Committee – NPAIHB tobacco action
- Salish Cancer Center, Legacy Cancer Institute, and NPAIHB – Cancer Survivorship
- Oregon Health Authority – new contract officer and Luci
- Tobacco meeting (NTCCP & WEAVE-NW) for
- Tobacco Fact Sheet Meeting
- Lummi Youth Tobacco meeting
- HPV Oregon roundtable conference meeting (2)
- OHSU PRC Tribal and Rural Advisory Board monthly meeting (2)
- BRFSS Meeting
- CRC Screening meeting with OHSU Clinicians
- NdN tribal tobacco policy workbook
- Quarterly Board Meeting
    - Staff veterans committee
- NPAIHB Staff picnic
- NARA "Spirit of Giving Conference"

Conference / Webinar calls

- CDC project officer
- CDC regional directors call
- CPCRN HPV Vaccination Workgroup Call
- GWU Webinar: Maximizing PN-BOT for Current Users
- PRC Advisory committee call
- Webinar – From changing norms to changing policy: young adult
  Tobacco use prevention in Oklahoma
- Webinar – Chronic disease self-management in diverse communities
- Obesity Prevention in Native Children:
  "Weighing In on Food Insecurity
- Call with WA DOH Comprehensive Cancer Program
- Using IIS to Increase HPV Vaccination Uptake Webinar – GWU
- Helping Cancer Survivors to End Tobacco Use and Improve Health Outcomes – NCI

- Logic Modeling and Update on NACDD Competencies for Chronic Disease Practice
- CPCRN HPV Vaccination Workgroup Call
- HPV Vax interview progress!

Northwest Tribal Dental Support Center

Joe Finkbonner, Executive Director
Ticey Mason, Project Manager
Bonnie Bruerd, Prevention Consultant
Bruce Johnson, Clinical Consultant
Kathy Phipps, Epidemiology Consultant

The Northwest Tribal Dental Support Center (NTDSC) is in their 16th year of funding. The overall goals of NTDSC are to provide training, quality improvement, and technical assistance to the IHS/Tribal Dental programs, and to ensure that the services of the NTDSC result in measurable improvement in the oral health status of the AI/AN people served in the Portland Area. NTDSC activities are listed in categories corresponding to the current grant objectives.

Ensure quality and efficient care is provided in Portland Area dental programs through standardization of care and implementation of public health principles to improve dental access and oral health outcomes.

- Clinical and prevention site visits were provided this quarter for Nooksack, NARA (Portland Urban program), and Coos Bay. NTDSC has completed site visits at 8 Portland Area dental programs, meeting the grant objective for this fiscal year. An additional four site visits are planned for November-December.

Expand and support clinical and community-based oral health promotion/ disease prevention initiatives in high-risk groups to improve oral health.

- NTDSC has expanded their collaboration with WA Dental Services Foundation (Delta Dental) to meet some identified mutual objectives. Ten dental programs are currently participating in the "Baby Teeth Matter" program that is aimed at increasing dental access for 0-5 year olds and reducing the number of children referred for dental work under general anesthesia. This program includes data collection, face to face and webinar meetings, and ongoing program evaluation. Data from the first year demonstrated that dental access for 0-5 year olds more than doubled. BTM developed new visual materials and social media strategies that are currently being implemented.

- NTDSC, in collaboration with WDSF is setting the groundwork for an "Elder Initiative". Tribal Health Directors were surveyed about barriers to oral health for elders, focus groups with 75 elders were completed, and more than 80 dental staff was surveyed at the NTDSC Annual Dental Meeting in July. This information will guide new strategies to improve dental access and oral health for AI/AN elders in the Pacific Northwest.

- Portland Area met all three dental GPRA objectives this past year.

- Quality Improvement objectives focused on prevention initiatives were completed by dental program staff during the NTDSC annual meeting in July 2016.

- NTDSC Prevention Consultant serves as the Portland Area dental representative on the national HP/DP Committee and the national Early Childhood Caries Committee.

Implement an Area-wide surveillance system to track oral health status.
Data from the surveillance system will be used to identify vulnerable populations and plan/evaluate clinical and community-based prevention programs.

- Portland Area completed the Basic Screening Survey for adults last fall, and the results were presented at the NPAIHB quarterly meeting in April 2016. This represents a significant effort from the 13 dental programs who participated in the survey and provides useful data for clinical and community-based program planning. This coming year, 6-9 year olds are being surveyed and the results will be available early in 2017.

Provide continuing dental education to all Portland Area dental staff at a level that approaches state requirements.

- NTDSC sponsored the Portland Area Dental Meeting July 19-21, 2016 in Suquamish, WA. A four-hour "Orientation Session" for new dentists and dental hygienists was provided prior to the full meeting. The full meeting (1 1/2 days) was followed by the Dental Directors meeting planned by Dr. Sixkiller and the Baby Teeth Matter meeting for participating dental programs. Through a combination of these meetings, CDE provided during site visits, Baby Teeth Matter sessions, and Area-wide webinars, NTDSC provided 35 hours of continuing dental education to 307 dental staff (many of them taking several courses), for a total of 1,317 CDE hours.

NTDSC consultants participate in email correspondence, national conference calls, and respond to all requests for input on local, Portland Area, and national issues.

Northwest Tribal Registry Project-Improving Data and Enhancing Access (IDEA)

Victoria Warren-Mears, P.I.
Sujata Joshi, Project Director
Monika Damron, Project Biostatistician
Jenine Dankovchik, Biostatistician
Email: IdeaNW@npaihg.org

Project news and activities

This quarter, we continued work on coding data from linkages with Washington death certificates, Oregon and Washington hospital discharge records, and Oregon birth certificates. We held our second Health Data Literacy Training on August 24-25 in Suquamish Washington. We began work on an analysis of gynecologic cancers with Dr. Amanda Bruegel of Oregon Health & Sciences University.

Current status of data linkage, analysis, and partnership activities

- *Northwest Tribal Registry (NTR) data linkages*
    - Linkage with Oregon hospital discharge 2014 records
- Tribal Health Profiles (THP) project
    - No updates
- Cancer Registry Data and Cancer Fact Sheets
    - We finalized the remaining CHSDA-level tribal cancer profiles; all Tribes should receive their profiles by the end of October 2016
    - Gynecologic Cancers Analysis
        - Ran preliminary statistics on gynecologic cancers for Dr. Amanda Bruegl (Oregon Health & Sciences University)
        - Identified additional variables to request from cancer registries for analysis
        - Began work on project protocol
- Death certificate Data
    - We created a Death Names dataset (1980-2015) for use in data linkages with tribal enrollment/clinic registration data
    - We created "raw" Washington death certificate file to pull in additional variables if needed
- Birth certificate data
    - Cleaned and re-coded Oregon birth certificate records from 1997-2007
- Substance Abuse Analysis
    - No updates
- Hospital discharge data
    - Finished cleaning and coding Washington 2014 hospital discharge records, merged with previous years' data
    - Began work on coding and preparing Oregon 2014 hospital discharge records for analysis
- Oregon Tobacco Fact Sheet Development
    - Finished most indicators for AI/AN tobacco fact sheet, compiled and presented data results during joint OHA/NPAIHB meeting

- Held second Health Data Literacy Training at Suquamish, WA
    - Updated curriculum and slides
    - Worked on logistics for reserving training space and arranging travel reimbursements for attendees

- *Data requests/Technical assistance*
    - Ran all ages and age-specific asthma hospitalization rates and created maps for Bill Lambert (Oregon Health & Sciences University)
    - Provided reporter with Washington Cancer fact sheet and other information related to environmental health studies
    - Provided technical assistance to Colville Tribe by providing language to add to DSA for linkage with enrollment data

- *Institutional Review Board (IRB) applications and approvals/Protocol development*
    - Received approved data sharing agreement for Oregon Hospital Discharge linkage
    - Received approval from Portland Area IRB on IDEA-NW progress report/continuation review application

- *Grant Administration and Reporting*
    - Completed OMH PDS grant report for Year 4 Quarter 4

- Received Year 5 Notice of Award for OMH grant
- Sent highlights of accomplishments over past 6 months to OMH project officer

- *Collaborations with other programs and other activities*
  - Made edits to Council for State and Territorial Epidemiologists Tribal Epidemiology Workgroup manuscript on data sharing, sent to lead author
  - Held internal Datasets 101 training for biostatisticians and epidemiologists
  - Worked with Tam Lutz and Nicole Smith to develop poster for TEC meeting at national Maternal and Child Health Epidemiology conference
  - Updated map links for NPAIHB Member Tribes map on website
  - Provided Eric Vinson with updates for NW Tribal Cancer Control Project's end of year report
  - Submitted Quarterly EpiDataMart audit form to IHS

Data dissemination

- Victoria sent 5 completed tribal cancer profiles to tribal contacts
- Presented "Beyond Accreditation: Using Data to Improve Community Health" at National Tribal Health Forum for Community Health Excellence

Travel

Linkages

- Oregon Hospital Discharge Linkage (Salem, OR) 8/11

Site visits

- Health Data Literacy Training, Suquamish Tribe 8/23-8/26
- Tribal Health Forum, Spokane (Kalispel Tribe) 8/29-8/30

Meetings, Trainings, and Conferences

- 2016 MCH Epidemiology Conference, Philadelphia, PA 9/12-9/15

Other Meetings, Calls and Trainings

- Meeting with OHA re: Tobacco Fact Sheets 7/13
- HD Literacy Training Planning Meeting 7/14
- ArcGIS Online Subscriptions Training 7/18
- CSTE Tribal Epidemiology Subcommittee Meeting 7/19
- Meeting re: National Tribal Public Health Forum 7/25
- Meeting with Amanda Bruegl re: gynecologic cancers 7/25
- OMH Bi-Monthly Conference Call 7/29
- Meeting re: CHARS Data 8/2
- Meeting with Tom Becker/Amanda Bruegl 8/5
- Planning meetings for HDL training 8/5, 8/17
- Staff Picnic 8/19
- MCH Projects meeting 9/8
- Meeting Amanda Bruegl 9/9
- Meeting with Sarah H. re: NTR evaluation project 9/27
- Datasets 101 Training 9/29

- OMH Bi-monthly Conference call 9/30

Data reports, fact sheets, and presentations are posted to our project website as they are completed:
http://www.npaihb.org/home/idea-nw/
Please feel free to contact us any time with specific data requests.
Email: sjoshi@npaihb.org or IdeaNW@npaihb.org
Phone: (503) 416-3261

THRIVE (Tribal Health: Reaching out InVolves Everyone)

Colbie Caughlan, Project Manager
Celena McCray, Project Coordinator

Site Visits

Tribal Site Visits

- Lower Elwha S'Klallam Tribe – July 6
- Muckleshoot Tribe – July 14
- Burns Paiute Tribe – August 12-16
- Quileute Tribe – August 24
- Quinault Indian Nation – August 26
- Upper Skagit Tribe – September 7-8
- Suquamish Tribe – September 14
- Siletz Tribe – September 19
- Confederated Tribes of the Umatilla Indian Reservation – September 27

Out of Area Tribal Site Visits

- UNITY Conference, Oklahoma City, OK – July 22-26

Technical Assistance & Training

During the quarter, project staff:

- Participated in 67 meetings and conference calls with program partners.
- Disseminated 236 boxes of the new **Two-Spirit. Accepted and Loved. #WeNeedYouHere.**, **LGBTQ. Accepted and Loved. #WeNeedYouHere.** campaign for AI/ANs and world Suicide Prevention Day posters.
- All three *Healing of the Canoe* tribal subcontract sites have completed the HOC curriculum and surveys during this quarter and two of the three sites have signed up for an additional year of funding to continue HOC with this project.
- All three Tribes have received *Zero Suicide* training at their clinics under the IHS MSPI funding and coming up this year we will work together to implement the model.

During the quarter, THRIVE provided or participated in the following presentations and trainings:

- Presentations (11)– Suicide Prevention Presentation, 13 attendees at a PA 4 Gen-I social marketing boot camp, Olympia, WA; Zero Suicide in NW Tribes panelist during the morning pre-conference workshop, IHS Behavioral Health Conference, 80 attendees, Portland, OR; Zero Suicide in NW Tribes during the afternoon CSSRS pre-conference workshop with Dr. Ursula Whiteside, IHS Behavioral Health Conference, 20 attendees, Portland, OR; THRIVE/We R Native presentation with Native STAND curriculum, 35 participants and then at the I.H.S Physical Activity Kit training, 25 participants,

Burns, OR; Suicide Prevention Presentation and We R Native, 7 teems attendees at Native American Community Academy, Abq, NM; Suicide Prevention Presentation, 15 teen attendees at a PA 4 Quileute Gen-I social marketing boot camp, La Push, WA; Suicide Prevention resources and ZS in NW Tribes at the Tribal Mental Health Conference, 16 attendees in Bow, WA; Suicide Prevention resources and ZS in NW Tribes at the Four Corners conference, 10 attendees, Suquamish, WA; ZS in the NW Tribes at the Oregon State Youth Suicide Prevention Conference, 19 attendees, Portland, OR and; THRIVE & We R Native webinar for Pinon AZ high school students re: developing suicide prevention media campaigns

- Facilitation/Training (7) – Adobe connect Zero Suicide pilot sites training webinar for new reporting questions for data collection; *Zero Suicide* Training under the SASP grant for both the Muckleshoot Tribe, 25 participants & the Confederated Tribes of the Umatilla Indian Reservation, 9 participants, with Dr. Ursula Whiteside; two QPR gatekeeper trainings, 17 participants total, Port Angeles, WA; QPR gatekeeper training, 19 participants, Quinault, WA and; QPR gatekeeper training, 12 participants from NICWA
- Booth (1) – Staff attend the UNITY Conference where they disseminated THRIVE and WRN materials to hundreds of Native youth and chaperones in Oklahoma City, OK

During the quarter, the THRIVE project responded to 190 phone or email requests for suicide, bullying, or media campaign-related technical assistance, trainings, or presentations.

Health Promotion and Disease Prevention

THRIVE Media Campaign: All THRIVE promotional materials are available on the web. Materials include: posters, informational rack and tip cards, t-shirts, radio PSAs, and Lived Experience videos.

The next expansion of the suicide prevention campaign is being developed to reach the Native Veteran population and is slated to launch for Memorial Day in May 2017.

MSPI - Gen-I Messages: Number/Reach of We R Native Facebook messages addressing…

- Suicide = 18 posts, 527,222 people reached
- Mental health = 17 posts, 45,209 people reached
- Substance prevention = 7 posts, 18,746 people reached
- Youth leadership/empowerment = 50 posts, 317,289 people reached

Other Administrative Responsibilities

Staff Meetings

- EpiCenter meetings
- All-staff meetings
- Project Director meetings
- Wellness Committee – monthly meetings and events

Publications

- Submitted newsletter article about THRIVE Conference for the August NPAIHB Qtrly Health News and Notes

Reports/Grants

- Submitted grant application for the NIH Collaborative Hub grant on July 7 with Oregon Health and Science University and Seattle Children's Research Hospital.
- Submitted 2016 Qtr 3 reporting data for the SAMHSA GLS grant on July 29.
- Submitted FFR Qtrly budget numbers to IHS for MSPI PA 2 and PA 4.

- Completed and submitted the NPAIHB QBM Qtrly report on July 29.

Administrative Duties

- Budget tracking and maintenance: Ongoing.
- Managed Project Invoices: Ongoing.
- Staff/Intern oversight and annual evaluations: Ongoing.
- Managed Project Subcontracts: Ongoing

Wellness for Every American Indian to View and Achieve Health Equity (WEAVE)

Victoria Warren-Mears, Principal Investigator
Nanette Yandell, Project Manager
Jenine Dankovchik, Evaluation Coordinator
Nora Alexander, Health Educator/Communication Spec.
Birdie Wermy, National Evaluation Specialist
Ryan Sealy, Tobacco Specialist

Meetings

External committee meetings

- 15-Jul-16Community Workshop Planning
- 10-Aug-16 HTC Team Meeting
- 16-Aug-16 HTC Team Meeting
- 15-Sep-16 Indian Day Committee Meeting
- 20-Sep-16 Community Workshop Planning Session w/ FGC

Internal Meetings

- 08-Jul-16 WEAVE TEAM
- 08-Jul-16 WEAVE-NW Team Meeting
- 11-Jul-16 All staff meeting
- 14-Jul-16 WEAVE-NW Team Meeting
- 14-Jul-16 Wellness Committee
- 14-Jul-16 Planning for data literacy training
- 04-Aug-16 WEAVE Gathering Planning Meeting
- 05-Aug-16 Health Data Literacy Workshop Planning
- 05-Aug-16 policy toolkit workgroup
- 16-Aug-16 Tribal Policy Workgroup
- 17-Aug-16 WEAVE project update
- 25-Aug-16 Native Fitness Meeting
- 27-Aug-16 Health Data Literacy workshop planning meeting
- 06-Sep-16 Tobacco Intervention Action Committee
- 08-Sep-16 WEAVE-NW check-in
- 08-Sep-16 Cancer Meeting
- 08-Sep-16 MCH sub-group meeting
- 12-Sep-16 All staff meeting
- 29-Sep-16 Data meeting

Meetings with Sub-Awardees

- 12-Jul-16 Update call with Swinomish
- 02-Sep-16 Call with Cow Creek to discuss data collection tools for Million Hearts Program

- 02-Sep-16 Met to discuss moving Lummi program to the Tribal School
- 21-Sep-16 Call with Chehalis to discuss year 2 scope of work and budget
- 22-Sep-16 Call with Nooksack to discuss personnel changes and year 2 budget

Meetings with Funding Agency

- 07-Jul-16 CDC CHWIC All Hands Echo Session
- 13-Jul-16 Tobacco Fact Sheet meeting
- 14-Jul-16 Monthly call with CDC Project Officer
- 05-Aug-16 GHWIC Evaluation 3D sub-group monthly meeting
- 17-Aug-16 GHWIC monthly evaluation workgroup call

Meetings

- 18-Aug-16 GHWIC Component 2 ECHO Session
- 15-Sep-16 GHWIC C2 Call
- 21-Sep-16 GHWIC Evaluation Monthly Call

Meetings with other government partners

- 12-Jul-16 Tribal Policy Tool Kit

Meetings with Tribal Communities

- 30-Sep-16 Call with CTUIR to plan community focus groups

Other types of meetings

- 14-Jul-16 Sustainability Training Call
- 18-Jul-16 Residence Inn Meeting
- 17-Aug-16 Event Meeting with DoubleTree
- 19-Aug-16 Planning meeting with presenters coming for sub-awardee gathering

Summary of Meetings by Type

Internal:	19
Conference/committee:	5
Tribal Community:	1
Funding Agency:	8
Sub-Awardee:	5
Community (non-tribal):	0
Government Partner:	1
Other:	4
Total Meetings:	*43*

Site Visits

Date(s)	Tribe	Short Summary	WEAVE-NW Staff
07/20/16	Quinault Tribe	Site Visit with Quinault	NA, JD, NY
07/21/16	Skokomish Tribe	Site Visit with Skokomish	NA, JD, NY
07/26/16	Nooksack Tribe	WEAVE Site Visit with Nooksack	NA, NY
07/27/16	Swinomish Tribe	Site Visit with Swinomish	NA, NY
07/28/16	Port Gamble S'Klallam Tribe	Site Visit with Port Gamble S'klallam	NA, JD, NY
08/11/16	Siletz Tribe	Site visit to check on sub-award progress	NA, JD
08/18/16	Chehalis Tribe	Site visit to check in on Chehalis sub-award progress	JD

Total number of site visits this quarter: 7

Professional Development

Date	Title	WEAVE-NW Staff	Topics
09/26/16- 09/27/16	Native American Nutrition Conference	NA	Obesity, Diabetes, Nutrition, PSE, Physical Activity
09/29/16- 09/29/16	Dabbling in the Data: A Hands-On Guide to Participatory Data Analysis	JD	Health Literacy, Epidemiology/Analysis, Evaluation
09/22/16- 09/22/16	Participatory Data Analysis: Data Party Tips	JD	Health Literacy, Epidemiology/Analysis, Evaluation
09/27/16- 09/29/16	L.E.A.D. Conference Tulsa Oklahoma	RS	
09/20/16	From Changing Norms to Changing Policy: Young adult tobacco use prevention in Oklahoma	RS	Tobacco, PSE
08/24/16- 08/24/16	Youth Engagement: How Kids Can Impact Community Policy, Programs, and Planning	NA	PSE

Total number of professional development activities this quarter: 6

Technical Assistance Given

Evaluation planning

- 7/6/2016 Muckleshoot Sent workplan draft

Guidance to analyze their own data

- 9/1/2016 All GHWIC partners Provided guidance on recording and reporting denominator numbers for GHWIC performance measures in RPMS

Health education

- 7/27/2016 Swinomish Provided health education materials/brochures for them to use during youth activities
- 8/19/2016 Klamath Created a brochure and a hydration handout for the "Stop the Pop" campaign.

Other (specify)

- 7/15/2016 Coquille Sent invoicing notification to bring sub-awardee up-to-date in spending
- 7/15/2016 Grand Ronde Sent invoicing notification to bring sub-awardee up-to-date in spending
- 7/15/2016 Chehalis Sent invoicing notification to bring sub-awardee up-to-date in spending
- 8/8/2016 Colville Provided a template DSA for Colville
- 9/7/2016 Cow Creek Created Program Poster
- 9/27/2016 Muckleshoot, Swinomish, Nooksack, Quinault Debriefed and strategized next steps after Nutrition Conference to keep momentum

Policy development

- 9/30/2016 Siletz Provided advice on how to proceed with policy development with local grocers

Provided data report

- 7/12/2016 Swinomish Provided diabetes audit data and report from WTDP

Provided fact sheet

- 7/12/2016 Swinomish Provided cancer fact sheet

Sharing Resources;

- 7/5/2016 C1 Tribes and Sub-Awardees Tribal Digest sent out
- 7/12/2016 C1 Tribes and Sub-Awardees Tribal Digest sent out
- 7/15/2016 All GHWIC grantees Provided program sustainability tool resource for Tribal Digest
- 7/19/2016 C1 and Sub-awardee Tribes Tribal Digest sent out
- 7/20/2016 Quinault Provided list of upcoming trainings/conferences that will be supported through WEAVE funds along with registration information
- 7/21/2016 Skokomish Provided list of upcoming trainings/conferences that will be supported through WEAVE funds along with registration information
- 7/26/2016 Nooksack Provided list of upcoming trainings/conferences that will be supported through WEAVE funds along with registration information
- 7/26/2016 C1 Tribes and sub-awardee tribes Tribal Digest sent out
- 7/27/2016 Swinomish Provided funding resources for community walking trails
- 7/27/2016 Swinomish Provided list of upcoming trainings/conferences that will be supported through WEAVE funds along with registration information
- 7/28/2016 Port Gamble S'klallam Provided list of upcoming trainings/conferences that will be supported through WEAVE funds along with registration information
- 8/9/2016 GHWIC C1 & Sub-awardees Shared Tribal Digest
- 8/16/2016 GHWIC C1 & Sub-awardees Shared Tribal Digest
- 8/23/2016 GHWIC C1 & Sub-awardees Shared Tribal Digest
- 8/30/2016 GHWIC C1 & Sub-awardees Shared Tribal Digest
- 9/6/2016 C1 and C2 Tribes Tribal Digest shared
- 9/13/2016 C1 and C2 tribes Tribal Digest Shared
- 9/20/2016 C1 and C2 Tribes Tribal Digest shared
- 9/27/2016 C1 and C2 Tribes Tribal Digest shared

Survey design & implementation

- 7/19/2016 Grand Ronde Edited survey for nutrition class participants
- 9/9/2016 Lummi Provided guidance on tobacco survey design for Lummi

specifically

- 9/22/2016 NPAIHB staff Helped Nicole set up an Excel VBA form for data collection

Summary of Technical Assistance by Topic and Type

Types of TA given		Topic areas covered	
One-off analysis of our data for Tribe:	0	**Heart disease/stroke:**	20
Provided data report:	1	**Obesity:**	17
Provided fact sheet:	1	**Diabetes:**	19
Analysis of Tribe's own data:	0	**Tobacco:**	14
Guidance to analyze their own data:	1	**Nutrition:**	20
Interpretation of analysis results:	0	**Policy, Systems and Environment Change:**	23
Grant writing:	0	**Physical Activity:**	18
Report writing:	0	**Data use:**	10
Evaluation planning:	1	**Evaluation:**	8
Survey design and implementation:	3		
RPMS/EHR support:	0		
Focus group planning and implementation:	0		
Policy development:	1		
Health education:	2		
Sharing Resources (general):	0		
Other:	6		

Total number of times TA was given: *35*

Trainings

In-Person

- 8/24/2016 Health Data Literacy Workshop
- 9/13/2016 2016 Annual WEAVE-NW Sub-awardee Gathering

Webinar

- 8/23/2016 Engaging Native Youth in Health Policy Change Webinar
- 9/27/2016 WEAVE-NW webinar: End of Year Reports and Questions

Total number of trainings given this quarter: 4

Western Tribal Diabetes Project

Kerri Lopez, Director
Don Head, Project Specialist
Erik Kakuska, Project Specialist

Special projects

- Native Fitness XIII – August 20-31st 2016
  - Following up with NF invoices
  - Final invoice and reimbursement sent to trainers
  - Final invoice to keynote
  - More shoe solutions
- NextGen – slowly moving

- Complete NW Health Status Report
    - Expanded and added audit description to report
    - Formatting the Trends Report for the 2016 HSR
    - Bounding and sending out to tribal programs
- Draft of NW Tribal Comparison Report Component of the HSR
- Draft NW TA Report Completed
    - Side by side of audit for ta priorities
    - Training tool for WTDP
    - 2015 data for Northwest Aggregate Report for biostatistician
- Develop presentation TLDC
    - Northwest SDPI update
    - Best practices
    - Tribal activities
    - WTDP report
    - NWTEC diabetes funding
- Creative Design
    - NPAIHB newsletter – final edits for August QBM
    - NF agenda and workbook
    - Dancing on the Square flyers
- Dancing on the Square
    - Set up
    - Clean up
    - Work, work, work

Trainings / Site Visit

- Native Fitness final outcomes August 29-31
    - 180 participants
    - 80 programs
    - 20 breakout sessions
    - Motivational interview and historical trauma in Native communities
    - Nike N7 update
    - WTDP program update – data and tracking, audit issues and training
- DMS Training Albuquerque
    - Prepared and sent training package
    - Conference call to plan for remote training
    - IHS lab, training workbooks and curriculum - 22 participants
- DMS training Portland
    - 11 registered
- Reserved dates for 2017 trainings in training room

Technical Assistance

- Albuquerque Area TEC: TA Epi center director about a QMAN search for patients aged 50-75, who have not had a colorectal cancer screening nor a fecal occult blood test, and who have not been diagnosed with colorectal cancer. I conducted the search and sent the search summary, with instructions,
- Chehalis; TA for patients entered with DM code but do not have diabetes. Asking how to remove them all at once

- Chief Kina Health Clinic (Nashville) TA for trouble entering historical data. Suggested using DMU and found she did not have the correct security keys to operate RPMS. Gave her Site Manager the correct keys
- K'im:aw Diabetes Prevention & Management Program, TA to find patients who are not on the diabetes register, and are newly diagnosed with diabetes. I emailed instructions
- NARA – shared DPP information – DPP reimbursement – discussion about CDC program vs IHS
- Oklahoma: TA Can you delete a register? How; Gen report – identify active – inactive – transient; is there a date for last POV; 8 registers and multiple users (how to delete)
- Phoenix Area IHS, request for an updated copy of our Shortcut & Reference Manual at the Partnership Conference
- Phoenix Area IHS, TA Shortcut & Reference Manual, as well as the agenda as attended the DMS training
- Pine Ridge IHS: TA on how to create a prediabetes registry
- Pyramid Lake Health Clinic, TA information for the training in December
- Quinault: (3) TA for case management patient. Indicating the patient receives primary care elsewhere. Suggested to place status as transit. TA for generating a QMAN search for cancer patient screenings for elderly. TA for SOS audit. Denominator and numerator were not reflecting the best practice numbers when running a QMAN report
- Sauk-Suiattle; TA on updating patient information into NDW for establishing user populations number for SDPI grant IHS
- Siletz: Introduced to the new Diabetes Program Director sent HSR and NF information. Gave a quick tutorial on IHS Audit 2017
- Skokomish (4) information and registration for two employees, TA for if a patient dies, that is, should they be taken off the register change their status to DECEASED, but to leave them on the register; sent HSR; TA call about the grant requirements
- South Dakota; TA for a 'rolling audit' report; and SOS audit from last year. TA via QMAN, then running an interim report, while adding to last year's audit.
- Squaxin Island, (2) TA Audit report was still in draft form. I told her that the DDTP had not completed the data cleaning, and until then, it'd be listed as draft , TA to check their taxonomies, why Lisinopril was not being captured in their diabetes tab
- Swinomish, (2) TA for previous years' data for the diabetes program, sent a copy of their HSR; TA for Abnormal Eye exams. Gave instructions to run a QMANreport
- Urban Indian Center of Salt Lake, TA on target group into iCAre. Since they were basing it on BMS, I told them that they would have to use BMI Reports to make a template, search within that template for their diagnoses, and then save that template, and drop it into iCare using that template.
- Warm Springs; TA on CDC DPP program and reimbursement

Meetings/Conferences

- Nutrition Council of Oregon
- NdN tribal tobacco policy workbook
- All Staff meeting
- Project directors meeting
- Staff meetings –
    - WTDP & NTCCP

- Quarterly Board Meeting
    - Staff veterans committee
- NPAIHB Staff picnic
- NARA "Spirit of Giving Conference
- OHA planning for tribal session at Place Matters

Conference Calls:

- Improving Healthcare Delivery Data Project: Steering Committee Quarterly Conference Call
- SDPI Q&A Webinar
- SDPI FY 2017 Continuing Application Kickoff Webinar
- SDPI FY 2017 Best Practice and Target Population Group Webinar
- SDPI FY 2017 Continuing Application Walk-through
- SDPI FY 2017 Continuing Application Q&A,
- ADC Audit Planning Meeting,
- Medicare Diabetes Prevention Program
- ADC Audit Planning Meeting
- Partnerships at Play: State and local collaborations to facilitate community-clinical linkages
- Call on Tribal Diabetes Aggregate Report
- Logic Modeling and Update on NACDD Competencies for Chronic Disease Practice
- SDPI Question and Answer Session
- LMIC – Childhood Obesity
- Obesity Prevention in Native Children

HEALTHY NATIVE YOUTH

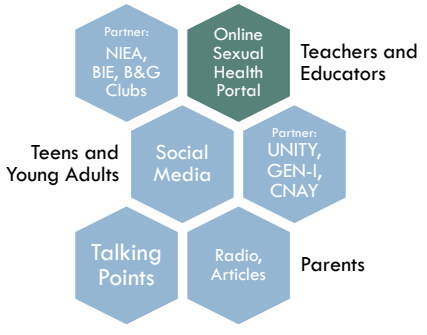
A ONE-STOP-SHOP FOR EDUCATORS WHO WANT TO EXPAND LEARNING OPPORTUNITIES FOR AI/AN YOUTH

October 2016

Workgroup Goal

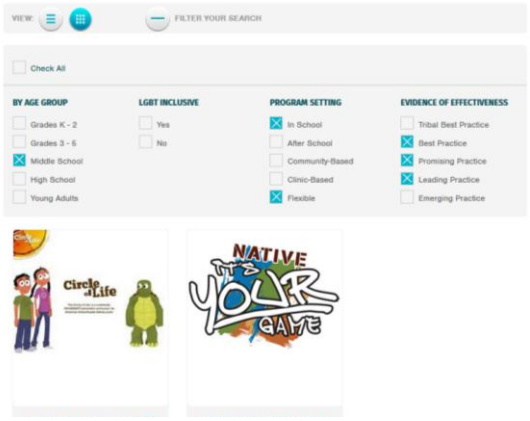
- Gain insights and connections to support the dissemination of culturally-appropriate sexual health programs to AI/AN youth.

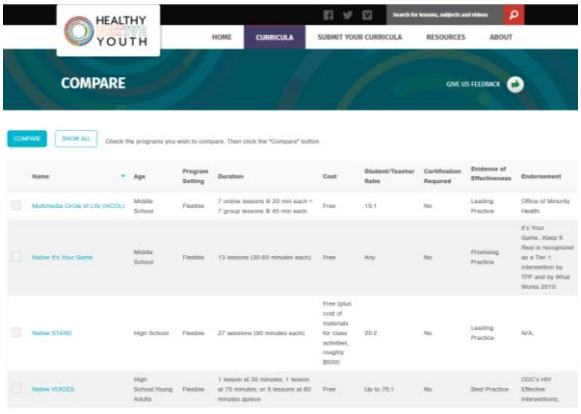
Communication Strategies

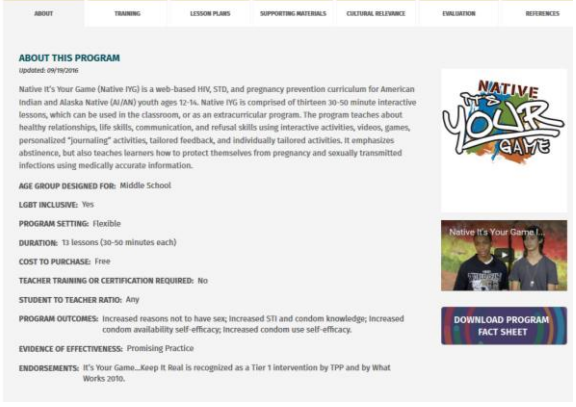


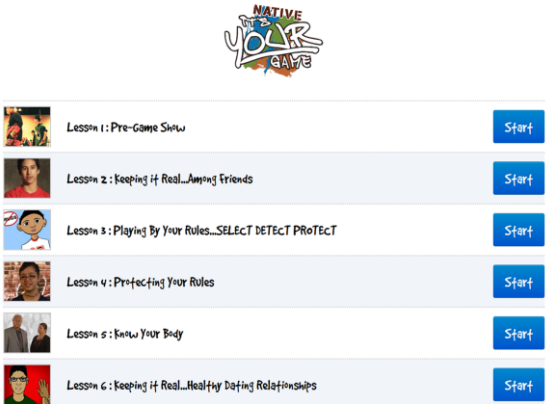
Website Goals

- Provide tribal health educators and teachers with a one-stop-shop to access to age-appropriate, culturally tailored sex education resources for AI/AN youth.
- Prepare tribal health educators and teachers to deliver this content.
- Measure the reach and impact of our efforts.


VIEW:
FILTER YOUR SEARCH
Check All
BY AGE GROUP
Grades K - 2
Grades 3 - 5
Middle School
High School
Young Adults
LGBT INCLUSIVE
Yes
No
PROGRAM SETTING
In School
After School
Community-Based
Clinic-Based
Flexible
EVIDENCE OF EFFECTIVENESS
Tribal Best Practice
Best Practice
Promising Practice
Leading Practice
Emerging Practice
Circle of Life
NATIVE
It's YOUR Game


HEALTHY YOUTH
HOME
CURRICULA
SUBMIT YOUR CURRICULA
RESOURCES
ABOUT
COMPARE
GIVE US FEEDBACK
COMPARE
SHOW ALL
Check the programs you wish to compare. Then click the "Compare" button.
Name
Age
Program Setting
Duration
Cost
Student/Teacher Ratio
Certification Required
Evidence of Effectiveness
Endorsement
Multimedia Circle of Life (MCOL)
Middle School
Flexible
7 online lessons @ 20 min each + 7 group lessons @ 45 min each
Free
15:1
No
Leading Practice
Office of Minority Health
Native It's Your Game
Middle School
Flexible
13 lessons (30-50 minutes each)
Free
Any
No
Promising Practice
It's Your Game...Keep It Real is recognized as a Tier 1 intervention by TPP and by What Works 2010.
Native STAND
High School
Flexible
27 sessions (90 minutes each)
Free (plus cost of materials for class activities, roughly $500)
20:2
No
Leading Practice
N/A.
Native VOICES
High School,Young Adults
Flexible
1 lesson at 35 minutes; 1 lesson at 75 minutes; or 5 lessons at 60 minutes apiece
Free
Up to 75:1
No
Best Practice
CDC's HIV Effective Interventions,


ABOUT
TRAINING
LESSON PLANS
SUPPORTING MATERIALS
CULTURAL RELEVANCE
EVALUATION
REFERENCES
ABOUT THIS PROGRAM
Updated: 09/19/2016
Native It's Your Game (Native IYG) is a web-based HIV, STD, and pregnancy prevention curriculum for American Indian and Alaska Native (AI/AN) youth ages 12-14. Native IYG is comprised of thirteen 30-50 minute interactive lessons, which can be used in the classroom, or as an extracurricular program. The program teaches about healthy relationships, life skills, communication, and refusal skills using interactive activities, videos, games, personalized "journaling" activities, tailored feedback, and individually tailored activities. It emphasizes abstinence, but also teaches learners how to protect themselves from pregnancy and sexually transmitted infections using medically accurate information.
AGE GROUP DESIGNED FOR: Middle School
LGBT INCLUSIVE: Yes
PROGRAM SETTING: Flexible
DURATION: 13 lessons (30-50 minutes each)
COST TO PURCHASE: Free
TEACHER TRAINING OR CERTIFICATION REQUIRED: No
STUDENT TO TEACHER RATIO: Any
PROGRAM OUTCOMES: Increased reasons not to have sex; Increased STI and condom knowledge; Increased condom availability self-efficacy; Increased condom use self-efficacy.
EVIDENCE OF EFFECTIVENESS: Promising Practice
ENDORSEMENTS: It's Your Game...Keep It Real is recognized as a Tier 1 intervention by TPP and by What Works 2010.
NATIVE
It's YOUR Game
Native It's Your Game I...
DOWNLOAD PROGRAM FACT SHEET



Surface level changes

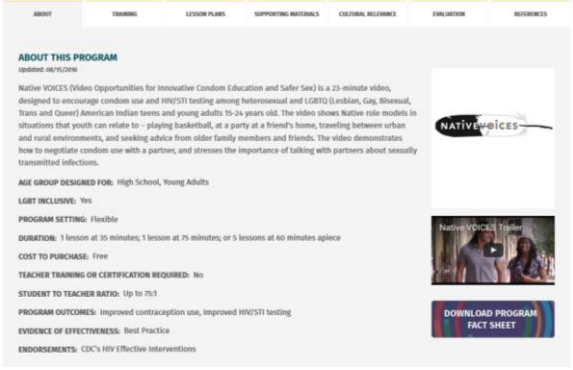
Tribal Elders & native health expert

Effectiveness study: by the numbers

- **2** study arms: Native IYG and Control
- **25** Tribal Sites randomized
- **3** regions: AK, NW, AZ
- **574** middle school aged youth enrolled
- **3** surveys: Pre, Post, 12-month follow-up

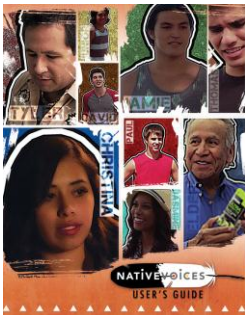
Youth who took Native IYG reported:

- More reasons not to have sex
- Increased STI knowledge
- Increased condom knowledge
- More confidence obtaining condoms
- More confidence about using condoms

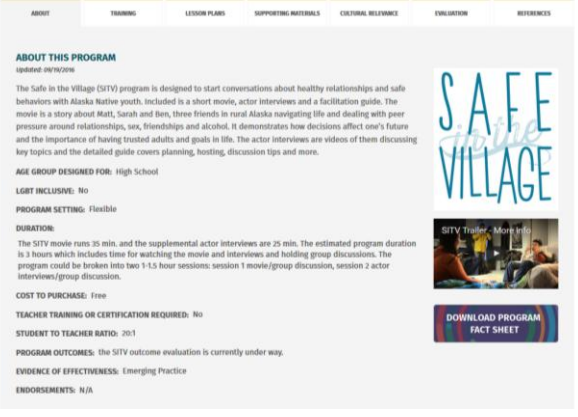


NATIVE VOICES www.youtube.com

Native VOICES Toolkit



- Native VOICES video (23 minutes)
- A condom demonstration video (1:40 minutes)
- A dental dam demonstration video (1:08 minutes)
- A selection of condoms and dental dams
- A users' guide



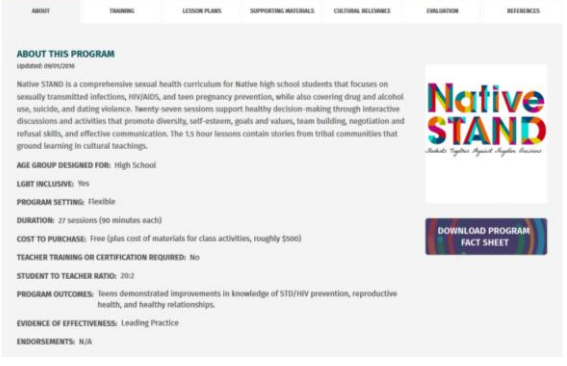
SITV Evaluation

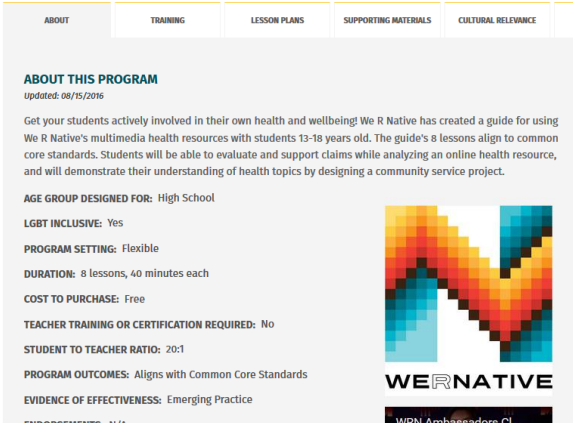
- September 2014 – December 2015
- 5 new communities in southwestern and northwestern Alaska (n= 105) with youth ages 15-19 years old
- Implemented facilitated Safe in the Village workshops in schools and community settings
- Participants filled out surveys before and immediately after the workshop and an online follow up survey 6 months after
- Data analysis is ongoing

SAFE VILLAGE

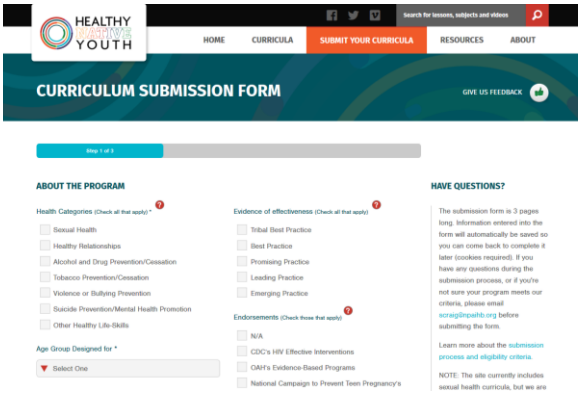
ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM




ABOUT
TRAINING
LESSON PLANS
SUPPORTING MATERIALS
CULTURAL RELEVANCE
ABOUT THIS PROGRAM
Updated: 08/15/2016
Get your students actively involved in their own health and wellbeing! We R Native has created a guide for using We R Native's multimedia health resources with students 13-18 years old. The guide's 8 lessons align to common core standards. Students will be able to evaluate and support claims while analyzing an online health resource, and will demonstrate their understanding of health topics by designing a community service project.
AGE GROUP DESIGNED FOR: High School
LGBT INCLUSIVE: Yes
PROGRAM SETTING: Flexible
DURATION: 8 lessons, 40 minutes each
COST TO PURCHASE: Free
TEACHER TRAINING OR CERTIFICATION REQUIRED: No
STUDENT TO TEACHER RATIO: 20:1
PROGRAM OUTCOMES: Aligns with Common Core Standards
EVIDENCE OF EFFECTIVENESS: Emerging Practice
WERNATIVE


MENU
learn more
WERNATIVE
For Native Youth, by Native Youth.


HEALTHY NATIVE YOUTH
HOME
CURRICULA
SUBMIT YOUR CURRICULA
RESOURCES
ABOUT
CURRICULUM SUBMISSION FORM
GIVE US FEEDBACK
ABOUT THE PROGRAM
Health Categories (Check all that apply) *
Sexual Health
Healthy Relationships
Alcohol and Drug Prevention/Cessation
Tobacco Prevention/Cessation
Violence or Bullying Prevention
Suicide Prevention/Mental Health Promotion
Other Healthy Life-Skills
Age Group Designed for *
Select One
Evidence of effectiveness (Check all that apply)
Tribal Best Practice
Best Practice
Promising Practice
Leading Practice
Emerging Practice
Endorsements (Check those that apply)
N/A
CDC's HIV Effective Interventions
OAH's Evidence-Based Programs
National Campaign to Prevent Teen Pregnancy's
HAVE QUESTIONS?
The submission form is 3 pages long. Information entered into the form will automatically be saved so you can come back to complete it later (cookies required). If you have any questions during the submission process, or if you're not sure your program meets our criteria, please email
scraig@npaihb.org
before submitting the form.
Learn more about the submission process and eligibility criteria.
NOTE: The site currently includes sexual health curricula, but we are

ANY OTHER HEALTH **TOPICS** THAT YOU THINK WE SHOULD ADD?

Eligibility Criteria

We are looking for programs that:

- **Promote** positive youth development and healthy-decision-making
- Were **purposefully designed** or adapted for AI/AN youth or young adults
- **Embrace cultural teachings** and learning styles of AI/AN youth
- Have been **evaluated** with AI/AN youth and demonstrated evidence of effectiveness*

Not sure if your program meets our criteria? Please send a brief description of your curriculum to scraig@npaihb.org before completing the full form.

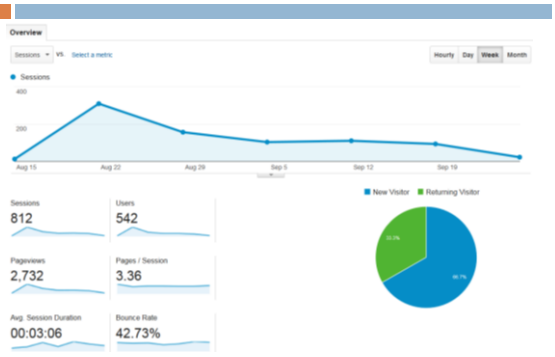
Process for Removal

If you wish to remove your curriculum from this website, please contact scraig@npaihb.org.

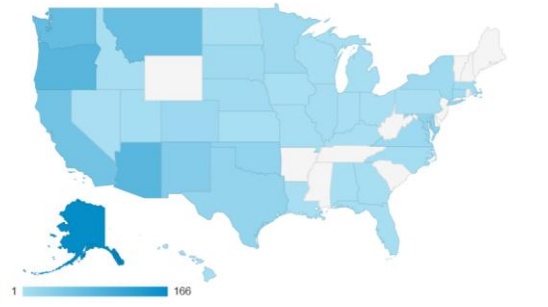
SUBMIT CURRICULUM

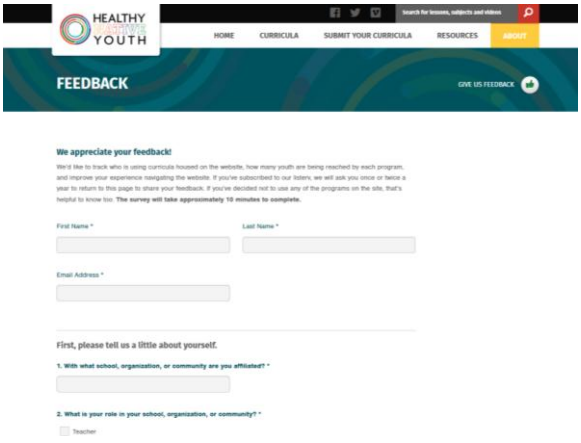
DO YOU KNOW OF **OTHER** CULTURALLY RELEVANT HEALTH CURRICULA THAT WE SHOULD REACH OUT TO, TO ADD?

Reach


Overview
Sessions
Hourly Day Week Month
Sessions
Aug 15 Aug 22 Aug 29 Sep 5 Sep 12 Sep 19
New Visitor Returning Visitor
Sessions 812
Users 542
Pageviews 2,732
Pages / Session 3.36
Avg. Session Duration 00:03:06
Bounce Rate 42.73%

Reach

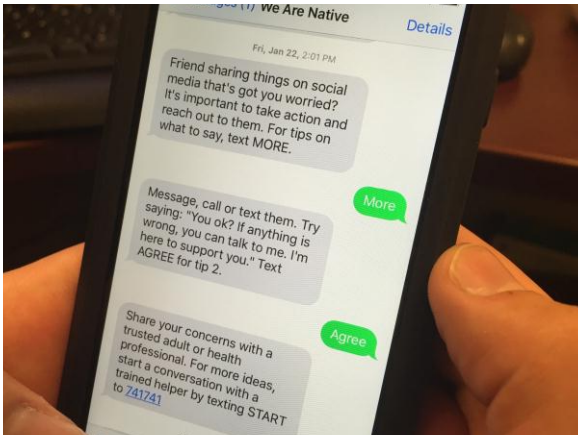

1
166


HEALTHY YOUTH
HOME
CURRICULA
SUBMIT YOUR CURRICULA
RESOURCES
ABOUT
FEEDBACK
GIVE US FEEDBACK
We appreciate your feedback!
First Name *
Last Name *
Email Address *
First, please tell us a little about yourself.
1. With what school, organization, or community are you affiliated? *
2. What is your role in your school, organization, or community? *
Teacher

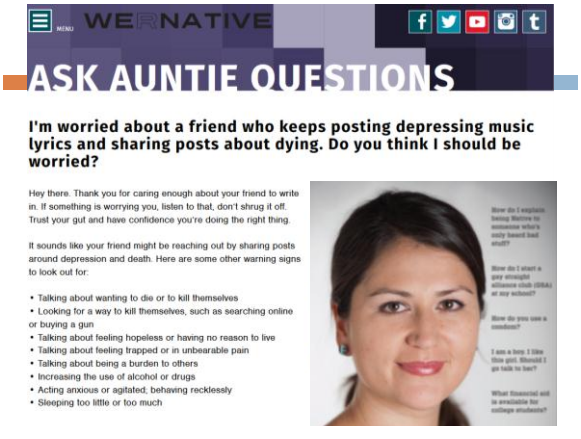
Concerning Posts on Social Media

We R Native and the Social Media and Adolescent Health Research Team (SMAHRT)

Tools for Youth and
Adults who work with Youth


We Are Native
Details
Fri, Jan 22, 2:01 PM
Friend sharing things on social media that's got you worried? It's important to take action and reach out to them. For tips on what to say, text MORE.
More
Message, call or text them. Try saying: "You ok? If anything is wrong, you can talk to me. I'm here to support you." Text AGREE for tip 2.
Agree
Share your concerns with a trusted adult or health professional. For more ideas, start a conversation with a trained helper by texting START to 741741


We R Native added 5 new photos — with Scott Kalama and 2 others
You don't have to do it alone. If you see a friend post something that concerns you, check out a few of these resources that can help.
Share
+2
Like
Comment
Share
Report
Chat


WERNATIVE
ASK AUNTIE QUESTIONS
I'm worried about a friend who keeps posting depressing music lyrics and sharing posts about dying. Do you think I should be worried?
Hey there. Thank you for caring enough about your friend to write in. If something is worrying you, listen to that, don't shrug it off. Trust your gut and have confidence you're doing the right thing.
It sounds like your friend might be reaching out by sharing posts around depression and death. Here are some other warning signs to look out for:
• Talking about wanting to die or to kill themselves
• Looking for a way to kill themselves, such as searching online or buying a gun
• Talking about feeling hopeless or having no reason to live
• Talking about feeling trapped or in unbearable pain
• Talking about being a burden to others
• Increasing the use of alcohol or drugs
• Acting anxious or agitated; behaving recklessly
• Sleeping too little or too much

Video for Adults who Work with Youth

- Introduction to the topic
- Real life experiences
  - Suicide or self-harm posted on social media
  - Responses to posts
- Training Goals
- Statistics
- Overview of our Study and Findings
- Tools for educators/adults
- Resources
  - QPR
  - Factsheets
  - Websites
  - Videos

Video: Next Steps

- Pilot evaluation of the video and accompanying tools/resources
- Make any needed changes
- Create a teacher's guide for placement on HealthyNativeYouth.org

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

2121 SW Broadway, Suite 300
Portland, Oregon 97201
Phone: (503) 228-4185
Fax: (503) 228-8182

Stephanie Craig Rushing, PhD, MPH
Director – Project Red Talon & THRIVE
scraig@npaihb.org

Colbie Caughlan, MPH
THRIVE Project Manager
ccaughlan@npaihb.org

Celena McCray
THRIVE Coordinator
cmccray@npaihb.org

Amanda Gaston, MAT
Ask Auntie
agaston@npaihb.org

David Stephens, RN
Multimedia Project Specialist
dstephens@npaihb.org

Tommy Ghost Dog
PRT Assistant
tghostdog@npaihb.org

Jessica Leston, MPH
STD/HIV Clinical Services Manager
jleston@npaihb.org

HEALTHY NATIVE YOUTH

RAISING HEALTHY NATIVE YOUTH

Through Culturally Relevant Health Education

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

Engaging. Relevant. Effective.

The site currently includes sexual health curricula, but will expand to include other health topics over the next year.

SUBMIT A HEALTH CURRICULUM

If you have a culturally-relevant health curriculum for AI/AN youth, consider housing it on www.HealthyNativeYouth.org. You'll receive feedback on program uptake and reach, with the ability to update training materials and lesson plans as needed.

Questions? *Please send inquiries to Stephanie at scraig@npaihb.org*

CURRENT SEXUAL HEALTH CURRICULA

MULTIMEDIA CIRCLE OF LIFE (MCOL)

Ages: Middle School | Program Setting: Flexible

VIEW MORE

NATIVE IT'S YOUR GAME

Ages: Middle School | Program Setting: Flexible

VIEW MORE

NATIVE STAND

Ages: High School | Program Setting: Flexible

VIEW MORE

NATIVE VOICES

Ages: High School, Young Adults | Program Setting: Flexible

VIEW MORE

SAFE IN THE VILLAGE

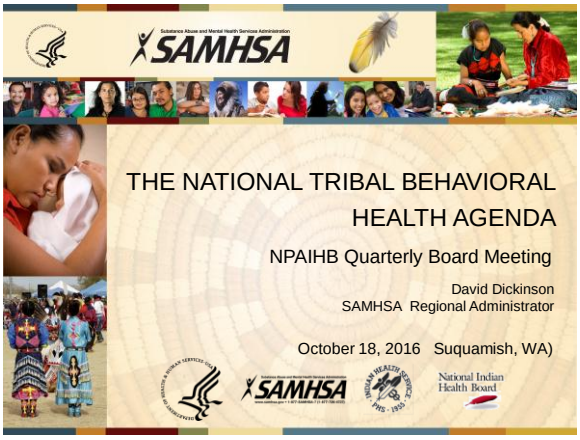
Ages: High School | Program Setting: Flexible

VIEW MORE

WE R NATIVE TEACHER'S GUIDE

Ages: High School | Program Setting: Flexible

VIEW MORE



The Sentiment

"We continue to address the impacts of alcohol and other drugs, youth suicides, domestic violence and the list continues. However, now is the time to address the source of these symptoms—historical and intergenerational trauma."

—Tribal leader, White House Tribal Nations Conference, 2014

SAMHSA

The Drivers

- Tribal leaders gave impetus to the National TBHA
  - SAMHSA's Tribal Technical Advisory Committee discussions led to concept for TBHA
  - Broader tribal leader call for coordination and collaboration to break silos and "work differently"
- High rates of behavioral health problems among American Indian and Alaska Native people
- Behavioral health issues are not isolated—there are correlations with physical health and social and economic conditions that require a more collective/collaborative approach

SAMHSA

The Messages

- Traumatic events have long-term impacts
  - *Need to heal from historical, intergenerational, and other traumas*
- Solutions must match the problem
  - *Use a socioecological approach*
- Prevention is the Priority
  - *Elevate prevention and support recovery*
- Infrastructure and delivery systems
  - *Systems and services must be fixed*
- Lack of information and stigma are in the way
  - *Raise awareness and educate tribal communities and partners*

SAMHSA

The Data: Substance Abuse

Substance Abuse—American Indians and Alaska Natives				
National Survey on Drug Use and Health 2013	age	AI-AN	Nat'l	Comparison
Alcohol				
alcohol use (current)	12+	37.3	52.2	↓
binge alcohol use	12+	23.5	22.9	↑
heavy alcohol use	12+	5.8	6.3	↓
Tobacco				
tobacco use (current)	12+	40.1	25.5	↑
cigarette use (current)	12+	36.5	21.3	↑
cigar use (current)	12+	6.1	4.7	↑
smokeless tobacco (current)	12+	5.3	3.4	↑
Illicits/Substance Abuse/SUD				
illicit drug use (current)	12+	12.3	9.4	↑
substance abuse or dependence	12+	14.9	6.6	↑
Non-medical Use of Rx Pain Relievers				
past year	12+	9.9	5.8	↑

SAMHSA

The Data: Mental Health

Mental Health—American Indians and Alaska Natives				
National Survey on Drug Use and Health 2013	age	AI-AN	Nat'l	Comparison
Mental health				
Any Mental Illness/AMI (past year)	18+	26.0	18.5	↑
Serious Mental Illness/SMI (past year)	18+	5.8	4.2	↑
Major Depressive Episode/MDE (past year)	18+	8.9	6.7	↑
Mental health service utilization (past year)	18+	15.7	14.6	↑
Suicidal thoughts	18+	4.8	3.9	↑
Comorbidity				
Co-occurring AMI-SUD	18+	7.4	3.2	↑
Co-occurring SMI-SUD	18+	1.1	1.0	↑

SAMHSA

Prescription Drugs

Great Lakes Inter Tribal Council*

- 30.9% of youth, 27.7% of minor adults and 24.9% of adults intentionally misused prescription medication
- 7.6% of youth think there is no risk to misusing prescription drugs; another 5.9% think there is only a slight risk
- 15.6% of youth, 34% of minor adults, and 28.1% of adults indicate it would be very easy to obtain non-prescribed prescription drugs if they wanted to

*SOURCE: 2011 community assessment of 10 tribes—SPF grant SAMHSA

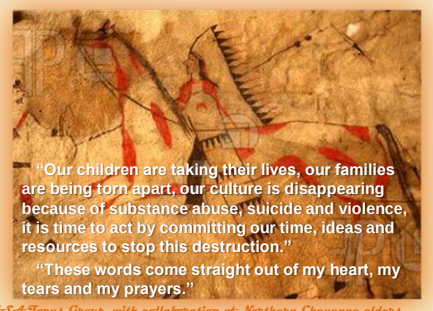
Prescription Drugs

Northwest Portland Area Indian Health Board

- From 2006-2012, there were 10,565 AI/AN deaths and 584,070 deaths among non-Hispanic whites (NHW) in ID, OR, and WA
- Drug overdoses accounted for 4.3% of all AI/AN deaths and 1.7% of all NHW deaths
- Majority of drug overdose deaths among AI/ANs (65.3%) and NHW (69.3%) were from prescription drugs

SAMHSA

Words of Wisdom



~AASA Focus Group, with collaboration of Northern Cheyenne elders

SAMHSA

What the TBHA is

- A document that provides a clear, national statement about the extent and need for prioritizing behavioral health problems
- A tool for improving collaboration on common issues across different entities/sectors
- A blueprint that harmonizes efforts and creates a collaborative approach for program and policy activities—no single entity can change outcomes alone

SAMHSA

What the TBHA is Not

- Not a silver bullet—will not fix problems, compounded over decades, overnight
- Not a strategic plan—nor a replacement for existing strategic plans (existing plans have a purpose and legal and/or policy directives)
- Not a list of prescribed actions that tribal, federal, state, and local governments or other stakeholders must take

SAMHSA

The TBHA Framework

- AI/AN Cultural Wisdom Declaration
- Six cross-cutting considerations
  - Youth, Culture, Identity, Individual Self-Sufficiency, Data, Tribal Leadership
- Five foundational elements upon which priorities and strategies were built
  - Historical and Intergenerational Trauma
  - Socio-Ecological Approach
  - Prevention and Recovery Support
  - Behavioral Health Systems and Support
  - National Awareness and Visibility
- Priorities and Strategies

SAMHSA

American Indian and Alaska Native Cultural Wisdom Declaration

- Developed by tribal representatives
- Elevates importance of tribal identities, culture, spiritual beliefs, and practices as essential for improving well-being
- Ensures cultural wisdom and traditional practices are taken into account and supported as fundamental elements of programs, policies, and activities for improving behavioral health

SAMHSA

Historical & Intergenerational Trauma

- Focus

  Support priorities and strategies that support healing
- Priorities
  - Ensure appropriate support systems are in place to support healing
  - Invest in community connectedness
  - Promote healing to break the cycle of trauma

SAMHSA

Social-Ecological Approach

- Focus

  Support priorities and strategies that capture the larger context within which AI/AN behavioral health issues are rooted and interventions to more effectively address them
- Priorities
  - Sustain environmental resources
  - Invest in necessary and reliable infrastructure
  - Support healthy families and kinship

SAMHSA

Prevention and Recovery Support

- Focus

  Support priorities and strategies to address issues that inhibit opportunities to intervene early and that are required to sustain positive emotional health
- Priorities
  - Develop programming that meets community needs
  - Mobilize and engage communities

SAMHSA

Behavioral Health Services/Systems

- Focus: support priorities and strategies to improve coordination, linkages, and access to behavioral health and related services
  - Target workforce development, recruitment, retention
  - Support flexible and more realistic funding
  - Support tribally directed programs
  - Support youth-based programming
  - Expand scope of current programming
  - Coordinate with law enforcement programs

SAMHSA

National Awareness and Visibility

- Focus

  Support priorities and strategies to improve understanding of AI/AN behavioral health disparities and their consequent impacts on physical health and well-being
- Priorities
  - Build tribal capacity
  - Build tribal partner capacity
  - Support tribally directed communication strategies

SAMHSA

Next Steps

- Tribal comment period ends October 30, 2016
- National Rollout
- Implementation activities in collaboration with NIHB, NCAI, and NCUIH

SAMHSA

The Power of the TBHA

- Based on tribal voices and priorities
- Opportunity to shape policies and programs
  - Supports wisdom of cultural and traditional practices alongside western approaches
  - Garners appropriate attention to priorities that address outstanding challenges
  - Mobilizes collaborators to act together
- Uses existing platforms (i.e., strategic plans, etc.) to "work differently"

SAMHSA

SAMHSA Region X Suicide Rates 2014

Rank	State [Division / Region]	Deaths	Rate
2	Alaska [P / West]	167	22.7
8	Oregon [P / West]	782	19.7
9	Idaho [M / West]	320	19.6
21	Washington [P / West]	1,119	15.9
	Nation	**42,773**	**13.4**

Source: Obtained 18 December 2015 from CDC/NCHS's *Mortality in the United States: 2014* Public Use File and Web Tables (released and accessed 18 December 2015; Table 19)

SAMHSA

Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant Program

This program supports states and tribes (including Alaska Villages and urban Indian organizations) in **developing and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration**. Such efforts involve public/private collaboration among youth-serving institutions and agencies and include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child- and youth-supporting organizations. A cross-site evaluation is conducted under a contract in the Division of Prevention, Traumatic Stress, and Special Programs.

SAMHSA

Current GLS Tribal Grantees (1)

- Crow Creek Sioux Tribe
- Oglala Sioux Tribe
- Chippewa Cree Tribe
- Rosebud Sioux Tribe
- Shingle Springs Band of Miwok Indians
- Indian Center, Inc.
- **Association of Village Council Presidents (AK)**
- Northern Cheyenne Tribe
- **Confederated Tribes of Colville Reservation (WA)**
- California Rural Indian Health Board
- American Indian Health & Family Services of SE MI, Inc.
- Native Americans for Community Action, Inc.
- **Southcentral Foundation (AK)**
- Pueblo of San Felipe

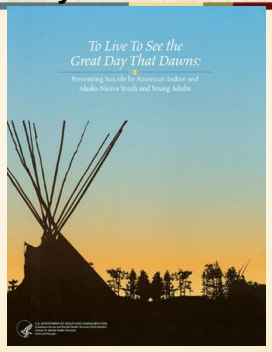
SAMHSA

Current GLS Tribal Grantees (2)

- United Indian Health Services, Inc.
- **Northwest Portland Area Indian Health Board (OR)**
- **Yellowhawk Tribal Health Center (OR)**
- Confederated Salish and Kootenai Tribes
- **Dena' Nena' Henash dba Tanana Chiefs (AK)**
- Muscogee (Creek) Nation
- **Native American Rehabilitation Assoc. (NARA) (OR)**
- Wichita and Affiliated Tribes
- Choctaw Nation of Oklahoma
- **Kawerak, Inc. (AK)**
- **Fairbanks Native Association (AK)**
- Native American Health Center, Inc
- **Tribes & Bands of the Yakama Nation (WA)**

SAMHSA

To Live to See the Great Day that Dawns



SAMHSA

Circles of Care History

- After years of advocacy and tribal consultation, Circles of Care was funded in 1998 by SAMHSA as a 3 year planning grant for AI/AN communities with financial and other support from BIA, IHS, OJJDP and NIMH
- Additional cohorts were funded in 2001 and 2005 by SAMHSA with small interagency agreements with IHS and NIMH to support technical assistance contracts
- In 2008 SAMHSA funded the fourth cohort and fifth cohort in 2011
- In 2014 SAMHSA not only funded, but expanded the sixth cohort both in number of grants and funds available for award

SAMHSA

Impact of the Circles of Care Program

- 49 AI/AN Communities have been awarded COC grants since 1998:
  - 32 Tribes or Tribal organizations
  - 15 Urban Indian Organizations
  - 2 Tribal Universities
- 20 of 38 “graduated” COC grantees have received Systems of Care grants either directly, or in partnership with another organization to implement their model
- Most of the other 18 have implemented their model through different strategies

SAMHSA

Circles of Care VI Grantees (2014-2017 Projects)

1. **Tanana Chiefs Conference - AK**
2. Native Americans for Com. Action (Flagstaff) AZ
3. Indian Hlth Ctr of Santa Clara Valley (San Jose)- CA
4. Quartz Valley Indian Reservation - CA
5. Ute Mountain Ute Tribe - UT
6. Osage Nation - OK
7. Lower Brule Sioux Tribe - SD
8. **Hoh Tribe - WA**
9. **Makah Indian Tribe - WA**
10. **Seattle Indian Health Board - WA**
11. Red Cliff Band of Lake Sup. Chippewa -WI

SAMHSA

Circles of Care VI Goals

- …to plan and design a holistic, community-based, coordinated system of care approach to support mental health and wellness for children, youth, and families.
- …increase the capacity and effectiveness of mental health systems
- …focus on the need to reduce the gap between the need for mental health services and the availability and coordination of mental health, substance use, and co-occurring disorders in AI/AN communities for children, youth, and young adults from birth through age 25 and their families.

SAMHSA

Circles of Care VI Goals (cont'd)

- …draws on the system of care philosophy and principles…
- …a system of care is defined as a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with mental health needs and their families.
- …families and youth work in partnership with public and private organizations to design mental health services and supports that build on the strengths of individuals and address each person's cultural and linguistic needs.

SAMHSA

Purpose

- …to prevent and reduce suicidal behavior and substance abuse among American Indian/Alaska Native young people up to and including age 24.
- …reduce the impact of substance abuse, mental illness and trauma on AI/AN communities through a public health approach
- …allow AI/AN communities to support youth and young adults as they transition into adulthood by facilitating collaboration among agencies.

SAMHSA

Background Note: Native Connections Principles

- *Community Involvement and Feedback*
- *Strengths-Based*
- *Grounded in Community Readiness*
- *Identify the Gaps, Pilot Solutions*
- *Lead Coordination Across the Agencies*
- *Foster Relationships*
- *Innovation in Serving AI/AN Youth*
- *Supported by AI/AN Technical Assistance*
- *Evaluated for Effectiveness in Saving Lives*

SAMHSA

New Native Connections Awards

10 new grants to Washington Tribes and Tribal Organizations

2 new grants to Oregon Tribes

26 total new Native Connections Grants in Region X (includes grant awards to Alaska Native Tribal Organizations)

SAMHSA

SAMHSA Funding Opportunities

- Visit the SAMHSA website:

http://www.samhsa.gov/

- Click on the "Grants" tab at top of homepage.
- Then click on "Fiscal Year 2016 Grant Announcements
- View individual announcements

SAMHSA

Applications Due Soon!

SAMHSA has released the following grants, available to Tribes, Urban Indian Programs and/or Tribal Colleges and/or Universities (TCUs).

Grant Program	Tribal Eligibility	Due Date
Campus Suicide Prevention Program - Funding Available: $1,521,000 - Number of Awards/Years: 15 (up to 3 years)	TCUs	12/07/2016
Adult Treatment Drug Courts and Adult Tribal Healing and Wellness Courts - Funding Available: $18,230,000 - Number of Awards/Years: 56 (up to 3 years)	Tribes and Tribal Organizations	12/12/2016
Circles of Care VII - Funding Available: $4,600,000 - Number of Awards/Years: 11 (3 years)	Tribes, Tribal Organizations, Urban Programs and TCUs	12/20/2016
Systems of Care (SOC) Expansion and Sustainability Cooperative Agreements - Funding Available: $15,045,000 - Number of Awards/Years: 5 - 15 (4 years)	Tribes and Tribal Organizations	1/03/2017

SAMHSA

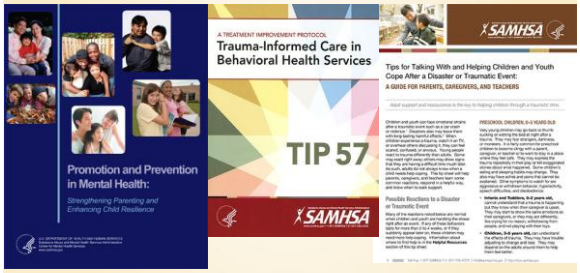
Changes in Application Process

- IMPORTANT: SAMHSA is transitioning to the National Institutes of Health (NIH)'s electronic Research Administration (eRA) grants system. Due to this transition, SAMHSA has made changes to the application registration, submission, and formatting requirements for all FOAs. All applicants must register with NIH's eRA Commons in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).
- Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process six (6) weeks in advance of the application due date.

SAMHSA

SAMHSA Store

www.store.samhsa.gov



SAMHSA

Collaboration: Foundation for Success

Center for **Substance Abuse Prevention**

Center for **Mental Health Services**

Center for **Substance Abuse Treatment**

Center for **Behavioral Health Statistics and Quality**

http://www.samhsa.gov

SAMHSA

Thank You!

For additional information, please contact:

otap@samhsa.hhs.gov

Region X Contact Information:

David Dickinson

SAMHSA Regional Administrator

david.dickinson@samhsa.hhs.gov

206-615-3893

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

September 30, 2016

Dear Tribal Leader:

We are writing to ask for your input on the draft National Tribal Behavioral Health Agenda (TBHA). The TBHA was developed through a series of discussions with tribal leaders, tribal administrators, and other representatives from tribal communities who contributed to the identification of foundational elements, priorities, and strategies for improving behavioral health. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Indian Health Service (IHS) led development of the TBHA with the support of the National Indian Health Board. The draft TBHA is a blueprint for strengthening policies, programs, and activities through collaboration among federal, tribal, and other partners.

The concept for a national TBHA began through discussions with tribal leaders on SAMHSA's Tribal Technical Advisory Committee (TTAC), which shared the impact that mental and substance use disorders was having on tribal communities and the importance of federal and tribal partners working differently together to make a difference. The concept for the TBHA was shared with tribal leaders on the U.S. Department of Health and Human Services' (HHS) Secretary's Tribal Advisory Committee, the IHS National Tribal Advisory Committee, Board of Directors of the National Indian Health Board, and during many meetings, such as the HHS Annual Tribal Budget Consultation Session and sessions at national and regional tribal conferences.

Input from tribal leaders, tribal administrators, and tribal representatives over the course of approximately 18 months was used in framing elements that were viewed as foundational for improving the behavioral health of tribal communities as well as developing cross-cutting considerations, priorities, and strategies. The draft TBHA also includes an American Indian and Alaska Native Cultural Wisdom Declaration to ensure that tribal wisdom and traditional practices are fundamental to efforts focused on improving the behavioral health and overall wellness of Native peoples.

Your input on the draft TBHA is requested during the comment period, which closes on October 30, 2016. To obtain an electronic copy of the draft TBHA and/or provide comments online, please go to http://store.samhsa.gov/TBHA/feedback/. Written comments, using the same format as the online form, may also be submitted via e-mail to tribalconsultation@samhsa.hhs.gov. All comments must be received by October 30, 2016.

Should you have questions, please contact Sheila Cooper at sheila.cooper@samhsa.hhs.gov or at 240-276-2005. We look forward to working with you to improve the behavioral health of American Indian and Alaska Native people and communities.

Sincerely,

Kana Enomoto
Principal Deputy Administrator

Enclosures:
Draft Tribal Behavioral Health Agenda
Copy of the Draft TBHA Online Submission Form

THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

Draft

The development of a TRIBAL BEHAVIORAL HEALTH AGENDA is long overdue. And the development of this particular document and its contents was the result of months of discussing, analyzing, validating, sharing, and revalidating. The Tribal Behavioral Health Agenda was a collaborative effort between many Tribes, leaders, organizations, and federal agencies.

The authors would like to acknowledge that the idea for this document originated from direct discussions with Tribal leaders around the challenges Tribes are facing with behavioral health.

It was their *passion vision* AND *dedication* that led to the development of this Agenda.

FEDERAL LEADERSHIP LETTER

DEAR TRIBAL LEADERS, FEDERAL PARTNERS, AND OTHER COLLABORATORS:

There has never been a more important time to work together to improve the behavioral health – mental and substance use disorders – of American Indians and Alaska Natives. Mental and substance use disorders are impacting tribal communities and, in many cases, rates for specific disorders are higher when compared to other communities in the United States. The relationship between behavioral health, overall health, and well-being is unequivocal. Behavioral health is influenced by factors that also influence overall health, and people with mental and substance use disorders may have higher rates of physical health problems.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Indian Health Service (IHS) are committed to collaborating with tribal nations, urban Indian health programs, other federal departments and agencies, and other partners to improve the well-being of American Indians and Alaska Natives. SAMHSA, as the lead federal agency for advancing the behavioral health of the nation, is working to reduce the impact of mental and substance use disorders on America's communities, including tribal communities.

IHS, in partnership with tribal health and urban Indian health programs, is working to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Through complementary missions, federal, tribal, urban Indian health, and other partners can work together to improve behavioral health and overall wellness.

The concept for the National Tribal Behavioral Health Agenda (TBHA) was born from the voices of tribal leaders who spoke compellingly about the extent to which mental and substance use disorders are impacting tribal communities. Beyond the issues, they also spoke about the need for partnership and working differently together in order to make a difference in the lives of American Indians and Alaska Natives. SAMHSA and IHS accepted the advice and worked with the National Indian Health Board to gather input on what would ultimately become the TBHA.

Through discussions, five elements which form the foundation for the TBHA were developed and affirmed by tribal leaders and tribal representatives. Therefore, many more discussions, content of what would become the priorities and strategies for the TBHA emerged and were affirmed. Thus, the TBHA includes foundational elements, priorities, and strategies that chart a course for more meaningful partnerships and opportunities for strengthening policies, programs, and activities.

The content and order of the information in the TBHA hold significance. Globally, there are three significant components to this document. These components include the American Indian and Alaska Native Cultural Wisdom Declaration (CWD); sections which provide background and form *Part One* of the document; and, sections which comprise the substance of the TBHA and are included in *Part Two* of the document.

The CWD was developed by tribal leaders and representatives who sought to elevate the importance of tribal identities, culture, spiritual beliefs, and practices for improving well-being. The intent of the CWD is to ensure that cultural wisdom and traditional practices are taken into account and supported as fundamental elements of programs, policies, and activities that are designed, or contribute, to improvements in behavioral health.

Part I of the document provides background on the historical and current contexts of tribal communities, data on targeted behavioral health issues faced by American Indians and Alaska Natives, and health care service system issues and considerations. The TBHA is a collaborative tool – it can be used by any entity that has the ability to contribute positively to tribal communities. As such, the information aims to achieve common understanding of the issues requiring partnership.

Part II of the document includes the foundational elements, priorities, and strategies of the TBHA that were derived through tribal input. The components of the TBHA are not all-inclusive but rather, collectively they reflect areas of agreement across many conversations that have been elevated for partnership. Part II also includes examples of current federal programming that are synergistic with the foundational elements, priorities, and strategies. The federal examples underscore that critical programs exist and can be effectively leveraged to improve behavioral health.

SAMHSA and IHS commit to working with you to advance the TBHA, improve behavioral health, and contribute to the well-being of American Indians and Alaska Native people.

AMERICAN INDIAN AND ALASKA NATIVE CULTURAL WISDOM DECLARATION

This statement is an attempt to motivate and set in motion, culturally derived efforts that will address the present state of health for American Indian and Alaska Native people. American Indian and Alaska Native tribes are diverse and unique in culture and traditions but share a common history in our relationship with the Federal government and common goals for improving the lives of our people. We hope this statement will be accepted and supported by American Indian and Alaska Native tribes as a statement of intent that will move us forward in preserving and promoting our identities and cultural and spiritual beliefs and practices while practicing our respective traditional wisdom in health protection that has been passed from generation to generation.

As indigenous people, we possess the culturally relevant knowledge and expertise to address and enhance the overall health and well-being of all American Indian and Alaska Native people across the country. We also expect this statement will be honored and implemented by U.S. Federal Agencies, state agencies, and private and non-profit organizations charged with improving the health status of American Indian and Alaska Native people.

BACKGROUND

Native Americans are experiencing vast health inequities as evidenced by high rates of cancer, diabetes, trauma, mental and substance use disorders (including suicide), and unintentional injury. Present efforts to address the health status of American Indian and Alaska Native- people remain marginally effective in alleviating these health disparities. While research and programs consistently recommend that prevention and health care programs also implement traditional practices and philosophies, barriers exist that prevent the successful implementation of culturally tailored health promotion and healing interventions.

The intent of this declaration is to address the existing barriers and move towards successful implementation of culturally driven health promotion models of care and healing. This declaration promotes the voice of American Indians and Alaska Natives to ensure success in embedding culturally relevant health promotion and healing interventions into all health and human service initiatives.

WE BELIEVE...

We honor the ancestral cultural knowledge, wisdom, ceremony, and practices of American Indian and Alaska Native tribes. Our respective cultural knowledge is sacred and has been practiced for centuries as evident in our shared inter-tribal survival and resilience. This traditional cultural wisdom predates the U.S. Constitution. We are experts of our own cultural wisdom. Our wisdom has been passed down orally from generation to generation, and the depths of our wisdom remains within the hearts and minds of our people. Our cultural wisdom exists solely for us. It is tribe specific and this sacred knowledge exists to benefit our health, our well-being, and the health and well-being of future generations. Our cultural wisdom is guarded and protected because of the history of broken promises and

broken trust we have experienced over and over again. Our cultural wisdom will remain protected. Our cultural wisdom will continue to be transferred orally, as it has been in the past. Our worldview on health and healing is holistic, encompassing the body, mind, spirit, nature and our environment.

WE WILL....

We will preserve and implement our cultural wisdom as a means to promote health and well-being in our communities through stories, songs, prayers, rituals, and ceremonies and other traditional practices. Our respective traditional wisdom, ceremonies, language, and customs will be implemented in our communities to benefit our present and future generations while we honor the ancestral and sacred elements of this knowledge and control its use and dissemination. All details of cultural wisdom will remain authentic to traditional ways of being, knowing, and doing. We will integrate authentic cultural interventions alongside existing healthcare promotion efforts to ensure a culturally tailored and culturally relevant approach to health promotion and healthcare delivery for American Indian and Alaska Native people.

WE KNOW....

We know that Native American wisdom exists within our stories, language, ceremonies, songs, and teachings. We know our Native ways are effective. We know that these ways are different from the Western worldview. We know we are experts in practicing and implementing our traditional ways to enhance the health of our people. We know our ways are unique and specific to Tribal groups. The authenticity of our Native American cultural wisdom is acknowledged and validated by our families, our clans, our communities. This knowledge has been validated for centuries by our ancestors. This knowledge exists within American Indian and Alaska Native communities, it is known by our people, and we will protect this sacred knowledge.

We expect the following from those agencies that have power, authority and funding relevant to American Indian and Alaska Native health including Tribal, State, Federal, private and non-profit organizations:

- TRUST
- RESPECT
- ACCEPTANCE
- COMMITMENT
- SUPPORT
- FINANCIAL RESOURCES

And to ensure the success of this declaration we recommend the following:

- Respect our intent to keep sacred knowledge private and allow details of this cultural knowledge and wisdom to remain with the knowledge keepers (elders, traditional healers, storytellers, and American Indian and Alaska Native people).
- Support our unique ideas and models of health and healing interventions that may not fit typical or standard western approaches.
- Modify your requirements to fit the relevant traditional tribal paradigm or allow room for flexibility when evaluating proposals submitted by American Indian and Alaska Native tribal nations.
- Provide adequate time and financial resources required to work in rural and remote areas, with hard to reach populations and within the legal frameworks of sovereign nations.
- Trust the Nations to deliver their culturally derived interventions.
- Accept our distinct American Indian and Alaska Native cultural ways of being, knowing and doing.
- Support our authority to practice American Indian and Alaska Native culture as practiced for generations, without modification, without restriction.
- Support the cost of structuring innovative and culturally tailored models of health promotion through advocating for additional funding in the form of budget increases and specific grant funding that targets unique American Indian and Alaska Native health promotion efforts.

The following individuals, Tribes/Nations and Other American Indian and Alaska Native community agencies and organizations support this statement.

SIGNATORIES **DATE**

ACKNOWLEDGMENTS

The development of the first National Tribal Behavioral Health Agenda (TBHA) is long overdue. The concept for the TBHA came from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Tribal Technical Advisory Committee (TTAC).

SAMHSA owes a debt of gratitude to Joe Garcia (Ohkay Owingeh Pueblo) whose vision initiated the TTAC discussion and who passionately spoke about the importance of Tribal leaders' voices in framing a behavioral health agenda for Tribal nations. SAMHSA also appreciates the leadership and guidance from other Tribal leaders on the TTAC whose collective voices helped shape and guide completion of the TBHA: Timothy Ballew II (Lummi Indian Nation), Brooks Big John (Lac du Flambeau Tribe), Amber Crotty (Navajo Nation), Anthony J. Francisco, Jr. (Tohono O'odham Nation), Andy Joseph, Jr. (Confederated Tribes of the Colville Reservation), Juana Majel-Dixon (Pauma Band of Luiseno Mission Indians), Keith Massaway (Sault Ste. Marie Tribe of Chippewa Indians), and Vernon Miller (Omaha Tribe of Nebraska).

The insight and guidance provided by the U.S. Department of Health and Human Services Secretary's Tribal Advisory Committee during many discussions about behavioral health and in particular, suicide in Indian Country, were invaluable in shaping the TBHA. In addition, the input and support from Tribal leaders on the Board of Directors for the National Indian Health Board were significant and appreciated.

Special appreciation is extended to Cathy Abramson (Sault Ste. Marie Tribe of Chippewa Indians) and Chester Antone (Tohono O'odham Nation) whose dedication to uplifting the behavioral health of American Indians and Alaska Natives and their engagement on the TBHA throughout its development have proven them to be champions for Native people.

The process for developing the TBHA was the result of months of information-gathering and discussing, analyzing, validating, sharing, and revalidating the input received. SAMHSA's Office of Tribal Affairs and Policy (OTAP) worked with the Indian Health Service's (IHS) Office of Clinical and Preventive Services (OCPS) and the National Indian Health Board (NIHB) to engage Tribal leaders, Tribal administrators, and Tribal members to obtain input and ensure that Tribal voices were honored in developing the TBHA. The following

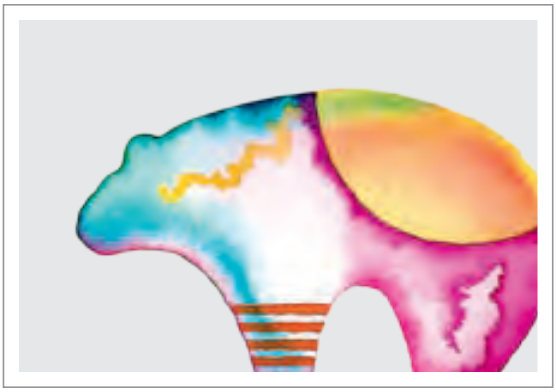
individuals are recognized for their leadership in bringing Tribal leaders' vision for the TBHA to fruition:

- **MIRTHA BEADLE**, OTAP, SAMHSA
- **STACY BOHLEN** (Sault Ste. Marie Tribe of Chippewa Indians), NIHB
- **SHEILA COOPER** (Seneca Nation), OTAP, SAMHSA
- **BEVERLY COTTON** (Mississippi Band of Choctaw Indians), Division of Behavioral Health (DBH), OCPS, IHS
- **JACQUELYNN ENGEBRETSON** (Ahtna Athabascan), NIHB
- **ROBERT FOLEY**, NIHB
- **HANKIE ORTIZ**, Bureau of Indian Affairs
- **MARCELLA RONYAK** (Confederated Tribes of the Colville Reservation), DBH, OCPS, IHS
- **DEBORAH SCOTT** (Cherokee Nation), Sage Associates, Inc.
- **ALEC THUNDERCLOUD** (Ho-Chunk Nation), OCPS, IHS

Appreciation is extended to the following individuals for providing technical expertise and support for the TBHA: Tom Anderson (Cherokee Nation), Oklahoma Area Tribal Epidemiology Center; Frank Bajowski, Cabezon Group, Inc.; Carla Britton, Alaska Native Epidemiology Center; Dawn Coley (Penobscot Nation), NIHB; Devin Delrow (Navajo Nation), NIHB; Kristin Hill, Great Lakes Inter-Tribal Epidemiology Center; Michael Koscinski, OIASA, OTAP, SAMHSA; Byron Larson (Northern Cheyenne Tribe), Urban Indian Health Institute; Caitrin Shuy, NIHB; Donna Cay Tharpe, Cabezon Group, Inc.; and the Tribal Law and Order Act Indian Alcohol and Substance Abuse Coordinating Committee's Data Workgroup.

The TBHA was a collaborative effort among tribes, Tribal leaders, national and regional Tribal organizations, SAMHSA Regional Administrators, SAMHSA staff members, and Federal partners. Three specific Tribal organizations – National Indian Health Board, National Council of Urban Indian Health, and National Congress of American Indians – were instrumental in supporting, advancing, and disseminating the TBHA. Although it is difficult to identify all supporters by name, the TBHA would not have been possible without all of you.

CONTENTS



Part Two

EXECUTIVE SUMMARY

THE VOICES

Suicide pacts among American Indian youth in small and tight-knit communities

Long waiting lists to see a health provider

Providers who have little understanding of historical and traditional practices

These comments are but a few of the concerns voiced by hundreds of Tribal members when asked about behavioral health issues in their communities. The story of American Indians and Alaska Natives is one of resiliency and survival. However, threats such as social injustices, perpetuated over multiple generations, continue to have enduring consequences for Tribal communities and contribute to the behavioral health problems being experienced today.

The problems – which result from adverse childhood experiences and traumatic events experienced historically and intergenerationally – are reflected in high rates of interpersonal violence, depressive symptoms (depression and unresolved grief and loss), substance use (alcohol and illicit drugs), and suicide. The root causes and resulting behavioral health issues impact other areas that contribute to well-being such as overall health, education, employment, child welfare, and engagement with the justice system that create an urgent need for tribes, Federal agencies, and other interested parties to work together differently and more effectively.

The idea for a comprehensive document focused on the behavioral health of Tribal communities was brought forward by concerned and engaged Tribal leaders. There is no one single national program or document that brings together and elevates the importance of behavioral health for Native people, identifies priorities developed by Tribal communities, and guides incorporation of strategies to improve the well-being of youth, families, and communities. Many individuals and organizations play a role in addressing behavioral health and their related problems and are at times loosely connected through a broad landscape of Tribal and Federal projects, programs,

initiatives, and funding streams that require better coordination to improve well-being.

To bring the TBHA idea to fruition, the Substance Abuse and Mental Health Services Administration, Indian Health Service, and the National Indian Health Board shared information and facilitated discussions and meetings with hundreds of Tribal leaders, Tribal administrators, Tribal members, advocates for American Indian and Alaska Native health, Native youth, and Federal agency representatives. From the many meetings and discussions emerged a series of overlapping opportunities and priorities that serve as the framework for the National Tribal Behavioral Health Agenda (TBHA). The TBHA is not a strategic plan; rather it is a guiding blueprint that will assist in strengthening policies and programs, aligning disparate resources, and facilitating collaboration. It identifies existing strategic plans and efforts that can serve as initial pathways for action and a single, unifying tool around which engaged parties can gather, utilizing common language and priorities. All parties have a responsibility and role to play in creating solutions that are viable and sustainable, and the TBHA provides the needed framework and priorities for doing so.

The TBHA framework is organized around five foundational elements that provide both content and direction. The foundational elements were dominant themes from early formative work with Tribal leaders and capture the opportunities and issues presented. Underlying each of the five foundational elements are priority areas that reflect the recurring issues raised by Tribal leaders, Tribal members, and stakeholders as outlined on the following page.

Within the priority areas are strategies that can be framed to address unique community circumstances. The strategies are not prescriptive and range from engaging key stakeholders in policy and systems changes to examining

staffing patterns to create a healthier and more responsive workforce. Some strategies are appropriate for Tribal governments, whereas others are more appropriate for Federal partners or even individual community members, reflecting opportunities where interested parties can engage.

Tribal leaders, Tribal council members, Tribal administrators, American Indian and Alaska Native health advocates, and Federal agency representatives have consistently called for coordination and collaboration among the distinct jurisdictions and entities whose efforts contribute to the health and well-being of American Indian and Alaska Native communities. The TBHA offers the opportunity for these parties to find common ground for developing interrelated and integrated actions for addressing the behavioral health needs of American Indians and Alaska Natives. This includes a commitment to incorporate the long-held wisdom and cultural practices of Tribal communities and Western approaches and systems in identifying solutions, garnering appropriate attention and resources for addressing outstanding challenges, and mobilizing collaborators to act together to combat localized behavioral health and related issues. The TBHA creates a platform that will allow Tribal and Federal partners to chart priorities for funding, programs, and policy decisions. Collaboration is the power of the TBHA.

THE TRIBAL BEHAVIOR HEALTH AGENDA FOUNDATIONAL ELEMENTS

1 HISTORICAL AND INTERGENERATIONAL TRAUMA

- SUPPORT SYSTEMS
- COMMUNITY CONNECTEDNESS
- BREAKING THE CYCLE

2 SOCIOECOLOGICAL APPROACH

- SUSTAINING ENVIRONMENTAL RESOURCES
- RELIABLE INFRASTRUCTURE
- HEALTHY FAMILIES AND KINSHIP

3 PREVENTION AND RECOVERY SUPPORT

- PROGRAMMING THAT MEETS COMMMUNITY NEEDS
- COMMUNITY MOBILIZATION AND ENGAGEMENT

4 BEHAVIORAL HEALTH SYSTEMS AND SUPPORT

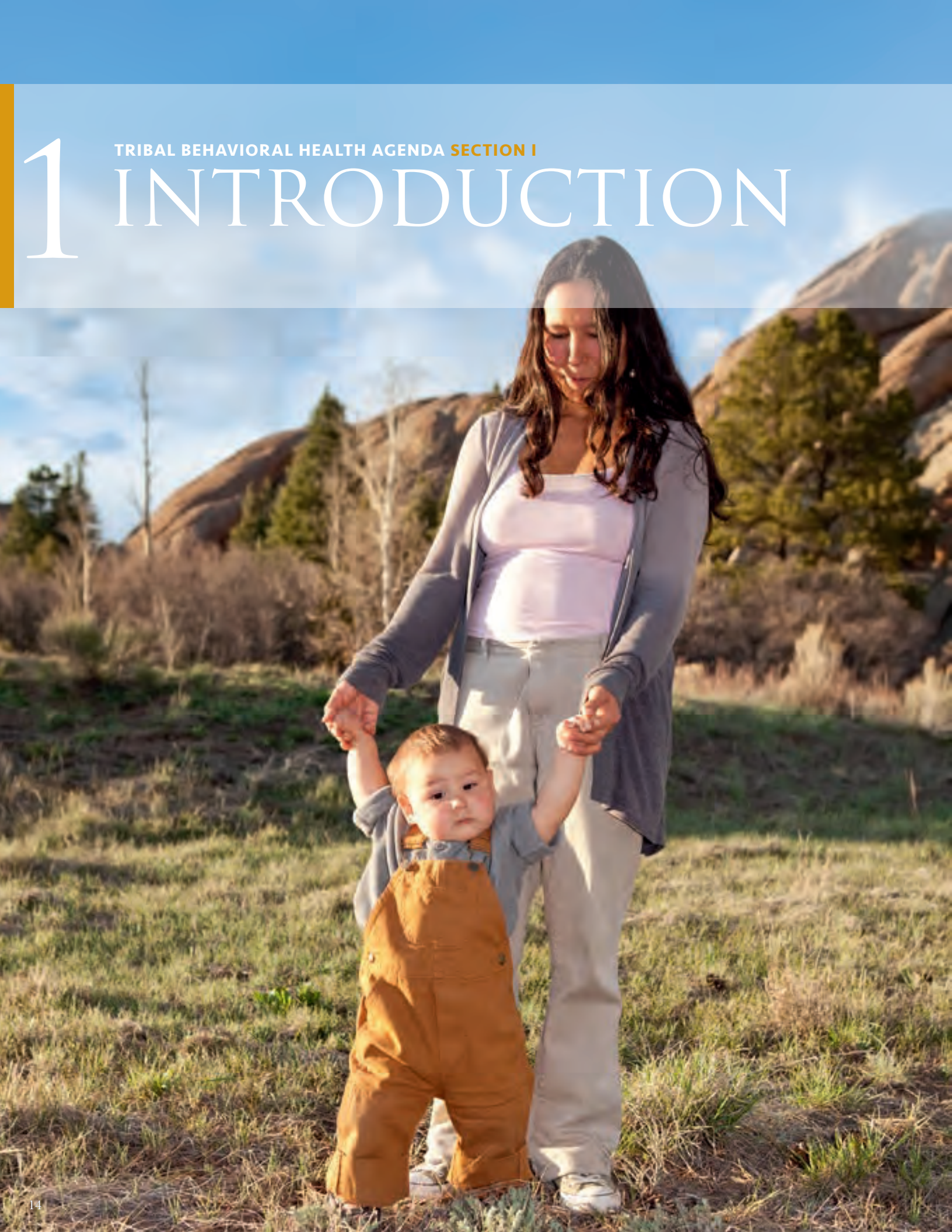
- WORKFORCE DEVELOPMENT
- FUNDING MECHANISMS
- TRIBALLY DIRECTED PROGRAMS
- YOUTH-BASED PROGRAMMING
- SCOPE OF PROGRAMMING
- LAW ENFORCEMENT AND JUSTICE PROGRAMS

5 NATIONAL AWARENESS AND VISIBILITY

- TRIBAL CAPACITY BUILDING
- TRIBALLY DIRECTED COMMUNICATION STRATEGIES
- PARTNER CAPACITY BUILDING

TRIBAL BEHAVIORAL HEALTH AGENDA **SECTION I**

1 INTRODUCTION



The significant health issues confronting American Indian and Alaska Native communities on a national scale are well known and well documented. What is not as well documented are the stories of success and survival that often accompany daunting health and behavioral health concerns. The term "behavioral health" refers to the promotion of mental health, resilience, and well-being; the prevention and treatment of mental and substance use disorders; and the support of those who are in recovery from these conditions, along with their families and communities.[1] Strength and resiliency are ingrained traits of American Indian and Alaska Native communities. Adaptability has become an equally important attribute as contemporary times and challenges have forced these communities to examine their health and wellness through the predominantly Western lenses of clinical care, programmatic effectiveness, sustainability, and impact.

Tribal leaders have voiced concerns about the state of behavioral health in Indian Country. Tragic stories have been shared of continuing suicides among youth in small, tight-knit communities. Stories have been shared of long waiting lists to see a behavioral health provider who is only in the community a limited number of days a month. Other stories have been shared of providers who are not knowledgeable enough of local traditions to work with their clients in a manner that honors historical and traditional practices. These stories paved the path to where we are today. Now is the time to inventory the collective knowledge, resources, and commitment for addressing behavioral health issues and converting opportunities to action.

The National Tribal Behavioral Health Agenda (TBHA) honors the history and trust relationship that the U.S. Government has with American Indian and Alaska Native tribes by acknowledging barriers, identifying common priorities, and proposing strategies that can be addressed by tribes, Federal agencies, and other entities working together. All parties have the goal of improving the well-being of American Indians and Alaska Natives, and the TBHA was created as a blueprint for informing programs, policies, and activities that can assist in reaching that goal.

PURPOSE OF THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

Tribal leaders, Tribal administrators, American Indian and Alaska Native health advocates, and Federal agency representatives have consistently called for coordination and collaboration among the distinct jurisdictions and entities whose efforts contribute to the health and well-being of American Indian and Alaska Native communities. One view is that the many programs and initiatives intended to improve the spiritual, physical, and emotional health of American Indians and Alaska Natives operate in isolation and would be more effective if they worked more closely together. Underpinning this view are the following tenets:

American Indians and Alaska Natives continue to face significant behavioral health problems, and the factors that serve as determinants of these health challenges vary greatly.

Behavioral health issues are not isolated. Behavioral health shares important correlations with physical health as well as with social and economic conditions in Tribal communities that require a more collective and collaborative approach. These correlations require a broader view of the components of a comprehensive prevention and treatment approach to behavioral health issues.

The high rates of behavioral health problems among American Indians and Alaska Natives create urgency for tribes, Federal agencies, and other entities to work together in a manner that meaningfully improves the well-being of Tribal communities.

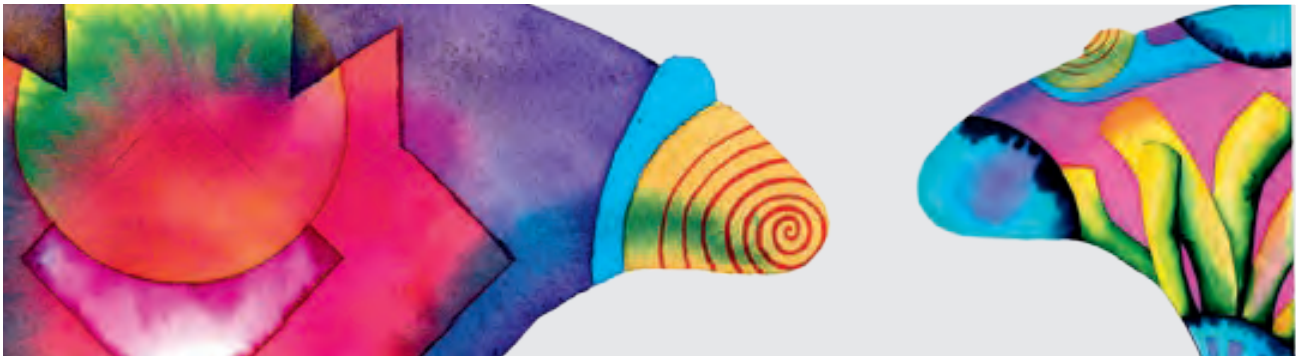
- The Federal Government has a trust responsibility for improving the health and well-being of American Indians and Alaska Natives.
- There is no single national program or document that elevates the importance of behavioral health for American Indians and Alaska Natives, identifies the collective priorities of Tribal communities related to behavioral health, and guides the development and/or incorporation of behavioral health-related actions to improve the well-being of American Indian and Alaska Native youth, families, and communities.

The TBHA is not a strategic plan. It is not intended to replace existing strategic plans or prescribe a set of actions that Tribal, Federal, state, and local governments or other stakeholders should take to address the behavioral health of American Indians and Alaska Natives. Rather, the TBHA is a blueprint that:

- Provides a clear national statement about the extent and need to prioritize behavioral health and related problems, their impact on the well-being of Tribal communities, and a set of strategies based on direct input from Tribal leaders and representatives.
- Identifies foundational elements that should be considered and integrated into both existing and potential programmatic and policy efforts.
- Elevates priorities for action that could or are likely to contribute to meaningful progress in tackling persistent behavioral health problems for Native youth, families, and communities.
- Creates a platform to allow Tribal and Federal collaborators to routinely examine funding, program, and policy priorities that best support opportunities to improve communication, align efforts, and make real and measurable improvements in behavioral health for American Indians and Alaska Natives.

DEVELOPMENT OF THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

The idea and necessity for a blueprint such as the TBHA were brought forward by the Tribal Technical Advisory Committee of the Substance Abuse and Mental Health Services Administration (SAMHSA), which comprises elected Tribal leaders. The concept was advanced by other equally concerned and engaged Tribal leaders who also witnessed inequities in resources available to non-Native communities, compared with Native communities experiencing significant challenges, such as multiple suicides. In response, SAMHSA and the Indian Health Service (IHS) worked to lay the foundation for what would become the TBHA. To bring this idea to fruition, SAMHSA, IHS, and the National Indian Health Board (NIHB) engaged in discussions with Tribal leaders and members, Tribal administrators, Tribal advocates for American Indian and Alaska Native health, and Federal agency representatives over an 18-month period through the end of 2015.



Input was received through facilitated sessions held independently or that took place during other scheduled Tribal and Federal gatherings and meetings (see Appendix 1. Highlights of Key National Tribal Behavioral Health Agenda Information-Gathering Sessions). Dedicated conference calls with elected Tribal leaders also took place concerning efforts to develop the TBHA. Because it was important to garner Federal input in the process, the U.S. Department of Health and Human Services (HHS) hosted a Federal interagency forum in December 2015 to discuss current Federal programming that might align with the TBHA. Federal interagency forum discussions demonstrated a synergy between Tribal and Federal representatives that substantial opportunity exists for greater collaboration. Participants at the forum included representatives from the following agencies:

- Administration for Children and Families (ACF), HHS
- Administration for Community Living (ACL), HHS
- Bureau of Indian Affairs (BIA), U.S. Department of the Interior
- Centers for Disease Control and Prevention (CDC), HHS
- Centers for Medicare & Medicaid Services (CMS), HHS
- Health Resources and Services Administration (HRSA), HHS
- IHS, HHS
- National Institutes of Health (NIH), HHS
- Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice (DOJ)
- SAMHSA, HHS
- Social Security Administration (SSA)
- U.S. Department of Veterans Affairs (VA)

Collectively, the input sessions allowed participants to share information on behavioral health and related priorities, the nature of behavioral health service delivery, significant successes and challenges, and considerations for advancing behavioral health among American Indian and Alaska Native people and communities. A qualitative strategy for analyzing the input received, in a manner that honored all of the feedback and input, was adopted. The development process was inherently iterative, with prior meetings and discussions shaping subsequent conversations to validate and supplement previous information and conclusions. Discussions were transcribed and then analyzed manually in teams of two or three people to examine similarities and identify broader themes. At the end of the process, data were categorized and collapsed into foundational elements and recommendations across all conversations. Across discussions, Tribal leaders and representatives agreed to the importance of a TBHA, the foundational elements, and considerations for the development of the TBHA.

2 HISTORICAL AND CURRENT CONTEXTS

Story of Survival

Each Tribal nation across the United States has a unique history, culture, language, and story, contradicting the generic and ethnic sameness that might be implied by the terms "American Indians" and "Alaska Natives."

FEDERALLY RECOGNIZED TRIBAL GOVERNMENTS

The United States has a unique government-to-government relationship with Indian tribes that is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders that establish and define a trust relationship with Indian tribes.

GEOGRAPHY

Within the boundaries of the United States, there are currently 567 federally recognized and dependent sovereign American Indian and Alaska Native nations, tribes, villages, and pueblos and 65 state-recognized tribes.[2] Federally recognized tribes with reservation lands are on one of 326 federally recognized American Indian reservations.[3] Through allotment policies established in the 19th century, many tribes lost communally held lands, with ownership passing out of Tribal jurisdiction. Tribal members continued to congregate in established communities, and today they account for tribes with no federally recognized reservations, such as the 39 tribes in Oklahoma.[4]

Through other policies focused on relocating or "terminating" tribes in the 1950s, American Indian and Alaska Natives from many tribes were moved to 12 urban areas to better access employment and to encourage assimilation.[5] Today, these urban areas are home to the larger urban American Indian and Alaska Native groups, with most living in small, scattered pockets across vast cityscapes.

POPULATION

American Indians and Alaska Natives total more than 5.4 million persons or 2% of the total U.S. population, with 48% identifying as solely one race and 52% identifying as American Indian and Alaska Native and at least one other race.[6] The majority of American Indians and Alaska Natives, about 71%, live in rural, urban, or suburban areas rather than on reservations.[7,8]

There are 15 states with 100,000 or more American Indian or Alaska Native residents – California, Oklahoma, Arizona, Texas, New York, New Mexico, Washington, North Carolina, Florida, Michigan, Alaska, Oregon, Colorado, Pennsylvania, and Minnesota.[9] The following 10 cities are home to the largest number of urban American Indian and Alaska Natives: New York City, Los Angeles, Phoenix, Oklahoma City, Anchorage, Tulsa, Albuquerque, Chicago, Houston, and San Antonio.[10]

Age and Education. American Indian and Alaska Native populations are overall younger than the general U.S. population. In 2014 the mean age of American Indians and Alaska Natives was 31.4 years compared with 37.7 years for the U.S. population at large.[11] American Indians and Alaska Natives also tend to be less well educated. The dropout rate for Native students is twice the national average, the highest of any U.S. ethnic or racial group. About 3 out of every 10 American Indian and Alaska Native students drop out before graduating from high school, both on reservations and in cities.[12]

UNEMPLOYMENT

Accurate estimates of unemployment rates for American Indians and Alaska Natives are not available;[13] however, rates are known to be high in many Native communities where economies are depressed and the number of available jobs is low. Common reasons for unemployment are lack of education, absence of jobs, and high rates of disabilities. Even when American Indians and Alaska Natives are similar to Whites in terms of factors such as age, sex, education, marital status, and place of residence, their odds of being employed are 31% lower than Whites.[14] This suggests the presence of factors that go beyond known conditions and include racial discrimination and geography. For example, American Indian and Alaska Native unemployment rates are lower in states with no reservations and higher in reservation states.

POVERTY

Compared with all other races, American Indians and Alaska Natives are most likely to live in poverty (28.3% compared with 15.5% for the U.S. general population).[15] Furthermore, in studies of both urban and rural communities, American Indians and Alaska Natives are approximately twice as likely as the general population in those same areas to be poor, unemployed, and without a college degree.[16, 17] In addition to the complexity of poverty and unemployment is the problem of underemployment. In environments where there is competition for employment (including both on reservations and in urban-based settings), American Indians and Alaska Natives may be economically forced to accept part-time or poorly paid work in lieu of no employment.[18]

MORBIDITY/MORTALITY

American Indians and Alaska Natives born today have a life expectancy that is 4.2 years less than all other races in the United States and continue to die at higher rates than others due to liver disease, diabetes mellitus, unintentional injuries, assault/homicide, and intentional self-harm/suicide.[19] Alcohol is considered to be the largest contributing factor to increased mortality,[20] and American Indians and Alaska Natives are five times more likely than other groups in the United States to die of alcohol-related causes.[21] However, there is significant variability for alcohol-specific deaths across American Indian and Alaska Native populations – from 18.3 per 100,000 in the Nashville area to 86.4 per 100,000 in the Aberdeen area.[22]

Historical and Intergenerational Trauma

Historical trauma is recognized as the root cause of much of the behavioral health disparities currently experienced by American Indians and Alaska Natives.[23]

Social injustices, perpetuated over multiple generations, have had enduring consequences for American Indian and Alaska Native families and communities. Research documents massacres, genocidal policies, pandemics from the effects of introduced diseases, forced relocations, forced removal of children through boarding school policies, and prohibition of spiritual and cultural practices (including the prohibition of the use of Native languages).[24, 25] Native youth who were removed from their homes were often beaten for communicating in the only language they knew – their Native language. Maria Yellow Horse Brave Heart defines these events as historical trauma: the collective complex trauma inflicted on a group of people who share a specific group identity or affiliation.[26, 27, 28, 29] The symptoms and long-term effects of historical trauma include psychological distress, poor overall physical and mental health, and unmet medical and psychological needs,[30] evidenced by increased exposure to trauma, depressive symptoms,[31] substance misuse,[32] and suicidal thoughts and attempts.[33]

The intergenerational effects of historical trauma on long-term health have been documented among American Indian and Alaska Native populations through adverse childhood event (ACE) studies. These studies assess the prevalence of personal experiences – physical abuse, verbal abuse, sexual abuse, physical neglect, emotional neglect, and family experiences – for example, an alcoholic parent, a mother who has been a victim of domestic violence, a family member in jail, a family member with a mental disorder, or the loss of a parent through divorce, death, or abandonment. Higher scores are correlated with poorer long-term outcomes. In the report "A Framework to Examine the Role of Epigenetics among Native Americans," Brockie, Heinzelmann, and Gil[34] report that "Native Americans disproportionately experience ACEs and health disparities, significantly impacting long-term physical and psychological health."

Traumatic events experienced by American Indians and Alaska Natives are not confined to a single catastrophic period in the past, nor are they confined to a single event but from many sources; they are ongoing and present in modern times.[35, 36] Inadequate funding of Federal treaty obligations keep access to health care precarious and undependable.[37] A history of unethical research authorized by the U.S. Government has created distrust and reluctance on the part of tribes to engage in large-scale studies that could provide information specific to American Indians and Alaska Natives about problems such as alcoholism, suicide, and depression.[38] Blood quantum requirements (also known as blood quantum laws), which originated in the Indian Reorganization Act of 1934 and were incorporated into many Tribal constitutions, create threats for future generations. Children of intertribal unions may not meet Tribal blood quantum requirements, thus eliminating their eligibility for Tribal membership and access to services.[39]

American Indians and Alaska Natives who are prosecuted in Federal courts face lengthier confinements than non-Natives prosecuted for the same crime in state courts[40] and are incarcerated at a rate 38% higher than the national average.[41] Native children are disproportionately represented in the foster care system and are placed with non-Native families despite the requirements of the Indian Child Welfare Act of 1978. For example, in South Dakota American Indian and Alaska Native children make up less than 15% of the child population, yet they represent more than half of the children in foster care.[42]

Although the symptoms and effects of historical trauma are well known, Native youth are neither likely to recognize that their present-life experiences, or modern-day traumas, are triggered by past events nor to make the connection to the root cause. This is despite the fact that American Indian and Alaska Native adolescents exhibit the effects of historical trauma through high suicide rates,[43] alcohol and other drug abuse and dependency,[44] and sexual risk-taking.[45]

Researchers studying the effects of historical trauma across generations of American Indians and Alaska Natives found that perceptions of historical trauma differed by age and generation. Elders were much more aware of the long-term consequences of historical trauma and easily connected it to loss of cultural knowledge, high rates of disease, alcoholism and other substance use, unhappiness, violence, premature death, and overall lack of health.[46] Although only one generation removed, the majority of elders' adult children did not think that the root cause of their adverse life conditions resulted from historical trauma and were more likely to view events such as community violence as temporally rather than historically linked. Two generations removed, the grandchildren of elders did not believe that historically traumatic events had any negative effects on their community or their own lives. Individuals in the study did not see themselves, their families, or their communities as subject to continued oppression through control by outsiders.[47] The perpetuation of self-destructive behaviors cannot be addressed or interrupted without a deeper understanding of how trauma impacted past generations and that it continues to impact present generations and is constantly triggered by the events, policies, and practices of modern times.

Despite historical and other traumas, American Indian and Alaska Native communities have managed to survive and thrive. During the 20th century American Indians and Alaska Natives rebuilt their nations, adapted to cultural and economic pressures, overcame adverse and destructive policies, and retained their place in the U.S. landscape.[48]

Time, history, and adversity have fostered inherent traits and beliefs that have engendered strong and resilient Native communities. An important value, and one that differs widely from the dominant society, is the importance of the group, be it tribe, community, or family. Tribal leaders and decisionmakers deliberate on the welfare and needs of the group rather than focus solely on individuals. There is consideration and mindfulness of the ramifications of present-day decisions on children and grandchildren, down to the Seventh Generation. Extended kinship networks provide strength, protection, and support, particularly during times of hardship. The resources of the group, such as food, shelter, transportation, and money, are shared to provide for the well-being and safety of all.[49]

Tribal language and stories ensure that the tribe's worldview is passed on to the next generation. There are words, definitions, and understandings distinct to a tribe's language that help Native youth understand their place in the tribe and in the world. Creation stories and teaching stories preserve identity while instilling resilience factors and cultural and social norms. Shared beliefs about the importance of balance – spiritual, physical, mental, and emotional – provide a framework for protecting and preserving the Tribal community and helping ensure the long-term viability of the tribe. All of these characteristics combine to create a powerful and resilient practice of culture and serve as strong protective factors against adversity.

3 BEHAVIORAL HEALTH: STATE OF URGENCY

The information presented in this document paints a difficult picture and underscores the urgency to address behavioral health among Native people. When armed with facts, Tribal leaders are better able to have open discussions about strategies within their community contexts, which hold potential for overcoming behavioral health challenges. These challenges are evident through comparisons of Tribal communities with nontribal communities; however, this often fails to highlight the exceptionality of these challenges as they exist with the cultural, community, geographic, economic, and psychosocial realities of American Indian and Alaska Native communities.[50]

An Indigenous definition of health is ". . . not just the physical well-being of an individual, but refers to the social, emotional, and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community."[51] American Indian and Alaska Native communities are aware of the physical health challenges of their people, but there are also behavioral health challenges that are often more difficult to discuss and that also impact overall health and well-being. These behavioral health challenges are associated with increased exposure to trauma, depressive symptoms,[52] substance misuse,[53] and suicidal thoughts.[54]

The list of exposures and outcomes assessed in this section is not necessarily exhaustive; rather, the information provided represent key factors for which plausibly representative data are available. There are many other factors that are potentially relevant here, but that are not adequately assessed via currently available data sources.

The following discussion of trauma identifies critical areas for targeted, renewed, or enhanced Tribal and Federal collaboration across programs, policies, and activities.

TRAUMA

INTERPERSONAL VIOLENCE (IPV)

Current rates of violent victimization for both American Indian and Alaska Native males and females in every age group are higher than for all other races. American Indian and Alaska Native females are at an elevated risk of intimate partner violence.[55, 56] Specifically, American Indian and Alaska Native women report higher rates of victimization on all measures of violence than their White/Non-Hispanic counterparts, including rape, other sexual violence, stalking, and partner physical violence and psychological aggression. American Indian and Alaska Native men report higher rates of victimization than White/Non-Hispanic individuals in other sexual violence and partner physical violence and psychological aggression (TABLE 1).

TABLE 1:

LIFETIME PREVALENCE OF SEXUAL VIOLENCE, STALKING VICTIMIZATION, AND INTIMATE PARTNER VIOLENCE

AI/AN VS. NON-HISPANIC WHITE ADULTS AGE 18+ – NISVS, 2011[A,B]

	WOMEN			MEN		
	%	95% CI	Estimated N	%	95% CI	Estimated N
WHITE NON-HISPANIC						
Rape	20.5	18.8-22.3	16,475,000	1.6	1.2-2.2	1,232,000
Other Sexual Violence	46.9	44.9-48.9	37,661,000	22.2	20.5-24.1	16,846,000
Stalking	15.9	14.4-17.5	12,749,000	4.7	3.9-5.8	3,581,000
IPV: Rape	9.6	8.4-10.9	7,730,000	--	--	--
IPV: Other Sexual Violence	17.1	15.6-18.7	13,710,000	7.6	6.5-8.9	5,777,000
IPV: Physical Violence	30.5	28.6-32.4	24,469,000	26.6	24.8-28.6	20,190,000
IPV: Stalking	9.9	8.6-11.3	7,935,000	1.7	1.3-2.3	1,279,000
IPV: Psychological Aggression	47.2	45.2-49.2	37,888,000	44.8	42.7-46.9	33,959,000
AMERICAN INDIAN/ALASKA NATIVE						
Rape	27.5	16.1-42.7	--	--	--	--
Other Sexual Violence	55.0	41.5-67.9	452,000	24.5	13.5-40.3	--
Stalking	24.5	14.2-38.8	--	--	--	--
IPV: Rape	--	--	--	--	--	--
IPV: Other Sexual Violence	--	--	--	--	--	--
IPV: Physical Violence	51.7	38.1-65.0	424,000	43.0	27.4-60.1	335,000
IPV: Stalking	--	--	--	--	--	--
IPV: Psychological Aggression	63.8	50.4-75.3	523,000	47.2	31.1-64.0	368,000

a Estimates from Breiding, M. J. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization – National Intimate Partner and Sexual Violence Survey, United States, 2011. Morbidity and Mortality Weekly Report: Surveillance Summaries (Washington, DC: 2002), 63(8), 1.

b This data collection does not allow estimates for all measures due to low sample sizes, and these comparisons have not been subjected to inferential testing.

American Indians and Alaska Natives fall victim to violent crime at more than double the rate of all other U.S. citizens,[57] and at least 70% of violent victimization experienced by American Indians and Alaska Natives is committed by non-Natives and usually while they are drinking. Nearly one-third of all American Indian and Alaska Native victims of violence are between the ages of 18 and 24 years, and about one violent crime occurs for every four persons of this age.[58] The combination of interpersonal violence layered over historical trauma creates compound negative effects for American Indians and Alaska Natives.

ADOLESCENTS AND VIOLENCE

Teen exposure to violence is associated with multiple adverse health outcomes, including depression, anxiety, suicidal ideation, substance use, posttraumatic stress disorder (PTSD), risky sexual behavior, and eating disorders.[59,60,61,62,63,64,65,66] To add to the limited information about American Indian and Alaska Native adolescents and violence, Morsette and colleagues studied exposure to violence and trauma among 302 American Indian and Alaska Native middle-school students and found that 77.5% had clinically significant levels of psychometrically assessed violence exposure and that 52% had clinically significant levels of PTSD.[67] Unwittingly, Native teens are experiencing the effects of historical trauma and in turn are reporting emotional and behavioral problems.

CHILDREN OF INCARCERATED PARENTS

Research regarding American Indian and Alaska Native children of incarcerated parents is derived from larger studies with no specific data for American Indian and Alaska Native children despite high rates of American Indian and Alaska Native adult incarcerations.[68,69,70,71,72] In an unpublished review of risks among 1,184 American Indian and Alaska Native students attending BIA residential boarding schools, 25% reported having a parent who had been incarcerated.[73]

Having an incarcerated parent can impact a child's mental health, social behavior, and educational prospects. Children may experience emotional trauma, a disrupted family life, and social stigma as a result of having a parent in prison or jail.[74] Financial hardship follows the loss of that parent's income,[75] and if parental rights are terminated, children may lose not only the parent but also the connection to their entire family if they are placed in foster care.[76]

Children of incarcerated parents may experience trauma related to their parent's arrest or events leading up to it[77] and are more likely to have faced other ACEs, including witnessing violence in their communities or directly in their household or exposure to alcohol and other substance use.[78] Due to the long-term negative effects of historical trauma across generations that have resulted in high rates of incarceration for American Indian and Alaska Native people, children are now experiencing historical trauma in new and current forms.

VETERANS

American Indian and Alaska Native males who serve in the U.S. Military do so in greater proportion than all eligible males in general – 3% of all American Indian and Alaska Native males, ages 20 to 44 years, compared with 2% of all U.S. males (all races) in the same age group. The U.S. Department of Defense reported that more than 24,000 active duty military personnel (out of the 1.4 million total personnel) were American Indians and Alaska Natives, including 3,900 women. There are more American Indian and Alaska Native women veterans (11.5%) than veteran women of other races (8.0%).[79] It is estimated that 22% of Native Americans age 18 years and older are current veterans,[80] and the population of older American Indian and Alaska Native veterans will likely increase 60% by 2020.[81]

In a study of Vietnam veterans and the long-term effects of exposure to war zone stress and other military dangers, researchers found that veterans are at risk for PTSD decades after exposure. They also found that PTSD rates for Native American Vietnam veterans are higher than for their White counterparts.[82,83] High rates of alcoholism among veterans may be the result of the use of alcohol to self-soothe psychiatric distress related to PTSD symptoms.[84,85] Survey data from the *American Indian and Alaska Native Veterans: 2013 American Community Survey* showed that American Indian and Alaska Native veterans were more likely to lack health insurance and to have a disability, service-connected or otherwise, than military veterans of other races.[86] The likelihood of American Indian and Alaska Native veterans being more likely to lack health insurance may be related their dual status – their potential eligibility to receive health care at an Indian Health Service or Tribal Health Program facility as well as a U.S. Veterans Administration health care facility.

DEPRESSIVE SYMPTOMS

DEPRESSION

In general, American Indians and Alaska Natives have comparatively poorer behavioral health. Although there are no large-scale studies to determine the prevalence of depression and other common mental health concerns among American Indian and Alaska Natives, available data indicate that problems exist at disproportionately high rates for both urban and reservation American Indians and Alaska Natives[87] and that approximately 30% of Alaska Natives in particular will suffer from depression at some point in their lifetimes.[88] In 2013 data from the National Survey on Drug Use and Health also indicated that American Indians

and Alaska Natives had significantly higher rates of mental health issues compared with the general population (26.0% versus 18.5%). In 2005, among U.S. adults age 18 and older who reported only one race, American Indians and Alaska Natives had the highest rates of serious psychological distress (25.9%) and major depressive episode (12.1%) within the past year.[89] American Indians, particularly males, experienced depressive disorders at higher rates than the general population.[90]

Among U.S. adolescents ages 12 to 20, American Indians and Alaska Natives had the highest lifetime major depressive episode prevalence and the highest major depressive episode prevalence in the past year.[91] Among 9,464 children participating in a depression study, American Indian and Alaska Native children had the highest self-reported depression rates, and depression increased with age, peaking between 16 and 17 years of age. In the same study, race was analyzed as an independent risk factor, and results showed that simply being American Indian or Alaska Native, apart from any other factor, increased the rate of depression 2.6-fold.[92]

Despite the need, service utilization rates for American Indians and Alaska Natives are low,[93] which is likely due to a combination of factors, including stigmatization, lack of culturally trained providers, and lack of services.[94]

GRIEF AND LOSS

The quality and intensity of interpersonal attachments within most American Indian and Alaska Native communities differ from the broader society, due in part to an extensive, complicated, and close-linked kinship network in Native communities. Higher morbidity and mortality rates, lower life expectancy, and higher rates of suicide and accidental death among American Indians and Alaska Natives often result in the loss of one or more family members annually.[95] As an example, among American Indian and Alaska Native youth attending a residential boarding school, 58% reported the loss of one or more close family members within the preceding 12 months.[96]

Unresolved grief may lead to depression or PTSD. Researchers have found that individuals who are grieving are also at risk of death from accidental, violent, and alcohol-related events and are more likely to attempt suicide (fatal and nonfatal).[97]

SUBSTANCE USE

Determining universal rates and risks of substance use for American Indians and Alaska Natives is difficult due to the diversity and geographical dispersion of American Indian and Alaska Native populations.[98,99] Overall, the rate of alcohol consumption among American Indians and Alaska Natives is significantly lower than the national average (43.9% vs. 55.2%, respectively).[100] However, there are differences by region and tribe. Some American Indian and Alaska Native communities have low rates, and others have distinctly higher rates.[101,102,103] American Indians and Alaska Natives who reside in urban or suburban areas, on average, drink more frequently than reservation-based American Indians and Alaska Natives and more heavily than the national sample and may be at particularly high risk for alcohol-related problems.[104] Diversity in rates and patterns of use across American Indian and Alaska Native groups is often due to substance availability, finances, presence of substance-using peers, and attitudes toward substance use.[105]

Although rates and risks vary across tribes, there is a body of knowledge that informs on patterns of use by American Indian and Alaska Native youth. In particular, youth on reservations are at the highest risk of developing alcohol-related problems.[106] Though American Indian and Alaska Native youth report higher rates of alcohol use at younger ages, rates of youth alcohol use among Native youth compared to national rates are generally similar or lower. Substance use begins early among American Indians and Alaska Natives and is often a result of stress events in the family.[107]

The 2013 Youth Risk Behavior Survey (TABLE 2) shows that American Indian and Alaska Native youth had higher rates of drinking alcohol before age 13 compared to national rates (28.2 compared to 18.6 respectively). Data from Monitoring the Future for the period of 2010-2014 show that the rate of any 30-day alcohol use was higher for American Indian and Alaska Native youth in the 8th grade compared to non-Native youth. However, the rate was lower for American Indian and Alaska Native youth in the 10th and 12th grades compared to non-Native youth in comparable grades. Early substance use is a clear marker of risk for prolonged and problematic use,[108,109,110] along with lower academic achievement, academic problems, drug use, and alcoholism later in life.[111]

TABLE 2:

AI/AN VS. NATIONAL YOUTH ALCOHOL USE DATA, YOUTH RISK BEHAVIOR SURVEY 2013[A]

Alcohol Use	National	AI/AN
Ever had at least one drink of alcohol	66.2 (63.7–68.5) 13,104	70.0 (58.0–79.8) 113
Drank alcohol before age 13 years	18.6 (17.2–20.0) 13,308	28.2 (17.0–42.9) 114
Currently drank alcohol	34.9 (32.8–37.1) 12,288	33.4 (23.9–44.4) 101
Usually obtained the alcohol they drank by someone giving it to them	41.8 (39.4–44.1) 4,239	N/A 33
Had five or more drinks of alcohol in a row	20.8 (19.1–22.7) 13,060	18.3 (11.7–27.5) 109
Reported that their largest number of drinks in a row was 10 or more	6.1 (5.2–7.1) 12,363	6.1 (2.5–14.2) 101

[a] Comparisons have not been subjected to inferential testing.

Table 3 shows that American Indians and Alaska Native crime victims report higher rates of offender alcohol/drug-involved violent victimizations (31.75 per 100,000 than all races combined (8.35 per 100,000). In addition, more American Indians and Alaska Native respondents report that the offender was drug or alcohol involved during the crime (41%) than the total sample (33%).

Drug overdose deaths from opioid use are of significant concern to Tribal communities. The Northwest Portland Area Indian Health Board reported that from 2006 to 2012, a total of 10,565 deaths occurred among American Indian and Alaska Native residents in the states of Idaho, Oregon, and Washington. There were 584,070 deaths among non-Hispanic Whites (NHWs) in the three-state region. Drug overdoses accounted for 4.3% (450) of all deaths among Northwest American Indians and Alaska Natives and 1.7% (9,868) of all deaths among NHWs. Of the drug overdose deaths, 65.3% (294) of American Indian and Alaska Native deaths and 69.3% (6,837) of NHW deaths were from prescription drugs. Furthermore, of the prescription drug overdose deaths, 77.2% (227) of American Indian and Alaska Native deaths and 75.4% (5,157) of NHW deaths were from opioid overdoses.[112]

A 2011 Great Lakes Inter-Tribal Council community assessment reflecting aggregated data from 10 Tribal nations, found that:[113]

- 30.9% of youth, 27.7% of minor adults, and 24.9% of adults intentionally misused prescription medication.
- 7.6% of youth think there is no risk in misusing prescription drugs; another 5.9% think there is only a slight risk.
- 5.2% of survey responders indicated it is very likely they will misuse prescription drugs in the next 6 months; another 6% indicate it is somewhat likely.
- 15.6% of youth, 34% of minor adults, and 28.1% of adults indicate it would be very easy for them to obtain prescription drugs without a prescription if they wanted them.

According to SAMHSA's Treatment Episode Data Set (TEDS), in 2012 there were about 1.7 million individuals admitted to substance use treatment facilities. Of these, 43,576 (2.5%) were American Indians and Alaska Natives. Approximately 77% of the American Indian and Alaska Native individuals admitted reported alcohol as a substance of abuse. Twenty-three percent of the American Indian and Alaska Native admissions were ages 15 to 24 years, and among this age group, 68.5% (6,885) reported alcohol as a substance of abuse. Among admissions for primary alcohol use, 80.5% (21,098) of American Indian and Alaska Native admissions reported that their age of first intoxication with alcohol was 17 years or younger.

SUICIDE

Studies show that both American Indian and Alaska Native adults and adolescents suffer from high rates of suicide.[114] In 2011 the suicide rate for all American Indians and Alaska Natives was 14.68 per 100,000 compared with the overall U.S. rate of 11.15 per 100,000.[115] American Indian youth experience the highest rates of youth suicide in the country, and suicide is the second leading cause of death.[116] In 2012-2013, the suicide rate for American Indian and Alaska Native young adult males was 34.3 per 100,000 compared

TABLE 3:

VIOLENT VICTIMIZATION RATE, BY VICTIM PERCEPTION OF OFFENDER'S ALCOHOL/DRUG INVOLVEMENT

NATIONAL CRIME VICTIMIZATION SURVEY (NCVS) 2004-2013[A,B]

Violent Victimization Rate*		Offender Alcohol/Drug Involved		
RACE OF VICTIM**	**TOTAL**	**YES**	**NO**	**DON'T KNOW**
All races	25.57	8.35	7.95	9.27
AI/AN	76.94	31.75	18.59	26.60
Non-AI/AN				
White – Non-Hispanic	25.14	8.71	7.96	8.48
Hispanic	22.85	6.38	7.01	9.46
Black – Non-Hispanic	31.23	7.85	9.62	13.76
Asian/Pacific Islander – Non-Hispanic	11.70	3.62	3.43	4.65
Two or more races – Non-Hispanic	166.31	29.82	83.60	52.89

Proportions		Offender Alcohol/Drug Involved		
RACE OF VICTIM	**TOTAL**	**YES**	**NO**	**DON'T KNOW**
All races	100%	33%	31%	36%
AI/AN	100%	41%	24%	35%
Non-AI/AN				
White – Non-Hispanic	100%	35%	32%	34%
Hispanic	100%	28%	31%	41%
Black – Non-Hispanic	100%	25%	31%	44%
Asian/Pacific Islander – Non-Hispanic	100%	31%	29%	40%
Two or more races – Non-Hispanic	100%	18%	50%	32%

[a] NCVS, Bureau of Justice Statistics (BJS), Department of Justice (DOJ) and the Uniform Crime Reporting (UCR), Federal Bureau of Investigation, DOJ.

[b] Comparisons have not been subjected to inferential testing.

* Violent victimizations include rape or sexual assault, robbery, aggravated assault and simple assault. The rate is defined as victimizations per 1,000 persons age 12 or older.

** The race/Hispanic origin categories used in this table are defined differently than those found in BJSreports. The AI/AN category includes persons who self-identified as being AI/AN, regardless of whether they also identified as being other races or Hispanic origin as well.

to 24.8 for non-Hispanic White males in the same age group. For American Indian and Alaska Native young adult females the rate was 9.9 per 100,000 compared to 5.5 for non-Hispanic White females 18-24. A 2008 Centers for Disease Control and Prevention study estimated that overall deaths for American Indian and Alaska Natives was underreported by 30% thus the suicide rate for American Indian and Alaska Native young adults are expected to be under estimated. [117-A] For Alaska Natives, suicide is the fourth leading cause of death, with a rate 3.6 times greater than the White population.[117-B]

Contributing factors to suicide risk in American Indian and Alaska Native communities often stem from persistent unemployment rates of 50 to 80% that lead to chronic poverty, poor educational outcomes, victimization, mental and substance use disorders, and exposure to violence.[118] In one study 77% of American Indian and Alaska Native males who had attempted suicide (fatal and nonfatal) had incomes of less than $10,000 per year, and 79% of them were unemployed.[119, 120] Adults who attempt suicide (fatal and nonfatal) increase the suicide risk for their children by 20%.[121] American Indian and Alaska Native youth report higher rates of having felt sad or hopeless, seriously considered attempting suicide, or made a plan about how they would attempt suicide (TABLE 4). Risks for American Indian and Alaska Native youth include exposure to multiple childhood traumas,[122] sexual and physical violence,[123] and family conflict.[124]

TABLE 4:

YOUTH RISK BEHAVIOR SURVEY (YRBS) 2013[a]

Suicide-Related Behaviors	National	AI/AN
Felt sad or hopeless	29.9 (28.3–31.6) 13,495	38.8 (28.9–49.7) 120
Seriously considered attempting suicide	17.0 (15.8–18.2) 13,491	27.4 (19.5–36.9) 120
Made a plan about how they would attempt suicide	13.6 (12.3–15.0) 13,485	23.1 (15.5–33.0) 120
Attempted suicide	8.0 (7.2–8.9) 11,982	N/A 98
Attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	2.7 (2.3–3.1) 11,750	N/A 90

[a] Comparisons have not been subjected to inferential testing.

4 HEALTH CARE AND SUPPORTIVE SERVICE CONSIDERATIONS

INDIGENOUS HEALING PRACTICES

Researchers who have interviewed American Indians and Alaska Natives across time and place about behavioral health report that, despite cultural and geographical differences, participants consistently referred to historical trauma and healing in discussions about mental health.[125] These terms focus on the group experience and describe an alternative perspective to illness and treatment when compared with typical Western practice, which tends to "reduce suffering to discrete illnesses with individually based causes and solutions." Holistic healing of a person within the context of their family and community is typically the emphasis within Indigenous cultures.[126,127,128] Historical and anecdotal knowledge also tells of how tribes have been engaged in healing practices through the use of ceremony and traditional medicines for centuries that have been effective at promoting health, stemming illness, and reinforcing balance in the individual and community. These practices include prayer, the use of herbs and plants for medicinal purposes, and ceremonies that evoke spiritual support for individual and community health.

INTEGRATION OF TRADITIONAL AND WESTERN PRACTICES

Traditional healing practices and ceremonies are important sources of help to many American Indians and Alaska Natives; however, the integration of these approaches with Western biomedical services is often tenuous,[129] with tension between traditional and Western providers.[130] At the same time, researchers are increasingly aware of the need for integrated care[131,132,133,134] and consideration of historical trauma.[135,136,137,138,139,140,141,142] Historical and anecdotal knowledge should be integrated with science-based medicine and measurement-based care. Scientifically rigorous assessment of efficacy and effectiveness must always be respectful and culturally competent – reflecting each tribal communities' and their individual members' concepts of illness and treatment objectives – in order to extend to tribal communities the same entitlement to high-quality, evidence-based practices for which other parts of the US health system are increasingly held to account. Important support for integrated behavioral health is the currently accepted evidence-based practice of the American Psychological Association[143] which calls for integration of cultural beliefs, values, and preferences into the treatment decisionmaking process.

The IHS issued a special memorandum in 1994 affirming its organizational commitment to protect and preserve the right of all American Indians and Alaska Natives to exercise their traditional practices and stating that IHS employees should also demonstrate respect for these practices.[144] In addition, other Federal agencies recognize and support the inclusion of traditional healing practices through grant programs and initiatives. Some tribes have made strides and have been quite successful in formalizing the integration of traditional healing practices into their health facilities, services, and programs to improve the well-being of their communities. Through the American Indian and Alaska Native Cultural Wisdom Declaration that is part of this document tribal nations are seeking greater support for inclusion of traditional practices as fundamental to effectively implementing funded programs in their communities.

Recovery from addiction to alcohol and other drugs is taking place with the assistance of culturally specific methods in American Indian and Alaska Native communities in North America. These communities not only utilize many of the recovery approaches that make up today's best practices but also use their own cultural and ethnic strengths as an important part of their addiction recovery.[145] Some of the most promising suicide prevention approaches involve evidence-based, trauma-informed interventions integrated with practices that promote Tribal language, culture, and traditional healing.[146] Tribal and youth regional treatment centers engage in varying degrees of integrated care to address substance use treatment and relapse prevention.

COMPONENTS OF INTEGRATED INTERVENTIONS

Interventions focused on individuals, families, and communities should occur early and be intergenerational. Content should include teachings on traditional narratives, beliefs, and practices and should address historical events in culturally appropriate ways and relate them to current conditions and family dynamics. Activities should emphasize active skills-building; facilitate communication and interaction among elders, parents, and youth; and those at the community level should avoid addressing more than one issue at a time. Traditional knowledge and practices should be incorporated into care.[147]

COMPONENTS OF INTEGRATED SYSTEMS

An integrated system links prevention and treatment systems and should include a flexible approach to provider-client and provider-patient relationships that allows for adaptive treatment approaches.[148] Staff members should be educated and culturally competent, and the community should be involved in implementing structural changes to affect surrounding conditions.[149,150]

HEALTH CARE AND SERVICE SYSTEMS

American Indians and Alaska Natives receive health care services through multiple sources, including the IHS, tribally operated facilities, urban Indian health care programs, the U.S. Veterans Administration (VA), private health care systems, and Federally Qualified Health Centers (FQHCs).[151] The IHS is one of the primary Federal agencies responsible for fulfilling the Federal Government's health care obligation to American Indian and Alaska Native tribes. Through treaty agreements with tribes, the Federal Government has committed to provide health care to American Indians and Alaska Natives, primarily in exchange for ceded land. To fulfill this component of the Federal Government's trust responsibility to tribes and Tribal members, a unique health care system has evolved that allows American Indians and Alaska Natives to receive physical and behavioral health services through a variety of mechanisms.

IHS, an HHS agency, is charged with providing primary care and behavioral health services to American Indians and Alaska Natives living on or near reservations. There are 12 regional service areas within the Indian Health Care System. Within IHS, the Division of Behavioral Health oversees programs that focus on alcohol and other substance use prevention, domestic violence prevention, forensic health care, mental health, methamphetamine use prevention, suicide prevention, telebehavioral health, and Youth Regional Treatment Centers (YRTCs).[152]

The IHS and tribes provide primary medical care and community health services mainly in small, rural communities in more than 670 locations across 36 states,[153] including 45 hospitals, 545 ambulatory facilities (231 health centers, 5 school-based health centers, 133 health stations, 176 Alaska Native village clinics, and 34 urban clinics. These facilities can be grouped into three categories:

- Facilities operated directly by IHS
- Facilities operated by tribes through a Tribal Health Authority (THA) by contract or compact with IHS
- Programs managed by urban Indian health programs to provide services to American Indians and Alaska Natives in certain urban areas

Tribes that receive health services from a facility operated directly by IHS are known as direct service tribes, and tribes that manage their own health systems are known as self-governance tribes. Many tribes are also served by community health (e.g., childhood immunizations, home visits) and environmental health (e.g., sanitation, injury prevention) programs, which may be administered by IHS or THA. Specialty services and types of medical care that are not available at a given facility are purchased from providers in the private health sector through a program that is now known as purchased and referred care (PRC).[154]

TABLE 5:

FY 2014 IHS ANNUAL PATIENT SERVICES	
Inpatient Admissions	44,677
Outpatient Visits	13,180,745
Alcohol and Substance Use Outpatient Visits	87,947
Mental Health Client Service Encounters	490,994
Alcohol and Substance Use Inpatient Days	8,238
YRTC Number of Youth Served (FY 2012)	915
Average age	15.8 years

The IHS and THAs apply stringent eligibility criteria to determine which patients qualify for PRC funding. The severely limited pool of PRC dollars also means that most PRC programs limit reimbursements for those diagnostic or therapeutic services needed to prevent immediate death or serious health consequences. Among other problems, this results in reduced access to screening services and contributes to increased mortality.

American Indians and Alaska Natives living in urban communities have been referred to as a "population in crisis" given their extreme poverty, poor health, and cultural isolation.[155] Their status is compounded by a number of factors, including lack of access to health services that are located on or near reservations, transportation challenges, distrust of government services, and risk of receiving mediocre or poor-quality care. Currently, there are 34 Urban Indian Health Programs supported through IHS. These urban Indian programs are eligible for FQHC status, and approximately 45% receive Medicaid reimbursement.

WORKFORCE DEVELOPMENT

Lack of mental health services may in part be attributable to a shortage of behavioral health service providers. Barriers to recruitment include funding disparities across IHS regions, lack of opportunity to maintain skills, lack of opportunity for professional growth, lack of exposure to best practices and new developments, isolated work locations, highly stressful work environments, and a lack of support staff members. For example, across IHS there are 16 allocated psychiatric nursing positions156 located in Alaska and Navajo Areas. The vacancy rate for these positions averaged 38% over calendar year 2010, demonstrating the difficulty in filling these positions.[157]

Developing a clinically skilled and culturally competent behavioral health workforce for Tribal communities lies in improving the pathways for Native young people to seek educational and training options that are accessible to them, both community-based, onsite and online. Providing avenues to advanced training and college education as well as working to improve existing school systems will assist in moving toward a culturally competent skilled workforce with an understanding of the attitudes, issues, and concerns of Native populations.

TABLE 6:

IHS EMPLOYEES	
Total (69% are American Indians/ Alaska Natives)	15,370
Nurses	2,480
Physicians	780
Engineers/Sanitarians	670
Physician Assistants/Nurse Practitioners	200
Dentists	280
Behavioral Health Providers	Over 500

INDIAN HEALTH CARE SYSTEM FUNDING

The Indian Health Care System is supported through annual congressional appropriations. The fiscal year (FY) 2016 IHS appropriation was $6.4 billion and includes slight increases for mental health and alcohol treatment programs.[158] Approximately 99% of the IHS budget is allocated to services and programs serving American Indians and Alaska Natives who live on or near reservations. The remaining 1% is allocated for urban Indian health clinics serving a portion of the remaining 71% of the population.[159,160] Many programs are also dependent on grant funding, Tribal revenue, and collections from third-party payers (e.g., Medicaid) to remain financially viable.[161] IHS estimates it receives 22% of the funding needed for the Urban Indian Health Program.

Historical estimates document per capita expenditures for health care for American Indians and Alaska Natives at less than half of those for Medicaid and lower than all other federally funded health systems, including prisons.[162] Former North Dakota Senator Byron Dorgan, who chaired the U.S. Senate Committee on Indian Affairs for 18 years, has expressed concerns that IHS, which serves the Nation's 566 tribes, has persistent funding challenges. "We need more mental health services to save the lives of our youngest First Americans," Senator Dorgan said. "Tribes and nonprofits may get two- or three-year grants to address an issue that cannot possibly be resolved in that amount of time."[163]

OTHER IMPORTANT FEDERAL SOURCES OF FUNDING

Tribes that operate their own health systems also invest in their systems beyond funds received through 638 compacts, contracts, and reimbursements from Medicare, Medicaid, and private insurance. In addition, tribes are eligible for grants, contracts, and other support from Federal agencies across the Executive Branch.

Federal departments and agencies such as SAMHSA, ACF, ACL, HRSA, DOJ, and others support programs that address one or more of the following health, safety, and/or wellness areas: suicide prevention; alcohol and other drug use prevention; services for Tribal youth that promote prevention, treatment, and recovery from mental and substance use disorders; services for pregnant and postpartum women with substance use disorders; development of systems of mental health services for children with serious emotional disturbances; early childhood development; Native language preservation and maintenance; economic self-sufficiency; Tribal healing to wellness courts that provide substance use treatment; domestic violence prevention; workforce training, development, and certification; and many other programs. Descriptions of some Federal programs are provided in Part II of this document. These and other funding opportunities support Tribal efforts to more comprehensively address factors that impact the behavioral health and wellness of Tribal communities.

ACCESS TO SERVICES

The Affordable Care Act (ACA) created a new portal to health care services for more than 500,000 American Indian and Alaska Native people. Those earning between 100% and 400% of the Federal poverty level may be eligible for advance premium tax credits and could qualify for zero or limited cost sharing plans under the Health Insurance Marketplace. And, many American Indians and Alaska Natives with low to no income (up to 138% of Federal poverty level) are now eligible for Medicaid if they live in a state that has expanded coverage. The ACA's amendments to the Indian Health Care Improvement Act expanded the types of services facilities can offer and included behavioral health services. With greater numbers of American Indians and Alaska Natives receiving some form of coverage, IHS will be better able to provide needed health care services.[164,165] The ACA has altered the landscape of service delivery by increasing the opportunity for access to much needed services.

The IHS is designated as a "payer of last resort," meaning that Medicare, Medicaid, and private insurance companies are billed before IHS is required to pay for medical costs. Medicare and Medicaid help increase access to care for American Indians and Alaska Natives. Medicare and Medicaid payments offset IHS and Tribal health care expenses without a reduction in IHS appropriated funding.

AVAILABILITY AND QUALITY OF SERVICES

The availability of IHS services varies by location. Most IHS clinics are in rural areas, and thus access to those clinics is limited for the large urban American Indian and Alaska Native population. Services and the availability of services also vary from service unit to service unit, often creating an unreliable and unpredictable level of care for those in Tribal or urban communities. Services are performed by both licensed and unlicensed health care providers.[166,167,168,169] All services, including public health, behavioral health care, and medical care, often are provided by an amalgam of IHS, Tribal, county, state, and nonprofit organizations.170,171 Distances to service providers, as well as insufficient resources for fuel and childcare, impact American Indian and Alaska Native use of services.[172]

In a study of 514 IHS and Tribal facilities, 82% reported providing some type of mental health service such as psychiatric services, behavioral health services, substance use treatment, or traditional healing practices, and to improve access, 17% (87) have implemented telemedicine for mental health services.[173] However, none provide inpatient psychiatric services. Without access to care, persons in psychiatric distress often end up in the hospital emergency department.[174]

Concerns regarding the quality of care available to American Indians and Alaska Natives have been raised. Significant efforts are underway to ensure the quality of care throughout the Indian Health Care System. These efforts include improvement, enhancement, modernization, and increased security of the health information technology system used for patient data; establishment of the IHS Quality Consortium to coordinate quality improvement activities among hospitals and clinics; addressing workforce shortages; and improving infrastructure.

In an effort to examine and prioritize behavioral health quality prevention, treatment, and recovery elements, SAMHSA developed the National Behavioral Health Quality Framework (NBHQF). The NBHQF is a document that guides the identification and implementation of key behavioral health quality measures that support funding decisions, monitoring of behavioral health, and delivery of behavioral health care. The framework is aligned with the National Quality Strategy and supports the three aims of better care – healthy people, healthy communities, and affordable care. The NBHQF also provides for dissemination of proven interventions and accessible care, which includes the affordability of care and the impact of health disparities.

ATTITUDES TOWARD BEHAVIORAL HEALTH AND SERVICES

Individual, systemic, and cultural barriers influence decisions about accessing behavioral health services. Within many American Indian and Alaska Native communities, there is a wide range of cultural beliefs surrounding mental health. Some American Indian and Alaska Native tribes do not stigmatize mental disorders, whereas others stigmatize only some mental disorders and still others stigmatize all mental disorders.[175] For some American Indian and Alaska Native tribes, speaking about negative things such as depression, suicide, and other mental disorders invites these things into their world, so such discussions are forbidden, avoided, or discouraged.

Researchers have found that culture plays an important role in one's attitudes toward psychotherapy,[176,177] decisions about starting treatment,[178] premature termination of treatment,[179,180] and eventual treatment outcome.[181,182] Across racial and ethnic groups, research indicates that attitude toward treatment is one of the best predictors of treatment use.[183,184,185]

Within American Indian and Alaska Native communities, culture may also be connected to place. Urban American Indians and Alaska Natives and those more familiar with mainstream medicine are more likely to utilize services than are American Indians and Alaska Natives with no experience with behavioral health treatment and counseling. Furthermore, Western modalities are more acceptable to American Indians and Alaska Natives who have assimilated into Western culture than to those who have not.[186]

SUPPORTIVE SERVICES

The Bureau of Indian Affairs' social services program supports an array of social service activities that strengthen Indian families, promotes family stability, and ensures health and well-being. The social services program manages applications for financial assistance, delivers child and adult protective services, provides services to children and families affected by alcohol and substance use and domestic/family violence, provides technical assistance and training to tribal contractors on regulatory issues and best practices approaches, and fulfills the BIA's fiduciary responsibility of managing supervised Indian Individual Monies (IIM) accounts.

BIA funding for tribal Indian Child Welfare Act (ICWA) programs support social workers that work with tribal courts, state courts, and Indian families in the areas of child protection. Children are reunified with their families when possible. When reunification is not possible, children are placed into Indian foster and adoptive homes.

BIA maintains a comprehensive plan for addressing the needs of Indian communities with high rates of domestic and family violence, and high incidences of child abuse and neglect. The plan focuses on strategies to expand family services related to domestic and family violence; improve collaboration and coordination between law enforcement and social services to more rapidly address instances of domestic and family violence and improve coordination of services with other tribal, state, and federal partners on domestic and family violence initiatives/activities in Indian Country. The plan also includes a gap analysis and best practices model; developing and scheduling domestic violence training; visiting Tribal domestic and family violence programs to learn more about their work, and providing technical assistance to tribes operating domestic violence/family violence prevention programs.

The Tiwahe Initiative was recently launched by BIA as a means for more holistically delivering services. The Tiwahe Initiative is a five-year comprehensive plan to strengthen Indian families and promote family stability in order to fortify tribal communities. The Tiwahe Initiative is a demonstration project and seeks to show how integration in the delivery of services to children, youth, and families will help preserve the family unit and support healthy and productive families. Under the Tiwahe Initiative, each Tiwahe site will be required to develop and submit a plan for an integrated service delivery model that is centered on the needs of their tribal community and addresses the interrelated problems that are often a result of child abuse and neglect, poverty, family violence, substance misuse, unemployment, and incarceration in American Indian and Alaska Native communities.

PUBLIC HEALTH AND RESEARCH INFRASTRUCTURE

There have been well-documented reports of breaches in research ethics,[187] violations of participants' rights,[188] and lack of respect for cultural practices in research. This has led to an understandable wariness of Western research on the part of American Indians and Alaska Natives. In addition, the comparatively small number of American Indian and Alaska Native researchers has limited research-based knowledge development on matters of health in Indian Country. This realization has led to a revitalization of research in Indian Country but with more Tribal control.

The Native American Research Centers for Health (NARCH) program is a collaboration between NIH and IHS. NARCH supports partnerships between American Indian and Alaska Native tribes or tribally based organizations and institutions that conduct academic biomedical and behavioral research. NARCH is a grant program that

provides opportunities for conducting research, research training, and faculty development to meet the needs of American Indian and Alaska Native communities.

There are 12 Tribal Epidemiology Centers (TECs) that work to improve the health of American Indians and Alaska Natives by identifying and understanding health problems and disease risks, strengthening public health capacity, and developing solutions for disease prevention and control.[189] These TECs have made progress in documenting the health problems facing American Indians and Alaska Natives.[190]

More and more tribes are taking an active role in public health practice and research in their communities. As an exercise in Tribal sovereignty and an acknowledgment that respectful research is still needed to advance the state of tribe-specific knowledge, a growing number of tribes have initiated their own Tribal review processes to govern research efforts undertaken on Tribal lands and with Tribal members. Other tribes are undertaking grant-funded collaborations with academic researchers and Federal agencies and active collaborations with state and county health departments. Many of these collaborations are based on the fundamentals of community-based participatory research, which provides a critical impetus for the development of interventions that build on cultural, community, and individual strengths to promote positive outcomes for American Indians and Alaska Natives.[191]

5 THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

The Historical and Current Contexts section of this document underscores the importance of developing the TBHA. That is, the contexts and factors that must be considered in an effort to improve the behavioral health of American Indians and Alaska Natives are complex and must be understood to create a blueprint for meaningful change. Ultimately, the intent is to help construct a more informed and productive path forward.

THIS PART OF THE DOCUMENT PROVIDES THE FRAMEWORK FOR THE TBHA BASED ON:

- TRIBAL INPUT
- INFORMATION FROM SELECTED FEDERAL STRATEGIC PLANS AND DOCUMENTS THAT PRESENT EXISTING PATHWAYS ON WHICH TO BUILD MORE COLLABORATIVE ACTIVITIES
- EXAMPLES OF EXISTING FEDERAL PROGRAMS THAT SUPPORT THE WORK THAT TRIBAL LEADERS AND TRIBAL REPRESENTATIVES BELIEVE ARE CRITICAL FOR SUPPORTING THE WELL-BEING OF THEIR COMMUNITIES

The intent of including the information noted above is to demonstrate that positive and useful efforts exist and can be built upon, that there is fertile ground to improve the coordination and collaboration that Tribal leaders are seeking, and that opportunities exist that can enhance behavioral health-related efforts by working together.

The most important aspect of the TBHA is that it was identified through discussions with Tribal leaders, tribal administrators, and Tribal members. It is important to note that:

- The TBHA is not an exact map but an initial step toward driving action in the same direction and along a common path. It is organized around five elements that were deemed to be foundational for designing an agenda that holds significance for Tribal communities. The foundational elements organically coalesced from conversations with Tribal leaders around their concerns with the state of behavioral health in Indian Country. Through the various meetings, discussions, and input opportunities that contributed to building this blueprint, the five foundational elements were affirmed and reaffirmed.
- The priorities that follow are a reflection of Tribal views and areas of importance through the Tribal perspective. It is significant to note that during conversations and input sessions many of the comments were not framed in terms of quantitative actions but rather in terms of the conditions that are necessary for positive emotional health and well-being to exist. As questions were posed, Tribal leaders and representatives used their cultural knowledge and experience as reference points for their comments. The framing and essence of Tribal input were consistent across discussions. The points of view shared were not optional but rather essential to a new state of collaboration among Tribal nations, Federal departments and agencies, and other interested parties – a state in which all parties commit to "working differently" together for the benefit of Tribal communities. This document honors and attempts to share input in the context in which they were given.
- Following an examination of the historical and current contexts that frame the state of behavioral health for American Indians and Alaska Natives today, the breadth and essence of Tribal input, and discussions around existing Federal programs and strategic directions, priorities for working collaboratively on a range of opportunities were developed. The opportunities extend beyond tribes and Federal agencies to state and local entities and other potential collaborators.

The foundational elements, priority areas, and strategies section begins on page 46.

CONSIDERATIONS FOR COLLABORATION

TRIBAL, FEDERAL, AND STATE GOVERNMENT RELATIONSHIPS

Very few of the challenges cited in this document can be successfully addressed without collaborative efforts on the part of tribes and other stakeholders – most notably Federal and state governments. Tribes are sovereign entities with distinct governing structures and authorities. However, Federal and state governments bring a wealth of resources from which tribes can and do benefit. Although there are actions that tribes undertake on their own, there are others where it is mutually beneficial to collaborate with other governments. The TBHA serves as a platform for engagement and a reference point for developing and improving governmental relationships and efforts that benefit American Indians and Alaska Natives.

ALIGNMENT OF LOCAL AND NATIONAL EFFORTS

Through a process of stakeholder engagement, the priority areas within the TBHA were created to reflect the current reality of behavioral health in Indian Country. Tribes and Tribal organizations and Federal departments and agencies had opportunities to provide input. The priority areas were validated through extensive conversations and represent a unity of thought that supports the alignment of local and national efforts under common themes. Tribal, Federal, state, and local governments, as well as other stakeholders, can begin the process of examining their own efforts, identifying where those efforts connect and align to the priorities areas in the TBHA and determining how they might contribute to furthering them.

The process of alignment helps ensure that resources are allocated and spent most effectively, efforts target priority issues, communication is open, and collaboration is fruitful. These activities could lead to more informed development of programs that more effectively allow tribes to respond in a manner that meets the unique needs of their communities. The activities also could lead to expansion of opportunities within existing programs that allow tribes to work in new areas, the inclusion of tribes or urban Indian health programs in funding streams that did not previously reach them, and flexibility to ensure that the programs allow for the incorporation of traditional ways as described in the American Indian and Alaska Native Cultural Wisdom Declaration in this document. Finally, these opportunities allow for growth of thought that tribes not only use evidence-based practices along with traditional practices but also develop practices that have evidence and can inform the work of other communities. There are opportunities of mutual benefit, and those benefits are bidirectional.

CREATION AND SUPPORT OF NEW EFFORTS

The priority areas contained in the TBHA can help a tribe, urban Indian health program, other governments, and other stakeholders design new program efforts or activities that carry out the recommendations through a new and innovative method. The priority areas can assist funders create or strengthen existing programs or initiatives, whereas tribes and urban Indian health programs can do the same at the local or area level. The priority areas and strategies lend themselves to incorporation into funding opportunity announcements, framing scopes of work, and/or joint development of initiatives and programs.

CROSS-CUTTING CONSIDERATIONS

Throughout the input-gathering sessions and TBHA development discussions, several considerations for improving behavioral health arose that cut across multiple foundational elements. These considerations related to actions that support recognition of youth, identity, culture, self-sufficiency, data, and Tribal leadership. To maximize collaborative work across the foundational elements, the cross-cutting topics are defined as follows.

YOUTH

American Indian and Alaska Native culture places importance on honoring youth and building strong foundations for future generations. Native youth hold an important role in the future of tribes; however, they are significantly and negatively affected by poverty, substance use, depression, and suicide and are at high risk for other behavioral health challenges. Healthy youth lead to healthy adults and healthy communities. Across foundational elements, youth were identified as an important part of the solution for issues they face as well as those faced by their peers, families, and communities. Behavioral health planning should incorporate the voices of youth and engage them in developing and implementing activities.

IDENTITY

American Indians and Alaska Natives connect their political identity with varying aspects of cultural, geographic, Tribal, familial, and social frameworks – creating a unique identity framework that is unique not only to American Indian and Alaska Native groups but also to American Indian and Alaska Native individuals. Understanding the sources of identity, honoring them, and embracing them can be a significant source of communal and individual strength that can be harnessed to combat behavioral health challenges. Behavioral health professionals who are actively working with American Indians and Alaska Natives can incorporate identity exploration into their treatment plans; community action plans can celebrate communal identities; education can take place to ensure that external collaborators, entities, and funders understand the nature of American Indian and Alaska Native identity; and, traditional practitioners can work with clinicians on how best to honor the identities of the people they serve.

CULTURE

Culture is the root of American Indian and Alaska Native identities – culture incorporates aspects of living, interpersonal and communal relationships, communication, worldviews, and spirituality. The uniqueness of Tribal cultures as well as their commonalities is a source of strength. Although each American Indian and Alaska Native tribe is unique, there are commonalities that tribes share, including valuing traditional practices, honoring elders, respecting nature, and emphasizing clan/community importance. American Indian and Alaska Native communities also have a Native language that serves to connect them to their culture and Tribal identities as well as create a strong cultural bond with other Indigenous communities. These commonalities affect the manner in which tribes conduct themselves, including in health care delivery and behavioral health program design and implementation.

Revitalization of American Indian and Alaska Native languages is essential to continuing culture and strengthening self-determination. Research has shown that use of languages builds identity and assists communities in moving toward social cohesion and self-sufficiency. Language and culture foster higher educational outcomes by Native youth as a result of lower levels of depression, increased academic achievement, and strengthened problem-solving skills.[192] Furthermore, American Indian and Alaska Native values and traditions are embedded in language, and there is

growing evidence that language and culture act as protective factors against suicide and suicidal ideation, substance use disorders, and other risky behaviors. Languages are among the most critical and meaningful culturally and linguistically based tools to not just survive, but to thrive.

In 2008 researchers could find only one article that examined the link between Indigenous language and health. The findings were significant: Bands with higher levels of language knowledge (as measured by a majority of its members having conversational-level abilities) had fewer suicides than those with lower levels. In fact, the rates of suicide in the bands with high language knowledge levels were "well below the provincial averages for both Aboriginal and non-Aboriginal youth." When the language knowledge factor was added to six other measures, "the presence of the language factor made a drastic difference in suicide rates." In all cases but one, the suicide rate dropped to zero when the language factor was added.[193]

Tribal consultation and listening sessions held by HHS indicate that investments in Native language programs are critical to Tribal communities. As educational institutions recognize that Native culture and language are inherent strengths, the self-worth and optimism of Native youth increase. It is by going back to traditional, ancestral, Indigenous ways of knowing based in culturally and linguistically specific values and norms that American Indian and Alaska Native communities will thrive on their own terms.

INDIVIDUAL SELF-SUFFICIENCY

Tribes and Tribal members are autonomous – they have the capacity to act independently on their own behalf. While tribes know best what works and does not work for their communities, Tribal members also have the ability to make individual decisions. At the individual level, self-sufficiency encompasses the full development of individuals – spiritually, mentally, physically, educationally, and economically among other ways – in a manner that contributes to their success in life. The intent is for one to have the capacity and initiative to take care of self and ultimately contribute to the well-being of their families and communities. The value is in being able to take care of self in order to effectively contribute to the lives of others. Individual self-sufficiency contributes to Tribal self-sufficiency and the responsibilities of sovereign nations to their people. Tribal representatives who contributed to building the TBHA believe that opportunities should exist across foundational elements that contribute to the ability of Tribal members and tribes to be self-sufficient. This could include availability, accessibility, and/or oversight of education and training opportunities; access to Native foods; access to prevention and treatment resources to address unique behavioral health challenges that exist in communities; referral networks across systems that support well-being; and law enforcement agreements, among others.

DATA

The problems of accuracy and access to viable data have long impacted American Indian and Alaska Native communities. Small sample sizes make it difficult to capture accurate data, and the same small sample sizes make sharing data even more tenuous for fear of violating confidentiality. Frequently data available to tribes is significantly outdated, requiring them to use data sets that may not reflect the reality within their community. And, all too often, American Indians and Alaska Natives are not a distinct group captured within larger data sets. Without access to timely and accurate data, communities are unable to capture their true needs, thereby inhibiting effective community-based planning and improvement of outcomes.

As a cross-cutting consideration, improving data accuracy, availability, and access offers real opportunities to improve definitions for data collection; strengthen Tribal data collection systems; provide capacity building for tribes and partners on how to collect and manage data that is tribally owned; interpret and use data to improve systems and programs; and create systems that allow partners to benefit from available data. These opportunities should be leveraged within strategies that support foundational elements and their accompanying priority areas and strategies.

TRIBAL LEADERSHIP

Tribal leaders care deeply for their communities and hold significant responsibility for the welfare of their people. They have the authority and communal support to take action and can serve as drivers of meaningful community change. To be most effective on behavioral health matters, Tribal leaders must be informed about problems in their communities; lead community-based dialogs to hear from their people about behavioral health and factors that influence wellness; work with their Tribal councils and with a range of Federal departments and agencies to address prevention as well as systems, facilities, and service needs; and seek, identify, and/or champion funding and programs that most effectively support behavioral health needs.

Throughout the input received for developing the TBHA, Tribal leaders and tribal representatives conveyed that Tribal leaders need to "own" the behavioral health challenges facing their communities in order to assume true leadership on the issue. Tribal leaders viewed as being the most effective on behavioral health were identified as champions who were informed and took a visible role in driving solutions.

> ***"We continue to address the impacts of alcohol and drugs, youth suicides, domestic violence and the list continues. However, now is the time to address the source of these symptoms – historical and intergenerational trauma."***
>
> *– Tribal leader, White House Tribal Nations Conference, 2014*

Improving the behavioral health of culturally, geographically, and socioeconomically diverse populations is a complex undertaking that requires a multipronged approach. There is no single strategy that will accomplish this task; there are interwoven factors and systems that may each require intense examination, deconstruction, and retooling. Individual behavioral health risk unfolds within the social settings of families, peer networks, schools, communities, and service systems and within the cultural and historical contexts of the tribe.[194] Health care systems are needed that provide new perspectives on integrating treatment for mental and substance use disorders with holistic well-being, including family, community, socioeconomic, and social supports.[195] Strategies need to be developed to effect system- and policy-level changes that reduce barriers to high-quality care and promote the well-being of American Indian and Alaska Native youth, families, and communities.[196]

FOUNDATIONAL ELEMENTS, PRIORITY AREAS, AND STRATEGIES

The foundational elements of the Tribal Behavioral Health Agenda were the first product of the many discussions held with Tribal leaders, Tribal administrators, and tribal representatives regarding the factors contributing to or exacerbating behavioral health challenges in Indian Country. Each foundational element includes priority areas that were gleaned from targeted conversations about the most pressing concerns. The priority areas contain strategies based on analysis of responses to questions related to desired outcomes, healthy communities, and stronger systems. What follows are the results of engagement and investigation into the state of behavioral health, prevalent attitudes regarding behavioral health, predominant barriers and challenges at the systems and community levels, and insights into potential solutions.

FOUNDATIONAL ELEMENT 1:

Historical and Intergenerational Trauma (HIT)

Dr. Maria Yellow Horse Brave Heart describes historical trauma as the "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma"[197] and includes the impact of chronic stress and trauma that negatively affect health. These impacts are magnified when entire communities experience and reexperience past and present trauma.

It is important to understand historical and intergenerational trauma from a variety of perspectives. First, understanding the sources of the trauma is important in creating a common understanding of how the past can contribute to the present. Second, understanding and learning how to take that information and openly discuss it are important steps. American Indian and Alaska Native people may not seek to discuss traumatic events or how they manifest in their daily lives for fear of giving the trauma power. It is vital to lay out the issues in such a way that Tribal members, allies, and other stakeholders (including Federal and state governmental entities) can understand and thus meaningfully engage in a discussion of healing.

Discussions regarding trauma should not be limited to adult Tribal members. Youth also experience intergenerational trauma but may not have the skills or language to conceptualize or talk about it in the context of modern-day pressures and situations. The purpose of discovering, uncovering, and talking about historical and intergenerational trauma is to support healing. The intent of Foundational Element 1 is not necessarily to further assess historical trauma but rather to support the development of priorities and evidence- and practice-based actions to support healing for Tribal members.

Healing practices should acknowledge the root causes of intergenerational and other types of trauma. Trauma that is directly experienced in the present compounds issues and reinforces the sense of hopelessness. Resources and community norms need to actively support the prevention of modern-day trauma and incorporate strategies to address historical and intergenerational trauma as a real and contributing factor to contemporary issues.

Federal Support for Addressing Trauma

A review of selected Federal strategic plans and documents identified a number of existing goals and recommendations focused on addressing trauma (see Appendix 3. Selected List of Federal Strategic Plans and Documents: Correlations With the National Tribal Behavioral Health Agenda). These plans and documents either cut across all populations or specifically focus on American Indians and Alaska Natives. For example, as part of its Strategic Plan "Leading Change 2.0: Advancing the Behavioral Health of the Nation," SAMHSA established trauma and justice as one of its six priorities; these priorities are linked to SAMHSA's policy, program, and financial planning. An objective within the Trauma and Justice Strategic Initiative focuses on integrating an understanding of trauma and strategies for implementing trauma-informed approaches across SAMHSA, interested Federal agencies, and other public service sectors. Similarly, a strategic initiative in ACF's Strategic Plan promotes the use of evidence-based and trauma-informed practices that effectively address the needs of children and families and encourage achievement of timely permanency for children in the child welfare system.

Recommendations in the Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence: Ending Violence so Children Can Thrive report[198] promote Tribal-state collaborations to meet the needs of children who have been exposed to violence. The recommendations also support training for American Indian and Alaska Native communities on the needs of children exposed to violence and for Federal employees who are assigned to work on issues pertaining to American Indian and Alaska Native communities to obtain training within the first 60 days of their job assignment. Additional recommendations focus on collaborations with organizations that specialize in treatment and services for traumatized children, the establishment of safe places where children exposed to violence can obtain services, and the promotion of youth afterschool programs that are culturally based and trauma informed.

Federal efforts such as SAMHSA's Tribal Behavioral Health Grant program focus not only on preventing and reducing suicidal behavior and substance use and promoting mental health but also on addressing the impact of trauma. Tribes and Tribal organizations can propose activities that are aligned with the particular needs of their communities, such as implementing community events to address historical and intergenerational trauma, beginning collective conversations about trauma, and building consensus on solutions. The IHS, through its Telebehavioral Health Center of Excellence, provides a range of behavioral health services, technical assistance, and training via electronic mechanisms on current and pressing behavioral health issues, including historical and intergenerational trauma. The NIH is funding the ongoing research study "Historical Trauma Informed Clinical Intervention Research and Practice," which could further Tribal efforts to address historical and intergenerational trauma in Tribal communities.

These and other Federal and Tribal strategic efforts and programs provide existing pathways on which to build or expand strategies that more effectively address healing from trauma.

Priority Areas and Strategies

Priority areas emerged from tribal input that focus on creating viable and appropriate support mechanisms, promoting community connectedness, and breaking the cycle of trauma. The following three priority areas reflect the views from the conversations. Following each priority area below are recommended strategies for addressing them.

HIT1 – Support Systems

At the core of this priority area is the importance of ensuring that families who have also been affected by traumatic events receive appropriate support. The intent is that all members of a family receive the support required for individuals and the collective to heal. Without support mechanisms for all family members, strategies to assist individual family members may fail. Incorporation of supports for the family will require program flexibility, collaboration, and commitment. It is important that tribes be informed of the resources available to them and, even more importantly, that tribes are comfortable with the competency and scope of the resources. Recommended strategies include:

- **HIT1.1:** Actively inform communities about the forms of trauma and their manifestations as a means for enhancing the potential for family engagement in services.
- **HIT1.2:** Incorporate into Federal, Tribal, and other programs opportunities for engaging family members who live with trauma as part of funded activities to ensure that they have access to support mechanisms.
- **HIT1.3:** Allow tribes, within existing programs and new funding streams, the flexibility to develop, tailor, and/or implement support mechanisms that best address their local and specific manifestations of trauma.
- **HIT1.4:** Incorporate opportunities to address unresolved grief as a root cause of behavioral health challenges and a core component in positive healing within programs that focus on Tribal communities.
- **HIT1.5:** Strengthen support systems across health, behavioral health, education, child welfare, and justice services programming to ensure continuity and availability of support for family members who connect through different systems.

HIT2 – Community Connectedness

The literature shows that an individual's sense of his or her own belonging, and connection to the communities he or she lives in, is a strong protective factor against many behavioral health issues, including suicide, depression, and substance use. Fostering connectedness with their communities includes expanding inherent strengths within a person and a community, strengths such as pride, self-esteem, community values, tradition, culture, and local resources. Recommended strategies include:

- **HIT2.1:** Expand opportunities for tribes to incorporate Native language learning and development as a means for strengthening pride, self-esteem, identity, and other contributions to community connectedness.
- **HIT2.2:** Provide support for creating new or maximizing existing healthy social structures and social supports through schools and other local settings that permit community members to engage and be validated as valuable members of the community.
- **HIT2.3:** Support Gathering of Native Americans (GONA) events to support community healing from historical trauma and enhance local prevention capacity through meaningful activities that incorporate healthy traditions; focus on a holistic approach to wellness; empower community members; and provide a safe place to share, heal, and plan for action.

PROJECT MAKING MEDICINE

This project is a culturally adapted, evidence-based training program for treating child physical and sexual abuse whose overarching goal is to improve clinician capability to provide early identification and a culturally appropriate response to victims of familial violence and abuse, particularly women and children, in American Indian and Alaska Native communities.

HIT3 – Breaking the Cycle

One of the most insidious aspects of historical trauma is its heritability. It is passed down through families and communities – most often unknowingly – exposing future generations to centuries-old sorrow and trauma. Opportunities to intervene in this process are often overlooked or not identified, and so the cycle continues. An important way to actively promote healing is to break this cycle and interrupt the passing down of messages and stigma that contribute to trauma. Trauma should be proactively addressed in informed ways by the appropriate parties (e.g., family members, teachers, leaders, traditional practitioners, behavioral health professionals). Recommended strategies include:

- **HIT3.1:** Align Tribal, Federal, and other programs that support actions to address trauma and prevent retraumatization as a means for supporting trauma-informed services that are continuous across systems.
- **HIT3.2:** Integrate authentic cultural interventions and culturally tailored evidence-based practices into existing Tribal programs as a means for reestablishing Tribal spiritual conditions of physical, mental, and spiritual health.
- **HIT3.3:** Review and modify Tribal, Federal, state, and other programs to recognize and address the impacts of adverse childhood experiences among American Indian and Alaska Native populations.
- **HIT3.4:** Widely diffuse strategies, in concert with established support mechanisms, across Tribal communities to encourage families to talk in safe ways about their own identities and experiences with trauma to begin the process of healing.
- **HIT3.5:** Develop a research agenda on current, historical and intergenerational trauma to aid building knowledge in areas that require further investigation.
- **HIT3.6:** Use existing workforce development/learning centers to intensify education for health, behavioral health, and other professionals about historical and intergenerational trauma and support efforts to more effectively address trauma in clinical and professional settings.

Who can help advance the historical and intergenerational trauma priorities?

CHART 1:

ADVANCING HISTORICAL AND INTERGENERATIONAL TRAUMA PRIORITIES	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
HIT1.1: Actively inform communities about the forms of trauma and their manifestations as a means for enhancing the potential for family engagement in services.	✓	✓	✓	✓	✓	✓
HIT1.2: Incorporate into Federal, Tribal, and other programs opportunities for engaging family members who live with trauma as part of funded activities to ensure that they have access to support mechanisms.				✓	✓	✓
HIT1.3: Allow tribes, within existing programs and new funding streams, the flexibility to develop, tailor, and/or implement support mechanisms that best address their local and specific manifestations of trauma.			✓	✓	✓	✓
HIT1.4: Incorporate opportunities to address unresolved grief as a root cause of behavioral health challenges and a core component in positive healing within programs that focus on Tribal communities.			✓	✓	✓	✓
HIT1.5: Strengthen support systems across health, behavioral health, education, child welfare, and justice services programming to ensure continuity and availability of support for family members who connect through different systems.				✓	✓	✓
HIT2.1: Expand opportunities for tribes to incorporate Native language learning and development as a means for strengthening pride, self-esteem, identity, and other contributions to community connectedness.				✓	✓	✓
HIT2.2: Provide support for creating new or maximizing existing healthy social structures and social supports through schools and other local settings that permit community members to engage and be validated as valuable members of the community.			✓	✓	✓	✓
HIT2.3: Support Gathering of Native Americans (GONA) events to support community healing from historical trauma and enhance local prevention capacity through meaningful activities that incorporate healthy traditions; focus on a holistic approach to wellness; empower community members; and provide a safe place to share, heal, and plan for action.	✓	✓	✓	✓	✓	✓
HIT3.1: Align Tribal, Federal, and other programs that support actions to address trauma and prevent retraumatization as a means for supporting trauma-informed services that are continuous across systems.				✓	✓	✓
HIT3.2: Integrate authentic cultural interventions and culturally tailored evidence-based practices into existing Tribal programs as a means for reestablishing Tribal spiritual conditions of physical, mental, and spiritual health.			✓	✓		
HIT3.3: Review and modify Tribal, Federal, state, and other programs to recognize and address the impacts of adverse childhood experiences among American Indian and Alaska Native populations.				✓	✓	✓
HIT3.4: Widely diffuse strategies, in concert with established support mechanisms, across Tribal communities to encourage families to talk in safe ways about their own identities and experiences with trauma to begin the process of healing.	✓	✓	✓	✓	✓	✓
HIT3.5: Develop a research agenda on historical and intergenerational trauma to aid building knowledge in areas that require further investigation.				✓	✓	✓
HIT3.6: Use existing workforce development/learning centers to intensify education for health, behavioral health, and other professionals about historical and intergenerational trauma and support efforts to more effectively address trauma in clinical and professional settings.			✓	✓	✓	✓

FOUNDATIONAL ELEMENT 2:

Socioecological (SE) Approach

Behavioral health challenges evolve in a multivariate environment that extends well beyond the individual. A socioecological approach aims to understand and address the problems recognized and to work within the construct of the social determinants of health. An individual exists within intersecting spheres of influence that include peers and social networks, families, communities, governing structures, economic systems and circumstances, and the even broader and often intangible influences of culture and history. These influencing factors impact an individual's attitudes about what is acceptable and how to behave and thus help shape the norms that create and solidify an individual's worldview.

Many factors shape how people conceptualize health, health care, and what is considered healthy. These factors are even more complicated in American Indian and Alaska Native communities where traditional spheres of influence are often in conflict with Western approaches. For example, a Western governance structure communicates a different style of leadership and engagement than a more traditional and historical Native approach. These powerful variables contribute to how a community responds to challenges and how resources are structured to address such challenges.

The intent of Foundational Element 2 is to both begin to understand the larger context and pressures within which American Indian and Alaska Native behavioral health issues are rooted and guide interventions and efforts to address root and base causes of these issues. Solutions to behavioral health challenges must target factors that contribute to the problem and cause it to proliferate. Approaches that are part of the socioecological model will bring in partners that have expertise or influence over a variety of factors that may support development of viable solutions – these factors include environment, justice, education, health, housing, labor, and transportation.

Whereas a socioecological approach could focus on a variety of factors, including those identified above, Tribal leaders, communities, and programs also can focus on factors contributing to sustaining environmental resources, reliable infrastructure, and healthy families and kinship.

Federal Support for Addressing Socioecological Factors

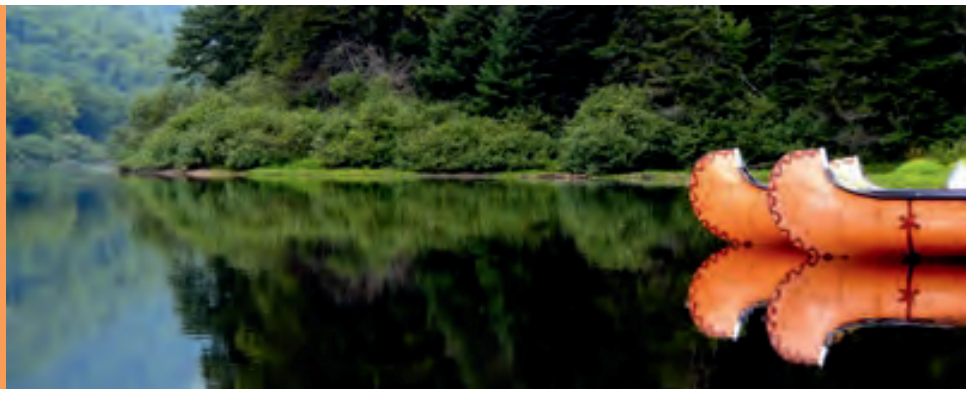
Federal agencies are supporting wide-ranging efforts to improve physical health and behavioral health. For example, NIH is conducting the ongoing study "Ojibwe Pathways" through the high school years. The study will use prospective data to investigate culturally specific protective factors that exist within the Ojibwe culture that may prevent, delay, or reduce the consequences of early-onset substance use and transition to regular substance use. It will also assess the risk factors associated with individual characteristics and the social contexts of Ojibwe children during their high school years.

The BIA, through its Housing Improvement Program, provides grants for cost-effective services to repair, renovate, or replace existing housing and provide new housing for eligible members of federally recognized Indian tribes. This program is carried out in collaboration with the U.S. Department of Housing and Urban Development and the U.S. Department of Agriculture.

The IHS's Great Plains Area and DOI's Bureau of Indian Education (BIE) established a formal partnership to deliver behavioral health services in BIE-operated schools. The IHS will evaluate this partnership as a potential national model of community- and school-based services.

The SSA, through its Video Service Delivery (VSD), has also developed a process that provides immediate services to tribes whose SSA field offices may be located great distances from reservations. VSD is a great resource for tribes such as the Pine Ridge Indian reservation in South Dakota, who experienced a 300% increase in claims. Through VSD, the SSA is able to process numerous services that are important to obtaining or maintaining information about services such as applying for a replacement Social Security Number card or changing an address.

The CDC, through its Good Health and Wellness in Indian Country program, uses a model to directly fund tribes to prevent heart disease, diabetes, stroke, and associated risk



factors in American Indian tribes and Alaska Native villages through a holistic approach to population health and wellness. Funded tribes use effective community-chosen and culturally adapted public health interventions using a combination of policy and environmental approaches, community clinical linkages, and health system interventions. This model also promotes the leadership of Tribal organizations and use of culturally adapted evidence-based interventions. Examples of program priorities include improvement in nutrition and physical activity and an increase in health literacy.

Priority Areas and Strategies

Priorities areas emerged from tribal input that focus on sustaining environmental resources, ensuring reliable infrastructure, and supporting healthy families and kinship. Following each priority area below are recommended strategies for addressing them.

SE1 – Sustaining Environmental Resources

One commonality tribes share is a strong connection to nature and the environment; nature is highly revered and treated with respect. The connection is not only spiritual but also a way of life that includes nature as a source of traditional foods and medicine. Tribes have experienced devastation that has endangered nature and hope to protect and preserve their environment. Recommendations include:

- **SE1.1:** Proactively advance collaborations among Tribal, Federal, and state programs to protect environmental resources as a vital part of the spiritual connection and traditional lifestyle.
- **SE1.2:** Incorporate actions across Tribal, Federal, and state programs that improve access to safe and healthy traditional foods.

SE2 – Reliable Infrastructure

Tribes and Tribal communities face many challenges when it comes to infrastructure. Unemployment rates throughout Indian Country are high, and housing shortages affect Tribal members. The lack of adequate housing not only poses obvious challenges for Tribal members but also impacts the ability to attract and support a critically needed health care workforce. Recommended strategies include:

- **SE2.1:** Strengthen educational capacity of schools and access to education resources.
- **SE2.2:** Collaborate with state and Federal agencies on creative opportunities for addressing the determinants of health, including opportunities to increase housing stock, facilitate transportation needs, and improve job readiness.

SE3 – Healthy Families and Kinship

Similar to community connectedness, family structures within Indian Country are vital sources of strength. However, family structures are becoming more fragmented, with many youth lacking strong parental figures in their lives. Strong family structures are important in helping youth grow into healthy and resilient adults. Elders are the gatekeepers of knowledge and tradition within Tribal communities, and tribes have suggested engaging elders in a more meaningful way by strengthening their connection with youth. Recommended strategies include:

- **SE3.1:** Support broader efforts to strengthen families as integral prevention and invention mechanisms and develop family-driven strategies for reinforcement.
- **SE3.2:** Collaborate across local, Tribal, state, Federal, and private and non-profit organizations to leverage opportunities to create safe and nurturing environments for youth.
- **SE3.3:** Expand collaboration across education, health, and human service systems that engage, support, and protect elders.

Who can help advance socioecological priorities?

CHART 2:

ADVANCING SOCIOECOLOGICAL PRIORITIES	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
SE1.1: Proactively advance collaborations among Tribal, Federal, and state programs to protect environmental resources as a vital part of the spiritual connection and traditional lifestyle.	✓	✓	✓	✓	✓	✓
SE1.2: Incorporate actions across Tribal, Federal, and state programs that improve access to safe and healthy traditional foods.			✓	✓	✓	✓
SE2.1: Strengthen educational capacity of schools and access to education resources.				✓	✓	✓
SE2.2: Collaborate with state and Federal agencies on creative opportunities for addressing the determinants of health, including opportunities to increase housing stock, facilitate transportation needs, and improve job readiness.				✓		
SE3.1: Support broader efforts to strengthen families as integral prevention and invention mechanisms and develop family-driven strategies for reinforcement.	✓	✓	✓	✓	✓	✓
SE3.2: Collaborate across local, Tribal, state, Federal, and private entities to leverage opportunities to create safe and nurturing environments for youth.			✓	✓	✓	✓
SE3.3: Expand collaboration across education, health, and human service systems that engage, support, and protect elders.			✓	✓	✓	✓

FOUNDATIONAL ELEMENT 3:

Prevention and Recovery (PR) Support

Strong public health delivery models emphasize early identification of community health issues to prevent the deterioration of health. Similarly, following an intervention, services should be available to provide ongoing, comprehensive support for recovery and prevention. Existing systems must be strengthened to assess for the availability of critical services, gaps in services, and opportunities for improvement to meet community needs.

Federal Support for Addressing Prevention and Recovery Support

A number of Federal strategic plans address prevention and recovery efforts. For example, IHS, through its American Indian/Alaska Native National Behavioral Health Strategic Plan, is working to launch a systemwide collaboration between those working in child abuse/neglect prevention and those working in behavioral health to coordinate services for the whole family. Additional IHS strategies support community-specific planning, readiness, and mobilization around the prevention of suicide, violence, and substance misuse.

SAMHSA, through "Leading Change 2.0: Advancing the Behavioral Health of the Nation," is working to enhance cooperation and coordination among Federal and non-Federal organizations to prevent and reduce underage drinking and to promote recovery-oriented service systems that include coordinated clinical treatment and recovery support. Recommendations developed through the Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence "Ending Violence so Children Can Thrive" report[199] also support access to culturally appropriate behavioral health and substance use prevention and treatment.

The noted Federal strategic plans and report and others support critical programming. IHS's Methamphetamine and Suicide Prevention Initiative (MSPI) expands community-level access to effective methamphetamine and/or suicide prevention and treatment programs. MSPI also enhances evidence- and practice-based methamphetamine and suicide prevention and treatment programs and community mobilization programs. The IHS Domestic Violence Prevention Initiative (DVPI) promotes the development of evidence- and practice-based models that represent culturally appropriate prevention and treatment approaches to domestic violence and sexual assault from a community-driven context. The DVPI expands outreach and increases awareness by funding programs that provide outreach, victim advocacy, intervention, policy development, community response teams, and community and school education programs.

The BIA's Domestic Violence Prevention Program focuses on developing strategies to expand family services related to domestic violence, improve teamwork between law enforcement and social services to more rapidly address instances of domestic and family violence, and improve the coordination of services with other domestic and family violence partners in Indian Country. This program addresses the unmet needs of Native communities with high rates of domestic and family violence and high incidences of child abuse and neglect. The BIA collaborates on this program with DOJ and HHS.

VA established the national Opioid Safety Initiative (OSI) to reduce unsafe opioid pain medicine prescribing. The purpose of the OSI is to prevent opioid overdose and addiction. This multipronged approach includes provider and patient education about the risks and benefits of opioid pain medicines for chronic non-cancer pain, increasing access to more effective and safe stepped care strategies for chronic pain management, co-prescribing of naloxone rescue kits for those at-risk of overdose, and, when indicated, providing medication assisted treatment for opioid

use disorder using buprenorphine/naloxone, methadone administered through an opioid treatment program, or extended-release injectable naltrexone. DOJ launched its Coordinated Tribal Assistance Solicitation (CTAS) in FY 2010 in direct response to concerns raised by tribal leaders about the Department's grant process that did not provide the flexibility tribes needed to address their criminal justice and public safety needs. DOJ designed this comprehensive approach to save time and resources and allow tribes and DOJ to gain a better understanding of the tribes' overall public safety needs.

Under CTAS, the Bureau of Justice Assistance offers justice systems and alcohol and substance misuse funding. Tribes are able to develop, enhance, and continue tribal justice systems, including law enforcement, pretrial services, risk and needs assessment development and implementation, diversion programming, tribal court services, detention programming, community corrections, re-entry planning and programming, justice system infrastructure enhancement, and justice system information sharing.

Tribes can also respond to and prevent alcohol- and substance use-related crimes, including alcohol and substance use prevention, healing to wellness courts, intervention, or treatment. They are also able to: (a) develop, implement, and enhance substance use prevention and treatment programs, including those that prevent and address the needs of drug-endangered children; (b) implement enhanced authorities and provisions under the Tribal Law and Order Act and the Violence Against Women Reauthorization Act of 2013; and (c) engage in comprehensive strategic planning to improve tribal justice and community safety as it relates to tribal courts and alcohol and substance use.

DOJ incorporated the Juvenile Healing to Wellness Courts program into the CTAS in FY 2015 to enhance the capacity of tribal courts to respond to the alcohol and substance use-related issues of youth under the age of 21.

Through the Garrett Lee Smith (GLS) State/Tribal Suicide Prevention Program, SAMHSA has funded 49 tribes, Tribal organizations, and urban Indian organizations to carry out youth suicide prevention projects. The purpose of the GLS Program is to support states and tribes in developing and implementing statewide or Tribal youth suicide prevention and early intervention strategies. The program strongly encourages collaboration among youth-serving institutions and agencies and includes schools, educational institutions, juvenile justice systems, foster care systems, substance use and mental health programs, and other child- and youth-supporting organizations.

SAMHSA's GLS Program cross-site evaluation found that these grants have had a lifesaving impact. Counties that implemented GLS-funded youth suicide prevention activities had lower rates of youth deaths by suicide and nonfatal suicide attempts than matched counties that did not. This was estimated to amount to 487 suicide deaths averted and 79,000 nonfatal suicide attempts averted. It is unknown whether the impact was equally distributed across states and tribes. However, the impact was stronger in rural counties. This powerful impact was present in the first year after the activities were implemented and faded in the second year, strongly suggesting the importance of embedding suicide prevention within a sustainable infrastructure in both states and tribes.[200, 201] In addition to the findings from the cross-site evaluation, local evaluations of some Tribal suicide prevention efforts have also been encouraging.

WHITE MOUNTAIN APACHE TRIBE (WMAT)

The WMAT suicide prevention program, working with the Johns Hopkins Center for American Indian Health, includes the evaluation of two culturally adapted interventions. These interventions are linked to a unique tribally mandated suicide surveillance system that identifies youth who have exhibited suicidal behavior. Preliminary results suggest a reduction in suicidal ideation for the interventions. An important element of the WMAT system is that every suicidal youth reported to the system receives rapid follow up by the Apache community workers, typically in their homes.

Lessons learned from a decade of SAMHSA-funded American Indian and Alaska Native suicide prevention efforts include:

- Suicide prevention efforts must be organized in a comprehensive way to be successful and must include all youth-serving organizations and institutions. Buy-in by the community and Tribal leadership is essential and can be facilitated by a Tribal resolution. Building organizational infrastructure from the beginning is important.
- Tribes need access to their own data to be able to plan meaningful and effective suicide prevention activities. Understanding that historical trauma affects resistance to evaluation is vital since, historically, evaluation meant that something would be taken away from a community or used without community consent. Data and evaluation should be used by the community for the community.
- Tribes should have protocols in place to guide how to respond to at-risk youth encountering any part of Tribal youth-serving systems.
- Youth with suicidal ideation or who have made a suicide attempt must receive active outreach in the community. Discharge from a hospital inpatient unit or emergency department cannot be considered sufficient to eliminate suicide risk; rather, connection with the youth needs to be maintained for a minimum of 90 days during this high-risk period.
- Trained community workers can play a vital role in suicide prevention efforts.
- Suicide clusters can have a profound, tragic, and potentially multigenerational impact on Tribal communities. Sharing learning and experiences in responding to a suicide cluster is of great significance in helping us learn how to prevent clusters from starting and how to interrupt them once they have begun.
- Health and mental health programs serving tribes would benefit from utilization of a systematic suicide prevention effort such as that encapsulated in the Zero Suicide prevention model.
- Coordinated crisis response and crisis intervention systems are critical.
- There is a need for increased family participation in suicide prevention work. Much of the federally supported work has focused on the community and youth, but there is a need to work more intensively on family involvement.

Priority Areas and Strategies

Priority areas that emerged from tribal input focus on restructuring programming to meet community needs and advance community mobilization and engagement. Following each priority area below are recommended strategies for addressing them.

PR1 – Programming That Meets Community Needs

All prevention and treatment programs are not designed to meet the diverse needs of differing communities, nor are they designed to readily incorporate traditional American Indian and Alaska Native worldviews that promote health and healing. Tribal communities must have the flexibility, support, and resources to implement prevention, treatment, and recovery programming that meet the needs of their populations. Recommendations include:

- **PR1.1:** Create and support culturally and spiritually based programming and healing that aligns with the diversity and needs of the local Tribal population.
- **PR1.2:** Support and coordinate reentry programming across service sectors and programming for incarcerated persons and their families, especially their children.

- **PR1.3:** Prioritize and collaborate on behavioral health-related prevention efforts as a primary strategy across education, health, behavioral health, child welfare, law enforcement, and other systems.

- **PR1.4:** Treat mental and substance use disorders as significant diseases that require support and services across the spectrum – from prevention for individuals at all levels of risk through recovery.

- **PR1.5:** Advocate for and support comprehensive suicide prevention efforts that incorporate protocols for at-risk youth and adults, required infrastructure for supporting suicide prevention, active community outreach following discharge from the hospital or the emergency department, trained community workers, and coordinated crisis response and intervention systems.

- **PR1.6:** Support, establish, or improve data collection systems to support the collection of information on suicide prevention activities that is managed locally or in collaboration with a Tribal Epidemiology Center.

- **PR1.7:** Support suicide prevention efforts that include youth, families, and communities.

- **PR1.8:** Build and sustain supportive environments in schools.

- **PR1.9:** Support and promote Tribal Healing to Wellness Courts, Veterans Courts (or the VA Diversion Courts Peer-to-Peer Support Program), and other courts that support recovery.

PR2 – Community Mobilization and Engagement

Behavioral health is a community health issue that requires a communitywide response. Given the importance of addressing behavioral health problems in many communities, Tribal leaders should take ownership of these issues and work with their Tribal councils, Federal agencies, and other interested parties to develop an appropriate local response. Strategies include:

- **PR2.1:** Formulate and implement long-term, communitywide engagement and mobilization strategies that emphasize community ownership of their issues and solutions.

- **PR2.2:** Support and train community members to serve as peer counselors.

- **PR2.3:** Actively address and support the behavioral health-related programming needs of urban- and reservation-based American Indian and Alaska Native populations.

Who can help advance prevention and recovery priorities?

CHART 3:

ADVANCING PREVENTION AND RECOVERY PRIORITIES	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
PR1.1: Create and support culturally and spiritually based programming and healing that aligns with the diversity and needs of the local Tribal population.	✓	✓	✓	✓	✓	✓
PR1.2: Support and coordinate reentry programming across service sectors and programming for incarcerated persons and their families, especially their children.	✓	✓	✓	✓	✓	✓
PR1.3: Prioritize and collaborate on behavioral health-related prevention efforts as a primary strategy across education, health, behavioral health, child welfare, law enforcement, and other systems.			✓	✓	✓	✓
PR1.4: Treat mental and substance use disorders as significant diseases that require support and services across the spectrum – from prevention for individuals at all levels of risk through recovery.	✓	✓	✓	✓	✓	✓
PR1.5: Advocate for and support comprehensive suicide prevention efforts that incorporate protocols for at-risk youth and adults, required infrastructure to supporting suicide prevention, active community outreach following discharge from the hospital or the emergency department, trained community workers, and coordinated crisis response and intervention systems.	✓	✓	✓	✓	✓	✓
PR1.6: Support, establish, or improve data collection systems to support the collection of information on suicide prevention activities that is managed locally or in collaboration with a Tribal Epidemiology Center.				✓	✓	✓
PR1.7: Support suicide prevention efforts that include youth, families, and communities.				✓	✓	✓
PR1.8: Build and sustain supportive environments in schools.	✓	✓	✓	✓	✓	✓
PR1.9: Support and promote Tribal Healing to Wellness Courts, Veterans Courts (or the VA Diversion Courts Peer-to-Peer Support Program), and other courts that support recovery.			✓	✓		✓
PR2.1: Formulate and implement long-term, communitywide engagement and mobilization strategies that emphasize community ownership of their issues and solutions.	✓	✓	✓	✓	✓	✓
PR2.2: Support and train community members to serve as peer counselors.			✓	✓	✓	✓
PR2.3: Actively address and support the behavioral health-related programming needs of urban- and reservation-based American Indian and Alaska Native populations.	✓	✓	✓	✓	✓	✓

FOUNDATIONAL ELEMENT 4:

Behavioral Health (BH) Systems and Support

As with all systemic issues, arriving at options for improving behavioral health services is complex. An assessment of applicable systems and their interactions with the community and community members is critical to identifying challenges and realistic opportunities for identifying resources for needed services. The source of resources can vary – Tribal, Federal, state, or private – and require that tribes and other stakeholders work together to create coordinated and effective systems for American Indian and Alaska Native peoples.

Issues that impact access, quality, and availability of health, behavioral health, and related services have long been raised by Tribal leaders, community members, and other stakeholders. The literature describes concerns related to personnel shortages, limited health care resources, and lengthy travel distances to obtain services. Other issues also inhibit access to appropriate services, including lack of referrals from school, detention, court appearances, housing needs, primary care, child welfare, and other systems.

The intent of Foundational Element 4 is not only to identify challenges but also to address priorities and strategies that improve coordination, linkages, and access to high-quality behavioral health services. The strategies include examination of the available workforce, development of the existing workforce, ensuring cultural competency in the delivery of services, and potential options for improving meaningful access. In Tribal communities, geographic distances to obtain services and staffing concerns inhibit community members from seeking services, but low utilization numbers also may reflect a belief that services are not effective or in line with an individual's path for healing or inclusive of the person's worldview. The reflection of belief systems within services and as part of service delivery is also a real consideration for American Indian and Alaska Native people who live in urban areas and may receive referrals to providers who have no historical experience in working with Native peoples.

Additional service and service system considerations always include concerns related to funding – amounts, streams, allocations, and adequacy. Substantive system change cannot take place without adequate resources to create and support the desired change. In keeping with the purpose and approach of the TBHA, specific and detailed recommendations about funding have not been made. Discussions regarding the funding of programs and initiatives should be managed by the appropriate Tribal and Federal authorities.

Foundational Element 4, one of the most complex foundational elements in the TBHA, creates substantial opportunities for collaboration. Potential collaborations may involve prevention, treatment, and care, including sources of referrals, education and communication, patient navigation, advocacy services, and more. It engages the community and its leadership to positively influence attitudes, foster support for improvements, and drive actions that align with and benefit local needs.

Federal Support for Addressing Behavioral Health Services and Systems Improvement

Behavioral health issues are addressed in many existing Federal strategic plans. For example, SAMHSA and IHS, through their strategic plans, collectively have nearly 20 objectives focused on suicide prevention and skilled follow up; implementing effective clinical and professional practices and standards for assessing and treating those at risk for suicide; raising awareness about prescription drug misuse; removing financial barriers and incentivizing effective care coordination and integrated treatment delivery; supporting culture-based approaches; and training and support for behavioral health providers.

The IHS's Behavioral Health Program provides vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. The IHS also operates the Alcohol and Substance Abuse Prevention Program to raise the behavioral health status of American Indian and Alaska Native communities

to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community driven and culturally competent. Tribal contracting has enabled both of these programs to transition from IHS to local community control.

The VA has established several telebehavioral clinics in IHS and Tribal health programs in Montana, Arizona, and Alaska to increase access to care closer to home. The intent is to increase access to behavioral health services for veterans in Tribal and rural communities through collaboration with local health care providers in the establishment of embedded VA telehealth clinics. The VA will explore opportunities to expand telebehavioral services to additional Tribal communities or clinics serving veterans.

SAMHSA also funds adult treatment drug courts and Tribal healing to wellness courts. Tribes funded through this program provide a coordinated, multisystem approach that combines the sanctioning power of treatment drug courts with effective substance use disorder treatment services to break the cycle of criminal behavior, alcohol and other drug use, and incarceration or other penalties. SAMHSA funds also are used to serve people diagnosed with a substance use disorder as their primary condition.

Workforce-related programs exist throughout the Federal Government. For example, HRSA, through its National Health Service Corps Program, seeks eligible clinicians (including mental and behavioral health professionals) to provide culturally competent, interdisciplinary primary health care services to underserved populations that reside in selected Health Professional Shortage Areas. HRSA also oversees a Behavioral Health Workgroup that assesses the behavioral health needs of Tribal communities in collaboration with SAMHSA's Regional Administrators and addresses identified needs by providing training and technical assistance. In addition, BIA, through its Job Placement and Training Program, funds tribes to provide training and work experience to decrease unemployment.

The NIH funded a study on evidence-based practices and substance use treatment for Native Americans. The study explored evidence-based practices to describe the factors associated with the decision to implement them in these programs, identify methods for more effective dissemination of evidence-based practices to substance use treatment programs serving American Indian and Alaska Native communities, and identify characteristics of the workforce implementing American Indian and Alaska Native substance use treatment measures.

The SSA offers a variety of benefits for Tribal members, including retirement and disability programs, Supplemental Security Income, Medicare, online account access with mySocialSecurity, and special programs. SSA is working to improve access and understanding of available programs such as the Medicare Extra Help Program to assist qualified beneficiaries with their Medicare Prescription drug plan costs; and, the Wounded Warriors program which offers expedited case processing for disability benefits for military service members.

The HHS Office of Minority Health's National Workforce Diversity Pipeline Program supports projects that develop innovative strategies to identify promising students in their first year of high school and provide them with a foundation to pursue successful careers in the health professions. The program seeks to address health disparities among racial and ethnic minorities by supporting networks of institutions focused on, and with demonstrated commitment and capacity to establish, pipeline programs to increase minority and disadvantaged students' awareness and pursuit of careers in health care, including behavioral health.

Priority Areas and Strategies

BH1 – Workforce Development

Tribes face staffing shortages at nearly all levels. Sometimes these shortages can mean that an individual in crisis is not able to receive immediate, adequate care. Furthermore, many tribes believe that behavioral health professionals would benefit from cultural competency training. In the face of high levels of unemployment and staffing shortages, improving the skills and practice of existing providers and addressing development of the behavioral health workforce using a "grow your own" model are highly favored. Strategies include:

- **BH1.1:** Support and develop collaboration among tribes, Tribal organizations, Tribal Colleges and Universities, and Federal agencies to establish local "grow your own" behavioral health education programs and provide basic training for local Tribal behavioral health aides (community workers).
- **BH1.2:** Establish partnerships between tribes and Addiction Technology Transfer Centers to support education, training for certification exams, and clinical supervision opportunities for behavioral health professionals working in Tribal facilities to obtain and maintain certification.
- **BH1.3:** Support the incorporation of traditional practitioners within service delivery systems and provide training on cultural and organizational competency for all employees.
- **BH1.4:** Actively pursue collaborations with the HRSA National Health Service Corps Program to recruit psychiatrists, behavioral health professionals, and other practitioners to work in Tribal facilities.

BH2 – Funding Mechanisms

Tribal behavioral health programs frequently struggle as a result of insufficient funding. Programs are frequently underfunded or funded only for a finite period. Furthermore, the requirements of some programs do not always align with other Tribal priorities, values, or traditional practices. Tribes have advocated for greater access to particular funding streams and for direct funding from Federal programs rather than through states. Strategies include:

- **BH2.1:** Assess state engagement with tribes and promote meaningful state/Tribal consultations.
- **BH2.2:** Monitor state behavioral health spending and support equitable resources and support to tribes and other entities providing services for Tribal members.
- **BH2.3:** Increase flexibility in funding requirements to tribes to support culturally based programming that meets the programmatic needs of Tribal communities.
- **BH2.4:** Develop flexibilities that allow tribes with multiple Federal grants to lower administrative costs, increase integration of funded programs, and enhance collaborative reporting.
- **BH2.5:** Prioritize behavioral health and related programs in all budgeting processes.

BH3 – Tribally Directed Programs

Tribes know best the needs of their communities. However, funders may not regularly consult with tribes about their programs and may thus develop program requirements, design evaluations, and require reporting using solely a Western lens. Strategies include:

- **BH3.1:** Consult with tribes on programs that tribes are eligible for prior to developing program announcements.
- **BH3.2:** Support and engage tribes in incorporating cultural interventions into program activities that allow them to more effectively meet program expectations.

- **BH3.3:** Support tribally driven assessments and implementation of strengths-based, Tribal best practices.
- **BH3.4:** Increase coordination and collaboration among Federal, state, Tribal, and/or urban programs by aligning resources, decreasing competition, and improving strategic planning.
- **BH3.5:** Engage tribes about their technical assistance and other support needs prior to developing technical assistance requirements.

BH4 – Youth-Based Programming

Youth hold an important position within Tribal communities – they are the literal future for tribes. Youth-specific programs in Tribal communities require additional support given the limited resources and services that may be available locally. Learning about culture is a strong protective factor, and providing education on behavioral health issues may help reduce the stigma surrounding treatment. Strategies include:

- BH4.1: Allow tribes the flexibility to engage youth in developing and implementing programming that targets American Indian and Alaska Native youth.
- BH4.2: Support targeted education for youth that incorporates learning their Native language, respective culture(s), and role that culture plays in supporting behavioral health.

BH5 – Scope of Programming

In response to service-related challenges, including, funding, staffing, facility shortages, and quality care, many tribes do not receive or are unable to provide a full continuum of care for their members. This often means that Tribal members must leave the community to receive care or not receive the care they need. Tribes have sought expansion in the scope of programming to ensure that Tribal members are able to receive vital care within their communities. Strategies include:

- BH5.1: Identify new models of care delivery that ensure more accessible intensive inpatient and long-term care.
- BH5.2: Establish Tribal, Federal, and/or state collaborations that bolster wraparound services.
- BH5.3: Support and immediately implement a collaboration that supports early intervention services for behavioral health.
- BH5.4: Expand telebehavioral services to additional Tribal communities or clinics.

BH6 – Law Enforcement and Justice Programs

American Indians and Alaska Natives with mental and/or substance use disorders often end up in the criminal justice system rather than receiving care. Incarceration frequently compounds already challenging preexisting conditions, and tribes are seeking greater collaboration between the behavioral health and criminal justice systems in a way that does not further victimize Native youth and adults, supports growth, and promotes healthy living. Strategies include:

- BH6.1: Strengthen collaborations among health, behavioral health, and justice system programs of the U.S. Department of Health and Human Services, U.S. Department of Justice, and U.S. Department of the Interior to strengthen programs for Native youth that keep them out of the criminal justice system and ensure they receive needed behavioral health services.
- BH6.2: Expand the Tribal healing to wellness court programs of the U.S. Department of Health and Human Services, U.S. Department of Justice, and U.S. Department of the Interior to support diversion of Tribal members with a mental and/or substance use disorder from the criminal justice system to local behavioral health care.

Who can help advance behavioral health systems and support priorities?

CHART 4:

ADVANCING BEHAVIORAL HEALTH SYSTEMS AND SUPPORT	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
BH1.1: Support and develop a collaboration among tribes, Tribal organizations, Tribal Colleges and Universities, and Federal agencies to establish local "grow your own" behavioral health education programs and provide basic training for local Tribal behavioral health aides (community workers).			✓	✓	✓	✓
BH1.2: Establish partnerships between tribes and Addiction Technology Transfer Centers to support education, training for certification exams, and clinical supervision opportunities for behavioral health professionals working in Tribal facilities to obtain and maintain certification.				✓		
BH1.3: Support the incorporation of traditional practitioners within service delivery systems and provide training on cultural and organizational competency for all employees.				✓	✓	✓
BH1.4: Actively pursue collaborations with the HRSA National Health Service Corps Program to recruit psychiatrists, behavioral health professionals, and other practitioners to work in Tribal facilities.				✓		
BH2.1: Assess state engagement with tribes and promote meaningful state/Tribal consultations.					✓	✓
BH2.2: Monitor state behavioral health spending and support equitable resources and support to tribes and other entities providing services for Tribal members.					✓	✓
BH2.3: Increase flexibility in funding requirements to tribes to support culturally based programming that meets the programmatic needs of Tribal communities.					✓	✓
BH2.4: Develop flexibilities that allow tribes with multiple Federal grants to lower administrative costs, increase integration of funded programs, and enhance collaborative reporting.					✓	
BH2.5: Prioritize behavioral health and related programs in all budgeting processes.				✓	✓	✓
BH3.1: Consult with tribes on programs that tribes are eligible for prior to developing program announcements.					✓	✓
BH3.2: Support and engage tribes in incorporating cultural interventions into program activities that allow them to more effectively meet program expectations.					✓	✓
BH3.3: Support tribally driven assessments and implementation of strengths-based, Tribal best practices.					✓	✓

	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
BH3.4: Increase coordination and collaboration among Federal, state, Tribal, and urban programs by sharing resources, decreasing competition, and improving strategic planning.				✓	✓	✓
BH3.5: Engage tribes on their technical assistance and support needs prior to articulating technical assistance requirements.					✓	✓
BH4.1: Allow tribes the flexibility to engage youth in developing and implementing programming that target American Indian and Alaska Native youth.					✓	✓
BH4.2: Support targeted education for youth that incorporates learning their Native language, respective culture(s), and role that culture plays in supporting behavioral health.	✓	✓	✓	✓	✓	✓
BH5.1: Identify new models of care delivery that ensure more accessible intensive inpatient and long-term care.				✓	✓	✓
BH5.2: Establish Tribal, Federal, and/or state collaborations that bolster wraparound services.				✓	✓	✓
BH5.3: Support and immediately implement a collaboration that supports early intervention services for behavioral health.				✓	✓	✓
BH5.4: Expand telebehavioral services to additional Tribal communities or clinics.				✓	✓	✓
BH6.1: Strengthen collaborations among health, behavioral health, and justice system programs of the U.S. Department of Health and Human Services, U.S. Department of Justice, and U.S. Department of the Interior to strengthen programs for Native youth that keep them out of the criminal justice system and ensure they receive needed behavioral health services.					✓	
BH6.2: Expand the Tribal healing to wellness court programs of the U.S. Department of Health and Human Services, U.S. Department of Justice, and U.S. Department of the Interior to support diversion of Tribal members with a mental and/or substance use disorder from the criminal justice system to local behavioral health care.					✓	

FOUNDATIONAL ELEMENT 5:

National Awareness (NA) and Visibility

Increasing the visibility of behavioral health issues is a key strategy for ensuring that stakeholders understand the unique challenges and potential solutions for American Indian and Alaska Native communities. These challenges can include geography, lack of access to basic resources, poverty, poor living conditions, and the impacts of traumatic events. Some tribes are concerned about extensive national visibility on issues that are better addressed locally, whereas other tribes believe that openly talking about and broadening engagement of appropriate authorities will lead to funding support and better solutions for their people. Increasing visibility while ensuring that Tribal governments have the ability to control messages shared can serve to strengthen a tribe's public and behavioral health response and readiness.

Federal Support for Addressing National Awareness and Visibility Priorities

The IHS funded five campaigns to increase national awareness, including "I Strengthen My Nation" (substance use prevention campaign); "Stand Up, Stand Strong" (bullying prevention campaign); "Community Is the Healer That Breaks the Silence" (suicide prevention campaign); "What Is Done to One Is Felt by All (family violence prevention campaign); and "My Mind, Body and Spirit Are Sacred" (sexual assault prevention campaign). In addition, IHS frequently shares information and highlights behavioral health resources, prevention and treatment practices.

Other examples of engagement by Federal agencies include NIH journal articles and publications on American Indian and Alaska Native substance use issues. In addition, SAMHSA developed the "Talk. They Hear You." underage drinking prevention campaign for Tribal communities and also recently published two reports on the prevention of suicide and suicide clusters in American Indian and Alaska Native Communities. The first report, "Preventing and Responding to Suicide Clusters in American Indian and Alaska Native Communities," interviews community members to learn more about the events and responses to youth suicide clusters between 2009 and 2011 and offers recommendations for Tribal communities and for Federal, state, and local partners. The second report, "Suicide Prevention in Alaska," informs Tribal communities, policymakers, and public health professionals about suicide prevention efforts in Native Alaska communities and recommends actions to advance future suicide prevention work within those communities.

Priority Areas and Strategies

NA1 – Tribal Capacity Building

Tribes have the ability to decide what information to share and what not to share, what warrants national attention and what does not, and what steps will benefit versus further damage their communities. Should Tribal leaders choose to address behavioral health issues locally or nationally, they will require data, support, and capacity development on ways to best communicate challenges and successes in their communities. Strategies include:

- NA1.1: Support and engage in capacity-building efforts to raise the collective capacity of tribes to speak about the effectiveness of culture in prevention and care and their own best practices.
- NA1.2: Support and raise the capacity of tribes to discuss the impact of historical and intergenerational trauma within their own communities and with external partners, if they choose.
- NA1.3: Actively educate Tribal communities about behavioral health in an effort to defeat stigma and normalize topics of behavioral and emotional health.
- NA1.4: Support and raise the capacity of tribes to create and implement media and public relations plans.

NA2 – Tribally Directed Communication Strategies

In order to communicate effectively with media outlets, external and internal communities, and governmental collaborators, tribes need support on how best to exchange information and communicate in a timely and effective manner. These plans and strategies must be developed and managed in partnership with tribes.

- NA2.1: Establish a national behavioral health communications campaign, in collaboration with tribes, to educate individuals about behavioral health issues affecting Tribal communities. The campaign would focus on specific mental and substance use disorders and/or co-occurring disorders that could be shared through multiple platforms and also tailored by tribes for local use. Broad national dissemination would ensure that urban Indian populations receive similar messages and support.

- NA2.2: Develop messages for American Indians and Alaska Natives that contain positive, Native-focused, media images and incorporate the voices of survivors and Tribal strengths to discuss issues and lived experiences.

- NA2.3: Package existing communications messages developed by Federal agencies and ensure that multiple agencies leverage the messages to improve diffusion to communities requiring support and stakeholders who can assist.

- NA2.4: Create web-based tools and resources that Tribal leaders and officials can utilize to craft media communication and public relations strategies, especially during times of crisis or increased need.

NA3 – Partner Capacity Building

There are many entities that engage with tribes on health-related matters, including Federal, state, and other governments; nonprofit and community-based organizations; health and service providers; insurers; emergency response systems; and the media. These entities require continuous capacity building when working with Tribal communities to effectively engage and support change. Strategies include:

- NA3.1: Institute targeted training and technical assistance across Federal agencies about American Indian and Alaska Native populations, sovereignty, the nature of the government-to-government relationship, and issues that contribute to well-being.

- NA3.2: Engage in meaningful Tribal consultation and communication.

- NA3.3: Institute measures to increase the capacity of partners and stakeholders to understand the scope of the diversity and behavioral health challenges within Indian Country and how to treat this information in accordance with Tribal direction.

Who can help advance national awareness and visibility priorities?

CHART 5:

ADVANCING NATIONAL AWARENESS AND VISIBILITY PRIORITIES	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
NA1.1: Support and engage in capacity-building efforts to raise the collective capacity of tribes to speak about the effectiveness of culture in prevention and care and their own best practices.	✓	✓	✓	✓	✓	✓
NA1.2: Support and raise the capacity of tribes to discuss the impact of historical and intergenerational trauma within their own communities and with external partners, if they choose.	✓	✓	✓	✓	✓	✓
NA1.3: Actively educate Tribal communities about behavioral health in an effort to defeat stigma and normalize topics of behavioral and emotional health.	✓	✓	✓	✓	✓	✓
NA1.4: Support and raise the capacity of tribes to create and implement media and public relations plans.	✓	✓	✓	✓	✓	✓
NA2.1: Establish a national behavioral health communications campaign, in collaboration with tribes, to educate individuals about behavioral health issues affecting Tribal communities. The campaign would target specific mental disorders, substance use, and/or co-occurring disorders that could be shared through multiple platforms and also tailored by tribes for local use. Broad national dissemination would ensure that urban Indian populations receive similar messages and support.				✓	✓	✓
NA2.2: Develop messages for American Indians and Alaska Natives that contain positive, Native-focused, media images and incorporate the voices of survivors and Tribal strengths to discuss issues and lived experiences.	✓	✓	✓	✓	✓	✓
NA2.3: Package existing communications messages developed by Federal agencies and ensure that multiple agencies leverage the messages to improve diffusion to communities requiring support and stakeholders who can assist.				✓	✓	
NA2.4: Create web-based tools and resources that Tribal leaders and officials can utilize to craft media communication and public relations strategies, especially during times of crisis or increased need.				✓	✓	✓
NA3.1: Institute targeted training and technical assistance across Federal agencies about American Indian and Alaska Native populations, sovereignty, the nature of the government-to-government relationship, and issues that contribute to well-being..						✓
NA3.2: Engage in meaningful Tribal consultation and communication.				✓	✓	✓
NA3.3: Institute measures to increase the capacity of partners and stakeholders to understand the scope of the diversity and behavioral health challenges within Indian Country and how to treat this information in accordance with Tribal direction.				✓	✓	✓

6 MOVING FORWARD

One of the messages that framed development of the TBHA remains one of the most important messages on which to frame the path forward: There is no single entity, program, or activity alone that will improve behavioral health outcomes for American Indians and Alaska Natives. Tribal leaders asked for tribes and Federal agencies to "work together differently" to improve the wellness of their communities. Through extensive conversations, Tribal leaders, Tribal administrators, and Tribal members from communities across Indian Country provided input on what they believed was best for healing their people from traumatic events compounded over time. And, despite the differences across tribes, geography, cultures, and language, they found areas of common benefit on which to frame priorities that allow for collaborative work across sectors and governments to target the factors contributing to behavioral health problems.

The National Tribal Behavioral Health Agenda is not an end but a continuing chapter in Tribal-Federal relations. It uses as a starting place the ideas and beliefs of Tribal communities to build a path forward. Within this document are examples of Federal strategic plan goals and recommendations that are being addressed and comport with the priorities and strategies of the TBHA. That is, the path for making progress on the TBHA is largely already paved. What proceeds from here are efforts to identify through existing, well-defined structures how to ensure uptake of the priorities, support meaningful collaboration, and assess progress on a continuing basis.

The framework, priorities, and strategies of the TBHA will be shared with Tribal leaders who are members of Federal Tribal advisory councils to determine areas they would like to advance that are within the scope of the agencies with whom they work. Updates from the work of these councils will be shared with the HHS Intradepartmental Council on Native American Affairs for guidance and coordination. Federal staff members who participated in the Federal Interagency Forum on developing the TBHA found the meeting a useful platform for addressing and coordinating work and requested future meetings. To that end, future meetings will be scheduled to assess progress and identify innovative ideas.

Information on collaborative actions with tribes will be documented in a "National Tribal Behavioral Health Agenda Report." The Tribal Law and Order Act's Interagency Alcohol and Substance Abuse Data Workgroup already has drafted an initial report specifically for the TBHA that includes data sets from multiple Federal departments and will serve as a data source for comparisons on the state of mental and substance use disorders in Indian Country.

Ultimately, this work requires examination and modification of some policies, programs, activities, and beliefs about developing programs that bear significance for American Indian and Alaska Native peoples. Tribal leaders have shared the power of cultural wisdom and traditional practices for their people. They have asked for all levels of government, including Tribal governments, to respect the authenticity of cultural wisdom; accept traditional ways of being, knowing, and doing; and commit to supporting their unique ideas of health and healing through multiple means. They have asked that all interested parties trust Tribal nations to do the best for their people.

Information has been shared, priorities have been identified, and a path has been established. It is now up to Tribal, Federal, and other partners to embrace and advance meaningful collaborations.

REFERENCES

(Endnotes)

1 Substance Abuse and Mental Health Services Administration (2016). Health Care and Health Systems Integration: Overview. Retrieved from http://www.samhsa.gov/health-care-health-systems-integration.

2 National Conference of State Legislatures. (2015). Federal and state recognized tribes. Washington, DC. Retrieved from http://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx.

3 U.S. Census Bureau. (2015). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved December 21, 2015, from http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff22.html.

4 Bureau of Indian Affairs. (2015). Frequently asked questions. Retrieved December 27, 2015, from http://www.bia.gov/FAQs/

5 Snipp, C.M. (1996). The size and distribution of the American Indian population: Fertility, mortality, migration, and residence. In G.D. Sandefur, R.R. Rindfuss, & B. Cohen (Eds.) *Changing Numbers, Changing Needs: American Indian Demography and Public Health* (pp. 17-52). Washington, DC: National Academy Press.

6 U.S. Census Bureau. (2015). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved December 21, 2015, from http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff22.html.

7 U.S. Census Bureau. (2010a). 2010 Census Summary File 1(SF1) 100% Data. Retrieved from http://factfinder2.census.gov.

8 U.S. Census Bureau. (2011). *Profile American: Facts for Features, American Indian and Alaska Native Heritage Month.* Washington, DC: U.S. Census Bureau.

9 U.S. Census Bureau. (2015). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved December 21, 2015, from http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff22.html.

10 U.S. Census Bureau. (2010b). The American Indian and Alaska Native Population: 2010. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf.

11 U.S. Census Bureau. (2015). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved December 21, 2015, from http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff22.html.

12 Faircloth, S.C., & Tippeconnic III, J.W. (2010). The dropout/graduation crisis among American Indian and Alaska Native students: Failure to respond places the future of Native peoples at risk. *The Civil Rights Project/Proyecto Derechos Civiles at UCLA* Los Angeles, CA.

13 U.S. Department of the Interior. (2013). *2013 American Indian Population and Labor Force Report.* Washington, DC. Retrieved from http://www.bia.gov/cs/groups/public/documents/text/idc1-024782.pdf.

14 Austin, A. (2013). Native Americans and jobs: The challenge and the promise *EPI Briefing Paper* #370. Washington, DC: Economic Policy Institute.

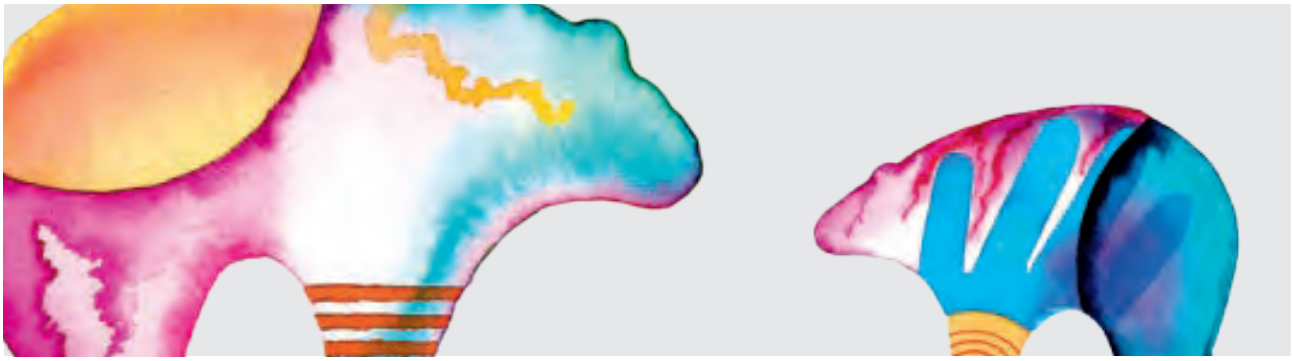
15 U.S. Census Bureau. (2015). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved December 21, 2015, from http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff22.html.

16 Castor, M.L., Smyser, M.S., Taualii, M.M., Park, A.N., Lawson, S.A., & Forquera, R.A. (2006). A nationwide population-based study identifying health disparities between American Indians/Alaska Natives and the general populations living in select urban counties. *American Journal of Public Health 96*(8), 1478-1484.

17 Goodkind, R.J., Ross-Toledo, K., & John, S. (2011). Rebuilding trust: A community, multiagency, state, and university partnership to improve behavioral health care for American Indian youth, their families, and communities. *Journal of Community Psychology 39*(4), 452-477.

18 Castor, M.L., Smyser, M.S., Taualii, M.M., Park, A.N., Lawson, S.A., & Forquera, R.A. (2006). A nationwide population-based study identifying health disparities between American Indians/Alaska Natives and the general populations living in select urban counties. *American Journal of Public Health 96*(8), 1478-1484.

19 Indian Health Service. (2015). Disparities. Rockville, MD. Retrieved from https://www.ihs.gov/newsroom/index.cfm/factsheets/disparities/.



20 Welty, T.K. (2002). The epidemiology of alcohol use and alcohol-related health problems among American Indians and Alaska Natives. In P.D. Mail, S. Heurtin-Roberts, S.E. Martin, & J. Howard (Eds.). *Alcohol Use Among American Indians and Alaska Natives: Multiple Perspectives on a Complex Problem* (Vol. 37, pp. 49-70). Bethesda, MD: U.S. Department of Health and Human Services.

21 Ehlers, C.L., Gizer, I.R., Gilder, D.A., Ellingson, J.M., & Yehuda, R. (2013). Measuring historical trauma in an American Indian community sample: Contributions of substance abuse dependence, affective disorder, conduct disorder, and PTSD. *Drug and Alcohol Dependence 133*, 180-187.

22 U.S. Department of Health and Human Services. (2009b). *Regional Difference in Indian Health: 2002-2003*. Rockville, MD: U.S. Department of Health and Human Services.

23 Alcantara, C., & Gone, J.P. (2007). Reviewing suicide in Native American communities: Situating risk and protective factors within a transactional-ecological framework. *Death Studies 31*(5), 457-477. doi: 10.1080/07481180701244587.

24 Stannard, D.E. (1992). *American Holocaust: The Conquest of the New World*. New York, NY: Oxford University Press.

25 Thornton, R. (1987). *American Indian holocaust and survival: A population history since 1492*. Norman, OK: University of Oklahoma Press.

26 Brave Heart, M.Y.H. (1999a). Gender differences in the historical trauma response among the Lakota. *Journal of Health and Social Policy 10*(4), 1-21.

27 Brave Heart, M.Y.H. (1999b). Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents. *Journal of Human Behavior in the Social Environment 2*(1-2), 109-126.

28 Brave Heart, M.Y.H. (2000). Wakiksuyapi: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare* (21-22), 245-266.

29 Braveheart, M.Y.H., & DeBruyn, I.M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research 8*(2), 56-78.

30 Barnes, P.M., Adams, P.F., & Powell-Griner, E. (2010). Health characteristics of the American Indian or Alaska Native adult population: United States, 2004-2008. *National Health Statistics Report 9*(20), 1-22.

31 Bombay, A., Matheson, K., & Anisman, H. (2011). The impact of stressors on second generation Indian residential school survivors. *Transcultural Psychiatry 48*(4), 367-391.

32 Lemstra, M., Rogers, M., Thompson, A., Moraros, J., & Buckingham, R. (2012). Risk indicators associated with injection drug use in the Aboriginal population. *AIDS Care 24*(11), 1416-1424.

33 Elias, B., Mignone, J., Hall, M., Hong, S.P., Hart, L., & Sareen, J. (2012). Trauma and suicide behavior histories among a Canadian indigenous population: An empirical exploration of the potential role of Canada's residential school system. *Social Science & Medicine 74*(10), 1560-1569.

34 Brockie, T.N., Heinzelmann, M., & Gill, J. (2013). A framework to examine the role of epigenetics in health disparities among Native Americans. *Nursing Research and Practice 2013*(Article ID 310395). doi: 1155/2013/410395.

35 Whitbeck, L.B., Adams, G.W., Hoyt, D.R., & Chen, X. (2004a). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology 33*(3-4), 119-130.

36 Whitbeck, L.B., Chen, X., Hoyt, D.R., & Adams, G.W. (2004b). Discrimination, historical loss, and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among American Indians. *Journal of Studies on Alcohol and Drugs 65*(4), 409-418.

37 Roubideaux, Y. (2005). Beyond Red Lake – The persistent crisis in American Indian health care. *The New England Journal of Medicine 353*(18), 1881-1883.

38 Hodge, F.S. (2012). No meaningful apology for American Indian unethical abuses. *Ethics & Behavior 22*(6), 431-444. doi: 101080/10508422.2012.730788.

39 Spruhan, P. (2006). A legal history of blood quantum in federal Indian law to 1935. *South Dakota Law Review 51*, 1-50.

40 Frosch, D. (2015). Federal panel reviewing Native American sentencing. Wall Street Journal. Retrieved from http://www.wsj.com/articles/federal-panel-reviewing-native-american-sentencing-1429608601.

41 Greenfield, L.A., & Smith, S.K. (1999). American Indians and crime. Washington, DC: U.S. Department of Justice. Retrieved from http://www.bjs.gov/content/pub/pdf/aic.pdf.

42 Walker, C. (2014). Judge: SD Indian child welare case can proceed. *Yahoo! News*. http://news.yahoo.com/judge-sd-indian-child-welfare-case-proceed-214004318.html.

43 Borowsky, I.W., Resnick, M.D., Ireland, M., & Blum, R.W. (1999). Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors. *Archives of Pediatric Adolescent Medicine 153*, 573-580.

44 Clark, D.B., Lesnick, L., & Hegedus, A.M. (1997). Traumas and other adverse life events in adolescents with alcohol abuse and dependency. *Journal of the American Academy of Child and Adolescent Psychiatry 36*(12), 1744-1751.

45 Bohn, D.K. (2003). Lifetime physical and sexual abuse, substance abuse, depression, and suicide attempts among Native American women. *Issues in Mental Health Nursing 24*(3) (333-352).

46 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

47 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

48 Fixico, D.L. (2013). *Indian resilience and rebuilding: Indigenous nations in the modern American West*: University of Arizona Press.

49 Annie E. Casey Foundation. (2009). Seeing the protective rainbow: How families survive and thrive in the American Indian and Alaska Native community. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-howfamiliessurviveindianandalaskan-2009.pdf#page=1.

50 National Aboriginal Community Controlled Health Organization. (2009). Retrieved from http://www.naccho.org.au/aboriginal-health/definitions/.

51 National Aboriginal Community Controlled Health Organization. (2009). Retrieved from http://www.naccho.org.au/aboriginal-health/definitions/.

52 Bombay, A., Matheson, K., & Anisman, H. (2011). The impact of stressors on second generation Indian residential school survivors. *Transcultural Psychiatry 48*(4), 367-391.

53 Lemstra, M., Rogers, M., Thompson, A., Moraros, J., & Buckingham, R. (2012). Risk indicators associated with injection drug use in the Aboriginal population. *AIDS Care 24*(11), 1416-1424.

54 Elias, B., Mignone, J., Hall, M., Hong, S.P., Hart, L., & Sareen, J. (2012). Trauma and suicide behavior histories among a Canadian indigenous population: An empirical exploration of the potential role of Canada's residential school system. *Social Science & Medicine 74*(10), 1560-1569.

55 Hess, K.L., Javanbakht, M., Brown, J.M., Weiss, R.E., Hsu, P., & Gorback, P.M. (2012). Intimate partner violence and sexually transmitted infections among young adult women. *Sexually Transmitted Diseases 39*(5), 366-371. doi: 10.1097/OLQ.0b013e3182478fa5.

56 Laudenslager, M.L., Noonan, C., Jacobsen, C., Goldberg, J., Buchwald, D., Bremner, J.D., & Manson, S.M. (2009). Salivary cortisol among American Indians with and without posttraumatic stress disorder (PTSD): Gender and alcohol influences. *Brain, Behavior, and Immunity 23*(5), 658-662. doi: 10.1016/j.bbi.2008.12.007.

57 Perry, S.W. (2004). American Indians and crime: A BJS statistical profile, 1992-2002. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

58 Greenfield, L.A., & Smith, S.K. (1999). American Indians and crime. Washington, DC: U.S. Department of Justice. Retrieved from http://www.bjs.gov/content/pub/pdf/aic.pdf.

59 Ackard, D.M., Eisenberg, M.E., Neumark-Sztainer, D. (2007). Long-term impact of adolescent dating violence on the behavioral and psychological health of male and female youth. *Journal of Pediatrics 151*(5), 476-481.

60 Alleyne-Green, B., Coleman-Cowger, V.H., Henry, D.B. (2012). Dating violence perpetration and/or victimization and associated sexual risk behaviors among a sample of innter-city African American and Hispanic females. *Journal of Interpersonal Violence 27*(8), 1457-1473. doi: 10.1177/0886260511425788.

61 Coker, A.L., McKeown, R.E., Sanderson, M., Davis, K.E., Valois, R.F., Huebner, E.S. (2000). Severe dating violence and quality of life among South Carolina high school students. *American Journal of Preventive Medicine 19*(4), 220-227.

62 Lormand, D.K., Markham C.M., Peskin, M.F., Byrd, T., Addy, R.C., Baumler, E.R., Tortolero, S.R. (2013). Dating violence among urban, minority, middle school youth and associated sexual risk behaviors and substance use. *Journal of School Health 83*(6), 415-421.

63 Roberts, T.A., Klein, J.D., & Fisher, S. (2003). Longitudinal effect of intimate partner abuse on high-risk behavior among adolescents. *Archives of Pediatrics and Adolescent Medicine 157*, 875-881.

64 Silverman, J.G., Raj, A., Mucci, L.A., & Hathaway, J.E. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association 286*(5), 572-579.

65 Temple, J. R., & Freeman, D. (2011). Dating violence and substance use among ethnically diverse adolescents. *Journal of Interpersonal Violence, 26*(701-718).

66 Wolitzky-Taylor, K.B., Ruggiero, K.J., Danielson, C.K., Resnick, H.S., Hanson, R.F., Smith, D.W, Saunders, B.E. & Kilpatrick, D.G. (2008). Prevalence and correlates of dating violence in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry 47*(7), 755-762.

67 Morsette, A., van den Pol, R., Schuldberg, D., Swaney, G., & Stolle, D. (2012). Cognitive behavioral treatment for trauma symptoms in American Indian youth: Preliminary findings and issues in evidence-based practice and reservation culture. *Advances in School Mental Health Promotion 5*, 51-62. doi: 10.1080/1754730X.2012.664865.

68 Greenfield, L.A., & Smith, S.K. (1999). American Indians and crime. Washington, DC: U.S. Department of Justice. Retrieved from http://www.bjs.gov/content/pub/pdf/aic.pdf.

69 Lakota People's Law Project. (2015). Native lives matter. *Lakota People's Law Project.*

70 Males, M. (2014). Who are police killing. *Center on Juvenile and Criminal Justice.* Retrieved from www.cjcj.org website: http://www.cjcj.org/news/8113.

71 Perry, S.W. (2004). American Indians and crime: A BJS statistical profile, 1992-2002. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

72 Ryan, L. (2015). Divest from incarcerating youth, reinvest in our youth. National Council on Crime & Delinquency. Retrieved from http://www.nccdglobal.org/blog/divest-from-incarcerating-youth-reinvest-in-our-youth.

73 Scott, D. (2015). *Rapid risk assessments for American Indian youth.* Believing in Native Generations. Anadarko, OK. Retrieved from http://bling562.org/projects/

74 La Vigne, N.G., Davis, E., & Brazzell, D. (2008). Broken bonds: Understanding and addressing the needs of children with incarcerated parents. Washington, DC: Urban Institute.

75 General Assembly of the Commmonwealth of Pennsylvania. (2011). *The effects of parental incarceration on children: Needs and responsive services.* Retrieved from http://jsg.legis.state.pa.us/resources/documents/ftp/documents/children%20of%20incarcerated%20parents.pdf.

76 U.S. Government Accountability Office. (2011). Child welfare: More Information and Collaboration Could Promote Ties Between Foster Care Children and Their Incarcerated Parents. Retrieved from http://www.gao.gov/products/GAO-11-863#sthash.yUnhMngw.dpuf.

77 La Vigne, N.G., Davis, E., & Brazzell, D. (2008). Broken bonds: Understanding and addressing the needs of children with incarcerated parents. Washington, DC: Urban Institute.

78 Phillips, S.D., & Gleeson, J.P. (2007). What we know now that we didn't know then about the criminal justice system's involvement in families with whom child welfare agencies have contact. Retrieved from http://www.f2f.ca.gov/res/pdf/WhatWeKnowNow.pdf#sthash.yUnhMngw.dpuf.

79 U.S. Department of Veterans Affairs (2015). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from http://www.va.gov/vetdata/docs/specialreports/aianpaper9-12-06final.pdf

80 U.S. Department of Housing and Urban Development. (2015). *Native Americans in the military*. Retrieved from http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/ih/codetalk/onap/veterans.

81 Holiday, L.F., Bell, G., Klein, R.E., & Wells, M.R. (2006). *American Indian and Alaska Native veterans: Lasting contributions.* Washington, DC: VA Office of Policy Assistant Secretary for Policy, Planning, and Preparedness.

82 Friedman, M.J., Ashcraft, M.L., Beals, J.A., Keane, T.M., Manson, S.M., & Marsella, A.J. (1997). *Maatsunaga Vietnam Veterans Project (Volumes 1 and 2)*: National Center for Posttraumatic Stress Disorder and National Center for American Indian and Alaska Native Mental Health Research.

83 Kulka, R.A., Schlenger, W.A., Fairbanks, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., & Cranston, A.S. (1990). *Trauma anad the Vietnam war generation: Report of findings from the National Vietnam Veterans Readjustment Study*. New York: Brunneer/Mazel.

84 Jacobsen, L.K., Southwick, S.M., & Kosten, T.R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Pschiatry 158*(8), 1184-1190. doi: 10.1176/appi.ajp.1184.

85 Ouimette, P., Read, J.P., Wade, M., & Tirone, V. (2010). Modeling associations between posttraumatic stress symptoms and substance use. *Addictive Behaviors 35*(1), 64-67. doi: 10.1016/j.addbeh.2009.08.009.

86 U.S. Department of Veterans Affairs (2015). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from http://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf

87 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review*. Seattle, WA: Urban Indian Health Institute.

88 Urban Indian Health Commission. (2007). *Invisible Tribes: Urban Indians and Their Health in a Changing World*. Seattle, WA.

89 Substance Abuse and Mental Health Services Administration. (2007). *Results from the 2006 National Survey on Drug Use and Health: National findings.* Rockville, MD.

90 Byers, L.G. (2006). Depression, discrimination, trauma, and American Indian ethnic identity. *ProQuest Information and Learning, 67*, 717.

91 Substance Abuse and Mental Health Services Administration. (2007). *Results from the 2006 National Survey on Drug Use and Health: National findings.* Rockville, MD.

92 Forrest, K.Y.Z., Leeds, M., Williams, A., & Lin, Y. (2001). *High depression rate in Native American children.* Paper presented at the 129th Annual Meeting of APHA. https://apha.confex.com/apha/129am/techprogram/paper_20430.htm.

93 U.S. Department of Health and Human Services (2010). National healthcare disparities report. Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr10/index.html

94 Wolsko, C., Lardon, C., Mohatt, G.V., & Orr, E. (2007). Stress, coping, and well-being among the Yup'ik of the Yukon-Kuskokwim delta: The role of enculturation. *International Journal of Circumpolar Health 66*, 51-61.

95 Kunitz, S.J. (2008a). Changing patterns of mortality among American Indians. *American Journal of Public Health 98*(3), 404-411.

96 Scott, D. (2015). *Rapid risk assessments for American Indian youth.* Believing in Native Generations. Anadarko, OK. Retrieved from http://bling562.org/projects/

97 Hall, K. (2015). How grief affects the body. Retrieved from http://www.qualityhealth.com/depression-articles/how-grief-affects-body.

98 Atkins, S., Lanfear, C., Cline, S., & Mosher, C. (2013). Patterns and correlates of adult American Indian substance use. *Journal of Drug Issues 43*(4), 497-516. Retrieved on May 12, 2015, from http://search.proquest.com.library.capella.edu/docview/1450252713?accountid=27965.

99 Trimble, J.E. (2007). Prolegomena for the connotation of construct use in the measurement of ethnic and racial identity. *Journal of Counseling Psychology 54*(3), 247-258.

100 Substance Abuse and Mental Health Services Administration. (2010). *Results From the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings.* HHS Publication No. SMA 10-4586). Rockville, MD: Office of Applied Studies. Retrieved from http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9Results.htm.

101 Beals, J., Spicer, P., Mitchell, C.M., Novins, D.K., & Manson, S.M. (2003). Racial disparities in alcohol use: Comparison of two American Indian reservation populations with national data. *American Journal of Public Health 93*(10), 1683-1685.

102 Walls, M.L., Whitbeck, L.B., Hoyt, D.R., & Johnson, K.D. (2007). Early-onset alcohol use among Native American youth: Examining female caretaker influence. *Journal of Marriage and Family 69*(2), 451-464.

103 Mitchell, C.M., Beals, J., Novins, D.K., & Spicer, P. (2003). Drug use among two American Indian populations: Prevalence of lifetime use and DSM-IV substance use disorders. *Drug and Alcohol Dependence 69*, 29-41.

104 Nez-Henderson, P., Jacobsen, C., & Beals, J. (2005). Correlates of cigarette smoking among selected Southwest and Northern Plains tribal groups: The AI-SUPERPFP study. *American Journal of Public Health 95*(5), 867-872.

105 Beals, J., Spicer, P., Mitchell, C.M., Novins, D.K., & Manson, S.M. (2003). Racial disparities in alcohol use: Comparison of two American Indian reservation populations with national data. *American Journal of Public Health 93*(10), 1683-1685.

106 O'Connell, J.M., Novins, D.K., Beals, J., & Spicer, P. (2005). Disparities in patterns of alcohol use among reservation-based and geographically dispersed American Indian populations. *Alcoholism: Clinical and Experimental Research 29*(1), 107-116.

107 Arizala 2012. The effects of parental historical trauma and stressful events on youth outcomes in American Indian families. *ProQuest Information and Learning* 73, 1281.

108 Kunitz, S.J. (2008b). Risk factors for polydrug use in a Native American poulation. *Substance Use and Misuse 43*, 331-339.

109 Novins, D.K. (2004). Substance use: The hazards for progression for adolescents ages 14 to 20. *Journal the American Academy of Child and Adolescent Psychiatry 43*, 316-324.

110 Whitbeck, L.B., Yu, M., Johnson, K.K., Hoyt, D.R., & Walls, M.L. (2008). Diagnostic prevalence rates from early to mid-adolescence among indigenous adolescents: First results from a longitudinal study. *Journal of the American Academy of Child and Adolescent Psychiatry 47*(8), 890-900.

111 O'Connell, J.M., Novins, D.K., Beals, J., & Spicer, P. (2005). Disparities in patterns of alcohol use among reservation-based and geographically dispersed American Indian populations. *Alcoholism: Clinical and Experimental Research 29*(1), 107-116.

112 Northwest Portland Area Indian Health Board IDEA-NW Project. 2016. Unpublished death certificate data from Idaho, Oregon, and Washington.

113 Great Lakes Inter-Tribal Council (GLITC), Substance Abuse and Mental Health Services Administration Strategic Prevention Framework State Incentive Grant (SPF-SIG) #5U79SP013935. WINAPC SPF-SIG: 2011 Aggregated Community Assessment. Prepared by BEAR Consulting, LLC (2012).

114 National Alliance on Mental Illness. (2009). American Indian and Alaska Native women and depression fact sheet. Retrieved from http://nami.org/Template.cfm?Section-Women_and_Depression&Template=/ConstantManagement/ConstantDisplay.cfm&ConstantID=88885.

115 Suicide Prevention Resource Center. (2011). *Suicide Among Racial/Ethnic Populations in the U.S. American Indians/Alaska Natives.* Newton, MA.

116 Centers for Diease Control and Prevention. (2014). *Web-based Injury Statistics Query and Reporting System.* National Center for Injury Prevention and Control. Retrieved from HTTP://www.cdc.gov/injury/wisqars/index.html.

117-A Alaska Native Epidemiology Center & Alaska Native Tribal Health Consortium. (2009). Alaska Native health Status Report. Anchorage, AK.

117-B Jiang, C., Mitran, A., Miniño, A., Ni, H. (2015). Racial and Gender Disparities in Suicide Among Young Adults Aged 18-24: United States, 2009-2013. Retrieved from http://www.cdc.gov.nchs/data/hestat/suicide/racial_and_gender_2009_2013.pdf

118 Taylor, M.A., Anderson, E.M., & Bruguier Zimmerman, M.J.B. (2014). Suicide prevention in rural, tribal communities: The intersection of challenge and possibility. *Journal of Rural Mental Health 38*(2), 87-97.

119 Strickland, J. (1997). Suicide among American Indian, Alaska Native, and Canadian aboriginal youth: Advancing the research agenda. *International Journal of Mental Health, 25*(4), 11-32.

120 U.S. Department of Health and Human Services. (2009a). *An American Indian/Alaska Native Suicide Prevention Hotline: Literature and Discussion With Experts, November 2009.* Retrieved from https://aspe.hhs.gov/basic-report/aian-suicide-prevention-hotline-literature-review-and-discussion-experts#risk.

121 Strickland, J. (1997). Suicide among American Indian, Alaska Native, and Canadian aboriginal youth: Advancing the research agenda. *International Journal of Mental Health, 25*(4), 11-32.

122 Anda, R.F., Butchart, A., Felitti, V.J., & Brown, D.W. (2010). Building a framework for global surveillance of the public health implications of adverse childhood experiences. *American Journal of Preventive Medicine 39*, 93-98. doi: 10.1016/j.amepre.2010.03.015

123 Strickland, J. (1997). Suicide among American Indian, Alaska Native, and Canadian aboriginal youth: Advancing the research agenda. *International Journal of Mental Health, 25*(4), 11-32.

124 Walls, M.L., Whitbeck, L.B., Hoyt, D.R., & Johnson, K.D. (2007). Early-onset alcohol use among Native American youth: Examining female caretaker influence. *Journal of Marriage and Family 69*(2), 451-464.

125 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

126 Cashin, J. (2001). Trauma and multigenerational trauma caused by genocide and oppression: A comparison of Western and Native American healing methods. *ProQuest Information and Learning* (61), 6758.

127 Frank, J.D. (1973). *Persuasion and healing.* Baltimore: Johns Hopkins University Place.

128 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

129 Whitesell, N.R., Beals, J., BigCrow, C., Mitchell, C.M., & Novis, D.K. (2012). Epidemiology and etiology of substance use among American Indian and Alaska Natives: Risk, protection, and implications for prevention. *American Journal of Drug and Alcohol Abuse 38*(5), 376-382. doi: 10.3109/000952990.2012.694527.

130 Manson, S.M. (2001). *Behavioral health services for American Indians: Need, use, and barriers to effective care*. Washington, DC: American Public Health Association.

131 Barlow, L.T., & Thompson, K.R. (2009). *Re-kindling the fire: Healing historical trauma in Native American prison inmates*: In Psychiatrists and Traditional Healers – Unwitting Partners in Global Mental Health. M. In Incayawar, R. Wintrob and L. Bouchard, Eds. Oxford, Wiley Blackwell.

132 Wright, S., Nebelkoph, E., King, J., Maas, M., Patel, C., & Samuel, S. (2011). Holistic system of care: Evidence of effectiveness. *Substance Use and Misuse 46*(11), 1420-1430.

133 Whitesell, N.R., Beals, J., BigCrow, C., Mitchell, C.M., & Novis, D.K. (2012). Epidemiology and etiology of substance use among American Indian and Alaska Natives: Risk, protection, and implications for prevention. *American Journal of Drug and Alcohol Abuse 38*(5), 376-382. doi: 10.3109/000952990.2012.694527.

134 Brown, B.G., Baldwin, J.A., & Walsh, M.L (2012). Putting tribal nations first: Historical trends, current needs, and future directions in substance use prevention for American Indian and Alaska youths. In C. Camp-Yeaky (Series Ed.) & S.R. Notaro (Vol. Ed.), *Advances in Education in Diverse Communities: Research, Policy and Praxis. 9*, pp. 3-47).

135 Brave Heart, M.Y.H. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work 68*(3), 288-305.

136 Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence 23*(3), 316-338.

137 Fisher, P.A., & Ball, T.J. (2003). Tribal participatory research: Mechanisms of a collaborative model. *American Journal of Community Psychology 32*(3-4), 207-216.

138 Gone, J.P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology 77*(4), 751-762.

139 Goodkind, R.J., Ross-Toledo, K., & John, S. (2011). Rebuilding trust: A community, multiagency, state, and university partnership to improve behavioral health care for American Indian youth, their families, and communities. *Journal of Community Psychology 39*(4), 452-477.

140 McCabe, G.H. (2007). The healing path: a culture and community-derived indigenous therapy model. *Psychotherapy 44*(2), 148-160.

141 Strickland, C.J., Walsh, E., & Cooper, M. (2006). Healing fractured families: Parents' and elders' perspectives on the impact of colonization and youth suicide prevention in a Pacific Northwest American Indian tribe. *Journal of Transcultural Nursing 17*(1), 5-12.

142 Walters, K.L., Simoni, J.M., & Evans-Campbell, T. (2002). Substance use among American Indians and Alaska Natives: Incorporating culture in an "Indigenist" stress-coping paradigm. *Public Health Reports 117*(1), 104-117.

143 American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist 61*, 271-285. doi: 10.1037/0003-066X.61.4.271.

144 Indian Health Manual, Special General Memorandum 94-8: Statement of Policy for the Traditional Cultural Advocacy Program. July 29, 1994. Retrieved from: https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_sgm_main&sgm=ihm_sgm_9408.

145 Coyhis, D., & Simonelli, R. (2008). The Native American Healing Experience. *Substance Use and Misuse 43*(12-13), 1927-1949.

146 Taylor, M.A., Anderson, E.M., & Bruguier Zimmerman, M.J.B. (2014). Suicide prevention in rural, tribal communities: The intersection of challenge and possibility. *Journal of Rural Mental Health 38*(2), 87-97.

147 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

148 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review*. Seattle, WA: Urban Indian Health Institute.

149 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

150 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review*. Seattle, WA: Urban Indian Health Institute.

151 Roubideaux, Y. (2004). A review of the quality of health care for American Indians and Alaska Natives. The Commonwealth Fund

152 Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

153 Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

154 Roberts, J., & Jones, J.D. (2004). Health disparities challenge public health among Native Americans. *Northwest Public Health* (Fall/Winter), 8-10.

155 Urban Indian Health Commission. (2007). *Invisible Tribes: Urban Indians and Their Health in a Changing World*. Seattle, WA.

156 Indian Health Service. 2011. Inpatient mental health assessmemt. Retrieved from https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf

157 Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

158 National Indian Health Board. (2015a). Congress unveils FY 2016 omnibus spending agreement. *Legislative Action Alert*. Retrieved from http://archive.constantcontact.com/fs190/1110714960954/archive/1123222688121.html.

159 Robert Wood Johnson Foundation. (2007). Significant health care needs of American Indians and Alaska Natives living in urban areas go unmet. Retrieved December 24, 2015, from http://www.rwjf.org/en/library/articles-and-news/2007/11/significant-health-care-needs-of-american-indians-and-alaska-nat.html.

160 Williams, T. (2013). Quietly, Indians reshape cities and reservations. *New York Times*. Retrieved from http://www.nytimes.com/2013/04/14/us/as-american-indians-move-to-cities-old-and-new-challenges-follow.html?_r=0.

161 Roberts, J., & Jones, J.D. (2004). Health disparities challenge public health among Native Americans. *Northwest Public Health* (Fall/Winter), 8-10.

162 Roubideaux, Y. (2005). Beyond Red Lake – The persistent crisis in American Indian health care. *The New England Journal of Medicine 353*(18), 1881-1883.

163 Woodard, S. (2012). Suicide is epidemic for American Indian youth: What more can be done? *NBCNews*. Retrieved from http://investigations.nbcnews.com/_news/2012/10/10/14340090-suicide-is-epidemic-for-american-indian-youth-what-more-can-be-done.

164 U.S. Department of Health and Human Services. How does the Affordable Care Act impact American Indians and Alaska Natives? Retrieved January 17, 2016, from http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/aca-and-american-indian-and-alaska-native-people/index.html.

165 Vestal, C. (2013). Affordable Care Act a hard sell for Native Americans. *Stateline*. Retrieved from http://www.usatoday.cm/story/news/nation/2013/10/15/state-line-obamacare-native-americans/2986747/.

166 Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

167 Office of Inspector General. (2011). *Access to mental health services at Indian Health Service and tribal facilities*. Washington, DC. Retrieved from http://oig.hhs.gov/oei/reports/oei-09-08-00580.pdf.

168 U.S. Department of Health and Human Services. (2011). *Behavioral Health Fact Sheet*. Rockville, MD. Retrieved from http://www.ihs.gov/PublicAffairs/IHSBrochure/Bhealth.asp.

169 Urban Indian Health Institute. (2011). *Community Health Profile: National Aggregate of Urban Indian Health Organization Service Areas.* Seattle, WA. Retrieved from http://www.uihi.org/wp-content/uploads/2011/12/COmbined-UIHO-CHP_Final.pdf.

170 Manson, S.M. (2001). *Behavioral health services for American Indians: Need, use, and barriers to effective care.* Washington, DC: American Public Health Association.

171 Novins, D.K., Moore, L.A., Beals, J., & Kaufman, C.E. (2012). A framework for conducting a national study of substance abuse treatment programs serving American Indian and Alaska Native communities. *American Journal of Drug and Alcohol Abuse 38*(5). doi: 10.3109/00952990.2012.694529.

172 U.S. Department of Health and Human Services. (2014). *Access to Mental Health Services at Indian Health Service and Tribal Facilities.*

173 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review.* Seattle, WA: Urban Indian Health Institute.

174 Indian Health Service. (2011). *Inpatient mental health assessment.* Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

175 Abdullah, T., & Brown, T.L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review 31*, 934-948.

176 Connor, K.O., Koeske, G., & Brown, C. (2009). Racial differences in attitudes toward professional mental health treatment: The mediating effect of stigma. *Journal of Gerontological Social Work 52*, 695-712. doi: 10.1080/01634370902914372.

177 Gonzalez, J.M., Alegria, M., & Prihoda, T.J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of Community Psychology 33*, 611-629. doi: 10.1002/jcop.20071.

178 Poleshuck, E.L., Cerrito, B., Leshoure, N., Finocan-Kaag, G., & Kearney, M.H. (2013). Underserved women in a women's health clinic describe their experiences of depressive symptoms and why the have low uptake of psychotherapy. *Community Mental Health Journal 49*, 50-60. doi: 101007/s10597-012-9500-7.

179 McCabe, K.M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal of Child and Family Studies 11*, 347-359. doi: 10.1023/A:1016876224388.

180 O'Sullivan, M.J., Peterson, P.D., Cox, G.B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology 17*, 17-30. doi: 10.1007/BF00931200.

181 Coyhis, D., & Simonelli, R. (2008). The Native American Healing Experience. *Substance Use and Misuse 43*(12-13), 1927-1949.

182 Gone, J.P., & Trimble, J.E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology 8*, 131-160. doi: 10.1146/annrev-climpsy-032511-143127.

183 Jimenez, D.E., Bartels, S.J., Cadenas, V., & Alegria, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care. *International Journal of Geriatric Psychiatry 28*, 1061-1068. doi: 10.1002/gps.3928. Jimenez, D.E., Bartels, S.J., Cadenas, V., & Alegria, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care. *International Journal of Geriatric Psychiatry 28*, 1061-1068. doi: 10.1002/gps.3928.

184 Vogel, D.L., Wade, N.G., & Hackler, A.H. (2007). Perceived social stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology 54*, 40-50. doi: 10.1037/0022-0167.54.1.40.

185 Zhang, N., & Dixon, D.N. (2003). Acculturation and attitudes of Asian international students toward seeking psychological help. *Journal of Multicultural Counseling and Development 31*, 205-222. doi: 10.1002/j.2161-191.2003.tb00544.x.

186 Zhang, N., & Dixon, D.N. (2003). Acculturation and attitudes of Asian international students toward seeking psychological help. *Journal of Multicultural Counseling and Development 31*, 205-222. doi: 10.1002/j.2161-191.2003.tb00544.x.

187 Drabiak-Syed, K. (2010). Lessons from Havasupai Tribe v. Arizona State University Board of Regents: Recognizing Group, Cultural, and Dignitary Harms as Legitimate Risks Warranting Integration into Research Practice. *Journal of Health & Biomedical Law, VI*: 175-225.

188 Advisory Committee on Human Radiation Experiments. *Chapter 12: The Iodine 131 Experiment in Alaska.* Retrieved at: https://bioethicsarchive.georgetown.edu/achre/final/chap12_4.html

189 National Indian Health Board. (2015b). Tribal epidemiology centers. Retrieved from http://www.nihb.org/tribal_resources/tribal_epidemiology.php.

190 Roberts, J., & Jones, J.D. (2004). Health disparities challenge public health among Native Americans. *Northwest Public Health* (Fall/Winter), 8-10.

191 Thomas, L.R., Donovan, D.M., Sigo, R.L., Austin, L., & Marlatt, G.A. (2009). The community pulling together: A tribal community-university partnership project to reduce substance abuse and promote good health in a reservation tribal community. *Journal of Ethnicity in Substance Abuse 8*(3), 283.

192 Pewewardy, C., & Hammer, P. C. (2003). Culturally Responsive Teaching for American Indian Students. ERIC Digest.

193 Hallett, D., Chandler, M.J., & Lalonde, C.E. (2007). Aboriginal language knowledge and youth suicide. *Cognitive Development 22,* 392-399.

194 Whitesell, N.R., Beals, J., BigCrow, C., Mitchell, C.M., & Novis, D.K. (2012). Epidemiology and etiology of substance use among American Indian and Alaska Natives: Risk, protection, and implications for prevention. *American Journal of Drug and Alcohol Abuse 38*(5), 376-382. doi: 10.3109/000952990.2012.694527.

195 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review.* Seattle, WA: Urban Indian Health Institute.

196 Brown, B.G., Baldwin, J.A., & Walsh, M.L (2012). Putting tribal nations first: Historical trends, current needs, and future directions in substance use prevention for American Indian and Alaska youths. In C. Camp-Yeaky (Series Ed.) & S.R. Notaro (Vol. Ed.), *Advances in Education in Diverse Communities: Research, Policy and Praxis. 9*, pp. 3-47).

197 Brave Heart, M.Y.H. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work 68*(3), 288-305.

198 U.S. Department of Justice. Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence: Ending Violence so Children Can Thrive, November 2014.

199 U.S. Department of Justice. Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence: Ending Violence so Children Can Thrive, November 2014.

200 Walrath, C., Godoy Garraza, L., Reid, H., Goldston, D. B., McKeon, R., (2015). Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Suicide Mortality. *American Journal of Public Health.* 105(5), pp. 986-993.

201 Godoy Garraza, L., Walrath, C., Goldston, D. B., Reid, H., McKeon, R., (2015). Impact of the Garrett Lee Smith Memorial Suicide Prevention Program on Suicide Attempts Among Youths. *JAMA Psychiatry*. 72(11): pp. 1143-9.

APPENDIXES

APPENDIX 1.
HIGHLIGHTS OF KEY NATIONAL TBHA INFORMATION GATHERING SESSIONS

EVENT	DATE	ACTIVITIES	APPROXIMATE PARTICIPATION
SAMHSA Tribal Technical Advisory Committee (TTAC)	2014 & 2015	Discussion on SAMHSA's internal Tribal Behavioral Health Agenda led to discussion on a national TBHA	8 tribal leaders (each year)
HHS Secretary's Tribal Advisory Committee	2014 & 2015	Discussion on accomplishments in health policy, services and resources and the need to continue momentum	14 tribal leaders 25 tribal representatives (each year)
White House Tribal Nations Conference	2014	First session on mental health was held	20 tribal leaders 20 audience members
HHS Regional Tribal Consultation – Nashville Area	2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented	5 tribal leaders and 25 audience members
Tribal Self-governance Conference Session	2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented with input sought	35 tribal leaders and members
National Tribal Advisory Committee on Behavioral Health	2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented with input sought	7 Tribal representatives, 3 IHS Behavioral Health staff and 8 audience members
Department of Health and Human Services Annual Tribal Budget Consultation Session	2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented with input sought	35 Tribal Leaders and 30 audience members
NIHB Board of Directors Meetings	March 4, 2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented	10 Tribal leaders 15 audience members
	Sept. 20, 2015	A discussion was held on the content of the THBA and a resolution was passed in unanimous support of the TBHA	11 Tribal leaders 10 audience members
	Jan. 21, 2016	Board received an update on the development of the TBHA and a question and answer session was held on the content of the TBHA	10 Tribal leaders 20 audience members
NIHB National Tribal Public Health Summit	April 7, 2015	A special three hour session was held where facilitated small groups brainstormed outstanding needs and potential solutions to behavioral health challenges in Indian Country	80 Tribal members, public health practitioners, or stakeholders

EVENT	DATE	ACTIVITIES	APPROXIMATE PARTICIPATION
NIHB Annual Consumer Conference	Sept. 21, 2015	A special session was held where Tribal and federal leaders discussed the need for a TBHA, and written and verbal input was gathered from participants on the content and structure for the TBHA	120 Tribal members, Tribal leaders, health advocates, or stakeholders
	Sept. 24, 2015	A world Café style input session was facilitated to elicit feedback on content for the TBHA	200 Tribal members, Tribal leaders, health advocates, or stakeholders
National Council of Urban Indian Health 2015 Annual Leadership Conference	May 21, 2015	An overview of the TBHA was provided and discussion held to obtain responses for the six topical questions related to the development of the TBHA.	100 Tribal members, Urban Indian health leaders, health advocates, or stakeholders
SAMHSA Native American Youth Conference	Nov. 17-19, 2014	Youth developed a positive identity for change in Native American communities and shared challenges, provided recommendations, and asked questions of federal officials	150 youth 100 adults
National Congress of American Indians Mid-Year Meeting	June 30,2015	Presented overview of the TBHA and facilitated a question and answer session during the Health Sub-committee Meeting	35 tribal leaders, tribal members and health stakeholders
National Congress of American Indians Annual Convention and Marketplace	Oct. 19, 2015	Presented overview of the TBHA and facilitated a question and answer session during the Health Sub-committee Meeting	35 Tribal leaders, Tribal members, health advocates, or stakeholders
	Oct. 20, 2015	Sponsored a resolution for consideration and ultimately approval by Health Sub-committee and the Human Resources Committee	30 Tribal leaders, Tribal members, health advocates, or stakeholders
	Oct. 21, 2015	Hosted a two-hour discussion group around behavioral health priorities and recommend actions	80 Tribal leaders, Tribal members, health advocates, or stakeholders
Online Comment Period	Oct. 1 – Nov. 30, 2015	An open submission portal was created where anybody could submit open-ended comments on the TBHA or any thoughts related to behavioral health in Indian Country	15 online submissions
Federal Interagency Forum	Dec. 14, 2015	Federal agencies were invited to join in a discussion about what programs and efforts they currently operate that could align with TBHA priorities, and about how a TBHA could be utilized by their agencies	20 representatives from federal departments, agencies or offices 4 representatives from National Native American organizations
IHS Direct Service Tribes Quarterly Meeting	June 2, 2016	Presented overview of the TBHA and a question and answer session	10 tribal representatives 6 audience members

APPENDIX 2.
SELECTED LIST OF FEDERAL STRATEGIC PLANS AND DOCUMENTS — CORRELATIONS WITH THE NATIONAL TRIBAL BEHAVIOR HEALTH AGENDA

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
				Foundational Elements[1]						Cross-Cutting Considerations[2]				
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
SAMHSA	2015-2018	Leading Change 2.0: Advancing the Behavioral Health of the Nation	Goal 1.1: Promote Emotional Health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues Objective 1.1.1: Prevent Substance abuse and promote emotional health and well-being in states, territories, tribes, and communities across the nation			•								•
			Goal 1.2: Prevent and reduce underage drinking and young adult problem drinking Objective 1.2.3: Enhance cooperation and coordination among federal agencies and non-federal organizations to prevent and reduce underage drinking among youth and young adults			•			•					•
			Goal 1.3: Prevent and reduce attempted suicides and deaths by suicide among populations at high risk			•	•		•					•
			Objective 1.3.1: Promote suicide prevention as a core components of health care services, including integrated primary care services, consistent with Goal 8 of the National Strategy for Suicide Prevention											
			Objective1.3.2: Promote and implement effective clinical and professional practices and standards for assessing and treating those identified as high-risk for suicidal behaviors, especially among primary care, mental health, and substance abuse service providers			•	•							
			Objective 1.3.3: Promote rapid, continued, and skilled follow up with individuals who have attempted suicide or experienced a suicidal crisis			•	•							
			Objective 1.3.4: Increase public preparedness to address the warning signs for suicide and actions to take in response					•						•
			Goal 1.4: Prevent and reduce prescription drug and illicit opioid misuse and abuse Objective 1.4.3: Raise awareness and bring prescription drug misuse and abuse prevention activities and education to schools, communities, parents, prescribers, health care professionals, and other patients			•	•	•						•

1 Foundational elements: Historical and intergenerational trauma (HT); Socio-ecological Approach (SA); Prevention and Recovery (PR); Health Systems (HS); National awareness and visibility

2 Cross-cutting Considerations: Youth (Y); Culture (C); Identity (I); Individual self-sufficiency (S); Data (D); Tribal Leadership (L)

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
				Foundational Elements[1]						Cross-Cutting Considerations[2]				
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
			Goal 2.1: Foster integration between behavioral health and health care, social support, and prevention systems Objective 2.1.2: Remove financial barriers and incentivize effective care coordination and integrated treatment delivery for people with mental illness and substance abuse conditions (for example: Schizophrenia, bi-polar disorder, and substance use disorder) through ongoing collaboration with federal partners and other stakeholders				•							•
			Goal 3.1: Implement and study a trauma-informed approach throughout health, behavioral health, and related systems Objective 3.1.1: Integrate an understanding of trauma and strategies for implementing a trauma-informed approach across SAMHSA, interested federal agencies, and other public service sectors	•			•							•
			Goal 4.1: Improve the physical and behavioral health of individuals with mental illness and/or substance use disorders and their families Objective 4.1.2: Promote recovery-oriented service systems that include coordinated clinical treatment and recovery support services			•	•							•
			Goal 6.1: Develop and disseminate workforce training and education tools and core competencies to address behavioral health issues Objective 6.1.4: In collaboration with HRSA, support investments in training the future behavioral health workforce to practice in integrated care settings and improve care for underserved populations				•							
			Goal 6.4: Influence and support funding for the behavioral health workforce Objective 6.4.1: Support the identification and analysis of pay incentives and barriers for behavioral health providers across settings				•						•	•
IHS	2011-2015	American Indian/ Alaska Native National Behavioral Health Strategic Plan	Strategic Direction I, Goal A. Mutual Tribal, Urban, and IHS planning and development of treatment services and programs. Action I.A.4: Develop recommendations and identify strategies to increase behavioral health data, generate aggregate data, and address data ownership issues. Utilize national, regional, and local data resources										•	
			Action I.A.7: Provide ongoing specialized prevention, intervention, and administrative training to better address new, emerging challenges in behavioral health and substance abuse clinical and program issues				•							
			Strategic Direction I, Goal B: Promoting national sharing of prevention, treatment, and education information Action I.B.4: Assess need for training and ongoing support of clinical supervisory positions in Tribal behavioral health programs and then collaborate with other Federal and Tribal resources, such as SAMHSA and research institutions, to promote train-the-trainer opportunities to enhance knowledge transfer and the application of agreed-upon behavioral health standards.				•							•

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA											
				Foundational Elements[1]						Cross-Cutting Considerations[2]					
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
			Action I.B.5: Support local and regional efforts to utilize traditional AI/AN practitioners or practices within the service delivery framework for behavioral health.				•							•
			Strategic Direction II, Goal A: Creating a common awareness of and supporting behavioral changes towards wellness, sobriety, and community health Action II.A.2: Create a website portal to identify and disseminate best and promising practices in behavioral health					•						•
			Action II.A.3: Work with Tribal Technical Advisory Group to ensure that culture-based and tradition-based approaches are designated as evidence-based practices for purposes of funding and reimbursement.				•			•				•
			Action II.A.5: Support community-specific planning, readiness, and mobilization around the prevention of suicide, violence, and substance abuse by providing resources, collaborations, or connections to other Federal partners.			•								•
			Strategic Direction II, Goal B: Increasing resiliency and protective factors for AI/AN youth. Action II.B.5: Involve AI/AN youth in the identification and planning of strategies for the prevention of youth violence, substance abuse, and suicide.			•			•					
			Action II.B.7: Launch a system-wide collaboration between those working in child abuse neglect prevention and those working in behavioral health in order to coordinate services for the whole family.			•								•
			Strategic Direction III, Goal A: Encouraging the development and promotion of behavioral health standards and credentials. Action III.A.6: IHS, in consultation with Tribal and Urban leaders, will examine the creation, development, and deployment of a nationally funded crisis team to respond to behavioral health crises without depleting local resources. The guidelines for declaring a state of emergency and processes required to access emergency resources will be made available to all communities on an ongoing basis.				•							•
			Strategic Direction III, Goal B: Integrating behavioral health within thestructure of health services. Action III.B.4: Identify benchmarks and outcome measures to assess whether behavioral health is being integrated into health delivery systems. [Note: this action was shortened].				•						•	
			Action III.B.8: In partnership with local community members and persons served (including youth), conduct an education and awareness campaign to inform providers, persons served, and community members about behavioral health issues and resources.				•	•						•
			Action III.B.9: Through local leadership, integrate behavioral health within the larger aftercare and prevention framework of housing, law enforcement, education, and social services.		•		•							•

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
				Foundational Elements[1]						Cross-Cutting Considerations[2]				
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
			Strategic Direction III, Goal C: Developing a skilled and culturally competent workforce to meet the demand for services. Action III.C.6: Seek additional funding for health career scholarships and web-based certification and licensure training specifically targeted at behavioral health professions, such as social work, psychology, counseling, etc. Change the priorities for health scholarships to emphasize behavioral health professionals training.				•							
			Action III.C.7: Implement a mentoring/internship/ preceptorship Initiative that provides recruitment of a new AI/AN workforce into behavioral health fields, by focusing resources and creating opportunities on a national and local level (e.g., National Behavioral Health Conference).				•							•
			Strategic Direction III, Goal D: Securing necessary reimbursement for behavioral health services. Action III.D.6: Seek support from CMS, IHS, and SAMHSA to ensure that cultural, traditional, or faith-based interventions and practices utilized in AI/AN behavioral health programs are considered as evidence-based programs or practices for purposes of reimbursement and provide training and technical assistance to secure evidence-based designation.				•			•				
			Strategic Direction III, Goal E: Sustaining interagency partnerships in order to support behavioral health. Action III.E.2: Work with tribal leaders to pursue increased multi- agency behavioral health funding and the development of a multi- agency behavioral health allocation process, including but not limited to HHS, HUD, DOI, ED, BIA, BIE, and other agencies.		•										•
			Action III.E.4: Modify the IHS Epidemiology cooperative agreements to		•								•	

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
				Foundational Elements[1]						Cross-Cutting Considerations[2]				
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
			facilitate an inter-agency approach to the collection and use of aggregate behavioral health data in Tribal/Urban, regional, and national profiles.											
ACF	2015-2016	Administration for Children and Families Strategic Plan	Goal One: Promote economic, health, and social well-being for individuals, families, and communities 1.2.1 We will support families through successful implementation of healthy marriage and responsible fatherhood programs that encourage responsible parenting, foster economic stability, promote stable relationships and healthy marriages, take into consideration trauma- informed care, and work to create positive child outcomes.	•										
			1.3.3 We will incentivize the development of asset-building programs in underserved states and territories and among special populations, such as Native Americans, refugees, and survivors of human trafficking		•									
			Goal Two: Promote Healthy Development and School Readiness for Children, Especially Those in Low-Income Families 2.1.5 We will promote better policies and practices with regard to the social-emotional and behavioral development of children, including reducing preschool expulsion, promoting universal developmental screenings, strengthening family-program relationships, and implementing mental health consultations.		•		•							
			2.3.2 We will implement and evaluate the Tribal Early Learning Initiative, targeted to support tribes' efforts to effectively coordinate and leverage Child Care Development Fund, Early Head Start-Head Start, and Tribal Maternal, Infant, and Early Childhood Home Visiting program funding.		•									
			2.4.1 We will partner with federal agencies that support community and economic development, environmental protection, and native languages in order to leverage existing resources and programs to maximize ACF's investment in projects funded by the Administration for Native Americans. These partnerships will expand ANA's reach into communities and make other federal resources more accessible to ANA grantees.		•					•				•
			2.4.4 We will collaborate with federal partners to actively encourage states, tribes, and territories to promote interoperability, and improve access to integrated health care and human services.		•	•							•	•
			Goal Three: Promote Safety and Well-being of Children, Youth, and Families	•										

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
				Foundational Elements[1]						Cross-Cutting Considerations[2]				
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
			3.1.1 We will promote the use of evidence-based and trauma-informed practices that effectively address the needs of children and families and encourage achievement of timely permanency for children in the child welfare system.											
			3.2.1 We will support youth and young adults in foster care in their transition to adulthood through technical assistance to state and tribal agencies and courts, and through policies, and programs that effectively address varying cultural/linguistic and other special needs, and the development of independence/self-sufficiency, including an emphasis on building financial capability, education and vocational training, and permanent connections with responsible, caring adults.		•				•	•	•			•
			3.3.4 We will establish common standards for ensuring that health and human service providers supported by ACF have the capacity to recognize the impact of domestic violence on the populations they serve, consider varying cultural/ linguistic and other special needs, and respond effectively and safely link program participants to domestic violence services as appropriate.			•		•		•				
			Goal Four: Support Underserved and Underrepresented Populations 4.1.6 We will promote and facilitate improved tribal/ state relations and policy at the regional and state levels to foster improved outcomes for Native American children, families, and communities.				•							•
			Goal Five: Upgrade the Capacity of the Administration for Children and Families to Make a Difference for Families and Children 5.2.10 We will work with the Native American Affairs Advisory Council to develop a data framework through which to collect, use, and share data more efficiently to inform decision making, educate stakeholders, increase the impact of ACF communications, and facilitate stronger partnerships to effectively address the demonstrated needs of Native American children, families, and communities.										•	•
OJJDP	Nov 2014	Attorney General's Advisory Committee on American Indian/ Alaska Native Children Exposed to Violence: Ending Violence so Children can Thrive	1.6 The legislative and executive branches of the federal government should encourage tribal-state collaborations to meet the needs of AI/AN children exposed to violence.											•
			1.7 The federal government should provide training for AI/AN Nations and for the federal agencies serving AI/AN communities on the needs of AI/AN children exposed to violence. Federal employees assigned to work on issues pertaining to AI/AN communities should be required to obtain training on tribal sovereignty, working with											

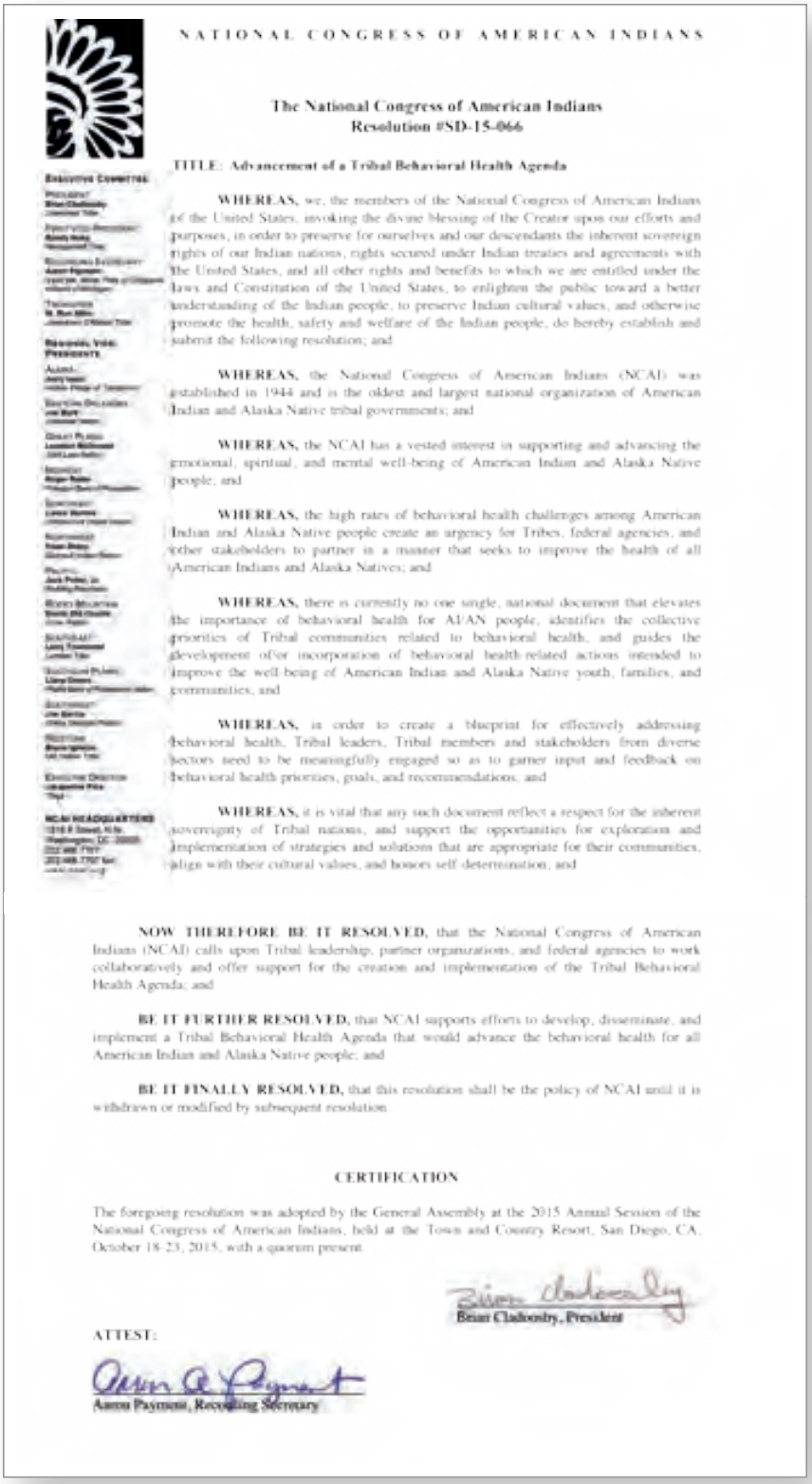
FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
				Foundational Elements[1]						Cross-Cutting Considerations[2]				
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
		This report was created as part of the Defending Childhood Initiative created by Attorney General Eric H. Holder, Jr. This initiative strives to harness resources from across the Department of Justice to: • Prevent Children's exposure to violence • Mitigate the negative impact of children's exposure to violence when it does occur; and • Develop knowledge and spread awareness about children's exposure to violence	tribal governments, and the impact of historical trauma and colonization on tribal Nations within the first sixty days of their job assignment.											
			2.4 The Indian Health Service (IHS) in the Department of Health and Human Services (HHS), state public health services, and other state and federal agencies that provide pre- or postnatal services should provide culturally appropriate education and skills training for parents, foster parents, and caregivers of AI/AN children. Agencies should work with tribes to culturally adapt proven therapeutic models for their unique tribal communities (e.g., adaptation of home visitation service to include local cultural beliefs and values).							•				
			2.6 The Secretary of Health and Human Services (HHS) should increase and support access to culturally appropriate behavioral health and substance abuse prevention and treatment services in all AI/AN communities, especially the use of traditional healers and helpers identified by tribal communities.			•				•				
			3.1.A The White House Native American Affairs Office, the U.S. Attorney General, the Secretaries of the Department of Interior (DOI) and Health and Human Services (HHS), and the heads of other agencies that provide funds that serve AI/AN children should annually consult with tribal governments to solicit recommendations on the mechanisms that would provide flexible funds for the assessment of local needs, and for the development and adaptation of promising practices that allow for the integration of the unique cultures and healing traditions of the local tribal community.	•						•				
			3.1.B The White House Native American Affairs Office and the U.S. Attorney General should work with the organizations that specialize in treatment and services for traumatized children, for example, National Child Traumatic Stress Network, to ensure that services for AI/AN children exposed to violence are trauma-informed.	•					•					
			3.1.C The White House Native American Affairs Office should coordinate the development and implementation of federal policy that mandates exposure to violence trauma screening and suicide screening be a part of services offered to AI/AN children during medical, juvenile justice, and/or social service intakes.		•		•		•					
			3.3 The White House Native American Affairs Office and responsible	•			•		•					

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
				Foundational Elements[1]						Cross-Cutting Considerations[2]				
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
			federal agencies should provide AI/AN youth-serving organizations such as schools, Head Starts, daycares, foster care programs, and so forth with the resources needed to create and sustain safe places where AI/AN children exposed to violence can obtain services. Every youth-serving organization in tribal and urban Native communities should receive mandated trauma-informed training and have trauma-informed staff and consultants providing school-based trauma-informed treatment in bullying, suicide, and gang prevention/intervention											
			3.5 The White House Native American Affairs Office should work with Congress and executive branch agencies in consultation with tribes to develop, promote, and fund youth-based afterschool programs for AI/An youth. The programs must be culturally based and trauma-informed, must partner with parents/caregivers, and when necessary, provide referrals to trauma-informed behavioral health providers. Where appropriate, local capacity should also be expanded through partnerships with America's volunteer organizations, for example, Americorps.		•		•		•	•				
			3.6 The White House Native American Affairs Office and the Secretary of Health and Human Services (HHS) should develop and implement a plan to expand access to Indian Health Service (IHS), tribal, and urban Indian centers to provide behavioral health services to AI/AN children in schools This should include the deployment of behavioral health services providers to serve students in the school setting.				•		•					
			NOTE: Chapter 3 following 3.6 goes on to explain that: "Federal agencies should work with public schools and Bureau of Indian Education (BIE)-funded schools to ensure that services are offered, preferably in the schools, to students attending BIE-funded schools. School-based services increase the availability and utilization of services and will increase safety in schools."											
BIE	July 2014	Findings and Recommendations Prepared by the Bureau of Indian Education Study Group Submitted to the Secretaries of the	Reform Area 4: Comprehensive Supports through Partnerships In September 2013, Secretary of the Interior Sally Jewell and Secretary of Education Arne Duncan appointed the American Indian Education Study Group to diagnose the causes of too common academic failure in BIE- funded schools. The Study Group, based largely on written comments and feedback received during tribal consultations, recommends that the	•	•									

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
				Foundational Elements[1]						Cross-Cutting Considerations[2]				
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	HT	SE	PR	HS	NA	Y	C	I	S	D	L
		Departments of the Interior and Education The Study Group's findings focus on five areas of reform: • Highly Effective Teachers and Principals • Agile Organizational Environment • Promote Educational Self- Determination for Tribal Nations • Comprehensive Supports through Partnerships • Budget that Supports Capacity- Building Mission	BIE focus on fostering five areas of reform. Issues raised related to partnerships and that are pertinent to the TBHA include: traumas faced by students and families, impact of trauma on academic performance, depression, substance abuse, poor health outcomes, high unemployment, rampant crime, support so that students come to class ready to learn, leveraging local and national expertise, and innovative partnerships to address social problems. The Study Group recommended that BIE's approach cut across all Federal agencies and their community-based programs that serve tribal communities to eliminate redundancy, disconnection, and waste of federal resources.											
			Select Partnership Recommendations:											
			• Coordinate with other Federal agencies so that community-based tribal grants help provide wraparound services to students attending BIE-funded schools.						•					
			• Work with Indian Health Service (IHS) to increase and institutionalize the practice of providing school-based services to ensure that students are ready to learn and can focus (e.g., provision of immunizations in time for start of school and counseling services)				•							

APPENDIX 3:
TRIBAL RESOLUTIONS SUPPORTING THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

National Congres of American Indians



NATIONAL CONGRESS OF AMERICAN INDIANS

The National Congress of American Indians
Resolution #SD-15-066

TITLE: **Advancement of a Tribal Behavioral Health Agenda**

WHEREAS, we, the members of the National Congress of American Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants the inherent sovereign rights of our Indian nations, rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the health, safety and welfare of the Indian people, do hereby establish and submit the following resolution; and

WHEREAS, the National Congress of American Indians (NCAI) was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments; and

WHEREAS, the NCAI has a vested interest in supporting and advancing the emotional, spiritual, and mental well-being of American Indian and Alaska Native people; and

WHEREAS, the high rates of behavioral health challenges among American Indian and Alaska Native people create an urgency for Tribes, federal agencies, and other stakeholders to partner in a manner that seeks to improve the health of all (American Indians and Alaska Natives; and

WHEREAS, there is currently no one single, national document that elevates the importance of behavioral health for AI/AN people, identifies the collective priorities of Tribal communities related to behavioral health, and guides the development of/or incorporation of behavioral health-related actions intended to improve the well-being of American Indian and Alaska Native youth, families, and communities; and

WHEREAS, in order to create a blueprint for effectively addressing behavioral health, Tribal leaders, Tribal members and stakeholders from diverse sectors need to be meaningfully engaged so as to garner input and feedback on behavioral health priorities, goals, and recommendations; and

WHEREAS, it is vital that any such document reflect a respect for the inherent sovereignty of Tribal nations, and support the opportunities for exploration and implementation of strategies and solutions that are appropriate for their communities, align with their cultural values, and honors self determination; and

NOW THEREFORE BE IT RESOLVED, that the National Congress of American Indians (NCAI) calls upon Tribal leadership, partner organizations, and federal agencies to work collaboratively and offer support for the creation and implementation of the Tribal Behavioral Health Agenda; and

BE IT FURTHER RESOLVED, that NCAI supports efforts to develop, disseminate, and implement a Tribal Behavioral Health Agenda that would advance the behavioral health for all American Indian and Alaska Native people; and

BE IT FINALLY RESOLVED, that this resolution shall be the policy of NCAI until it is withdrawn or modified by subsequent resolution.

CERTIFICATION

The foregoing resolution was adopted by the General Assembly at the 2015 Annual Session of the National Congress of American Indians, held at the Town and Country Resort, San Diego, CA, October 18-23, 2015, with a quorum present.

Brian Cladoosby, President

ATTEST:

Aaron Payment, Recording Secretary

National Indian Health Board

National Indian Health Board
Resolution 15 - 01

Declaration for Support of a Tribal Behavioral Health Agenda

WHEREAS, the National Indian Health Board (NIHB), established in 1972, serves all federally recognized American Indian and Alaska Native (AI/AN) Tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the federal government's trust responsibility to AI/AN Tribal governments; and

WHEREAS, the NIHB has a strong history of advancing the emotional, spiritual, and mental well-being of American Indian and Alaska Native people through the support of regulatory and Congressional action, advocacy for increased funding for behavioral health in Indian Country, creation of national venues to discuss behavioral health issues (such as suicide and substance use), and creation of educational and programmatic materials for Tribal public health professionals; and

WHEREAS, the high rates of behavioral health challenges among American Indian and Alaska Native people create an urgency for Tribes, federal agencies, and other stakeholders to partner in a manner that seeks to improve the health of all American Indians and Alaska Natives; and

WHEREAS, there is currently no one single, national document that elevates the importance of behavioral health for AI/AN people, identifies the collective priorities of Tribal communities related to behavioral health, and guides the development of/or incorporation of behavioral health-related actions intended to improve the well-being of American Indian and Alaska Native youth, families, and communities; and

WHEREAS, in order to create a blueprint for effectively addressing behavioral health, Tribal leaders, Tribal members and stakeholders from diverse sectors need to be meaningfully engaged so as to garner input and feedback on behavioral health priorities, goals, and recommendations; and

WHEREAS, the Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency that has allocated staff and resources to serve as the federal lead in the development and creation of a blueprint for advancing behavioral health in Indian Country; and

WHEREAS, SAMHSA and NIHB have forged a partnership to reach into Indian Country and engage Tribal leaders, Tribal members, community stakeholders, youth, partner organizations, and other federal agencies to create a Tribal Behavioral Health Agenda to serve as a single, national blueprint for shaping collaborations, prioritizing issues, elevating awareness, and establishing realistic, actionable items; and

NOW THEREFORE BE IT RESOLVED, that the National Indian Health Board will work to create a Tribal Behavioral Health Agenda to advance Tribal and federal action to improve the emotional, spiritual and mental health of American Indian and Alaska Native people; and

NOW THEREFORE BE IT RESOLVED, the National Indian Health Board calls upon Tribal leadership, partner organizations, and federal agencies to work collaboratively and offer support for the creation and implementation of the Tribal Behavioral Health Agenda.

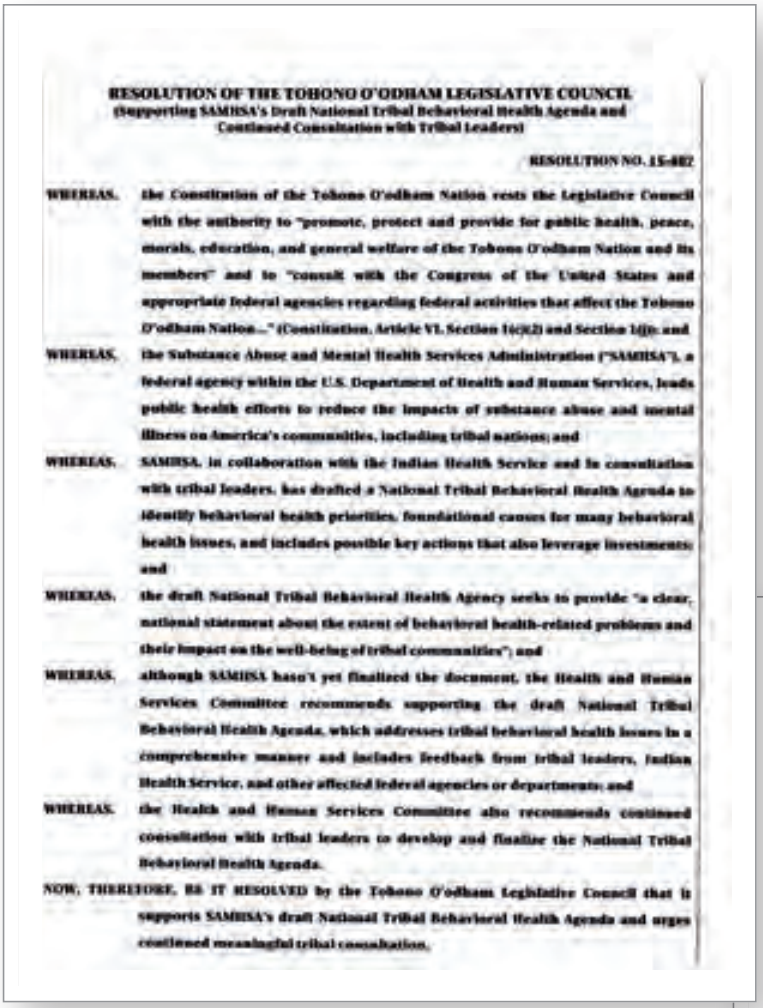
BE IT FINALLY RESOLVED, that National Indian Health Board supports efforts to develop, disseminate, and implement a Tribal Behavioral Health Agenda for all of Indian Country.

CERTIFICATION

The foregoing resolution was adopted by the Board, with quorum present, on the 20th day of September, 2015.

Lester Secatero
Chairperson

Tohono O'odham Nation



RESOLUTION OF THE TOHONO O'ODHAM LEGISLATIVE COUNCIL
(Supporting SAMHSA's Draft National Tribal Behavioral Health Agenda and Continued Consultation with Tribal Leaders)

RESOLUTION NO. 15-407

WHEREAS, the Constitution of the Tohono O'odham Nation vests the Legislative Council with the authority to "promote, protect and provide for public health, peace, morals, education, and general welfare of the Tohono O'odham Nation and its members" and to "consult with the Congress of the United States and appropriate federal agencies regarding federal activities that affect the Tohono O'odham Nation..." (Constitution, Article VI, Section 1(c)(2) and Section 1(jj); and

WHEREAS, the Substance Abuse and Mental Health Services Administration ("SAMHSA"), a federal agency within the U.S. Department of Health and Human Services, leads public health efforts to reduce the impacts of substance abuse and mental illness on America's communities, including tribal nations; and

WHEREAS, SAMHSA, in collaboration with the Indian Health Service and in consultation with tribal leaders, has drafted a National Tribal Behavioral Health Agenda to identify behavioral health priorities, foundational causes for many behavioral health issues, and includes possible key actions that also leverage investments; and

WHEREAS, the draft National Tribal Behavioral Health Agency seeks to provide "a clear, national statement about the extent of behavioral health-related problems and their impact on the well-being of tribal communities"; and

WHEREAS, although SAMHSA hasn't yet finalized the document, the Health and Human Services Committee recommends supporting the draft National Tribal Behavioral Health Agenda, which addresses tribal behavioral health issues in a comprehensive manner and includes feedback from tribal leaders, Indian Health Service, and other affected federal agencies or departments; and

WHEREAS, the Health and Human Services Committee also recommends continued consultation with tribal leaders to develop and finalize the National Tribal Behavioral Health Agenda.

NOW, THEREFORE, BE IT RESOLVED by the Tohono O'odham Legislative Council that it supports SAMHSA's draft National Tribal Behavioral Health Agenda and urges continued meaningful tribal consultation.

RESOLUTION NO. 15-407
(Supporting SAMHSA's Draft National Tribal Behavioral Health Agenda and Continued Consultation with Tribal Leaders)
Page 2 of 3

The foregoing Resolution was passed by the Tohono O'odham Legislative Council on the 13th day of OCTOBER, 2015 at a meeting at which a quorum was present with a vote of 3,821.4 FOR; -0- AGAINST; -0- NOT VOTING; and [0] ABSENT, pursuant to the powers vested in the Council by Article VI, Section 1(c)(2) and Section 1(jj) of the Constitution of the Tohono O'odham Nation, adopted by the Tohono O'odham Nation on January 18, 1986; and approved by the Acting Deputy Assistant Secretary - Indian Affairs (Operations) on March 6, 1986, pursuant to Section 16 of the Act of June 18, 1934 (48 Stat. 984).

TOHONO O'ODHAM LEGISLATIVE COUNCIL

Timothy Joaquin, Legislative Chairman

20 day of October, 2015

ATTEST:

Yvonne Wilson, Legislative Secretary

19 day of October, 2015

Said Resolution was submitted for approval to the office of the Chairman of the Tohono O'odham Nation on the 21 day of October, 2015 at 11:50 o'clock, a.m., pursuant to the provisions of Section 5 of Article VII of the Constitution and will become effective upon his approval or upon his failure to either approve or disapprove it within 48 hours of submittal.

TOHONO O'ODHAM LEGISLATIVE COUNCIL

Timothy Joaquin, Legislative Chairman

[X] APPROVED on the 21 day of October, 2015

[ ] DISAPPROVED at 2:13 o'clock P.m.

EDWARD D. MANUEL, CHAIRMAN
TOHONO O'ODHAM NATION

RESOLUTION NO. 15-407
(Supporting SAMHSA's Draft National Tribal Behavioral Health Agenda and Continued Consultation with Tribal Leaders)
Page 3 of 3

Returned to the Legislative Secretary on the 21 day of October, 2015, at 2:21 o'clock P.m.

Yvonne Wilson, Legislative Secretary

INDIAN HEALTH SERVICE · PHS · 1955 ·

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

National Indian Health Board

Opioid Prescribing

CAPT THOMAS WEISER, MD, MPH
MEDICAL EPIDEMIOLOGIST
PORTLAND AREA INDIAN HEALTH SERVICE
NORTHWEST TRIBAL EPIDEMIOLOGY CENTER

Background

- Opioid prescriptions have risen dramatically over the past 15-20 years
  - 1 in 4 receiving long-term opioid therapy, in primary care settings, struggle with opioid addiction
  - 300% increase in prescription sales since 1999- without overall change in reported pain
  - 259,000,000 prescriptions for opioids were written in 2012- enough for every adult in America to have a bottle of pills

Sources:
Office of the Surgeon General http://turnthetiderx.org/# ;
CDC: MMWR RR(65) 1: CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Background

- Annual incidence of opioid overdose and deaths has also risen:
  - Overdoses: In 2011, over 420,000 emergency room visits were related to misuse or abuse of prescription opioids, including intentional and unintentional overdose
  - Deaths: from 1999-2014, more than 165,000 people died from prescription opioid overdose
- Increased research has led to greater understanding of the dangers of long-term opioid prescribing and the lack of benefit

Sources:
Office of the Surgeon General http://turnthetiderx.org/# ;
CDC: MMWR RR(65) 1: CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Federal Steps

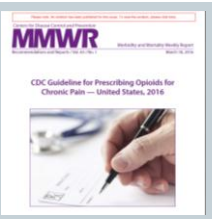
- Indian Health Service Indian Health Manual, Chapter 30 (2014) "Chronic Non-Cancer Pain Management" and Chapter 32 (2016)- "State Prescription Drug Monitoring Programs"
- CDC released new opioid prescribing guidelines in 2016
- Surgeon General: "Turn the Tide" campaign, 2016

IHS

- Chapter 30: Chronic Non-Cancer Pain Management
  - Pain assessment, management
  - Patient education, rights and responsibilities
  - Provider responsibilities- assessment, treatment, education and re-assessment
  - Treatment guidelines- opioid and non-opioid regimens
- Chapter 32: State Prescription Drug Monitoring Programs (PDMPs)
  - Area-State MOU
  - Prescribers, pharmacists may access
  - Requires providers to check PDMP before prescribing opioid medications

CDC

- Compiling data from State health departments and vital statistics
- Produced opioid prescribing guideline and other publications
- Produced provider and public educational materials



https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf

Office of the Surgeon General

- Initiated Turn the Tide Campaign http://turnthetiderx.org/#
- Visited tribal leaders in OK, visited Bethel, AK and an Alaska Native village.
- Sent letters to all physicians across the country
- Encouraged providers to take the pledge:

As HEALTH CARE PROFESSIONALS, we believe we have the unique power to end the opioid crisis. We pledge to:

1. Educate ourselves to treat pain safely and effectively.
2. Screen our patients for opioid use disorder and provide or connect them with evidence-based treatment.
3. Talk about and treat addiction as a chronic illness, not a moral failing.

State Steps- Idaho

- Idaho Board of Medicine Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain (Sept, 2013)
- Office of Drug Policy- "Prevention Idaho" administers the Substance Abuse Prevention Block Grant and the Strategic Prevention Framework State Incentive Grant
  https://prevention.odp.idaho.gov/index.html
- Public Campaign:
  - Betheparents.org
  - Lock Your Meds
  - Naloxone
- No ongoing campaign to address prescription opioid abuse

State Steps- Oregon

- Convened a Task Force to draft opioid prescribing guidelines for providers in OR, based on 2016 CDC guidelines
  https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/index.aspx
  - Included IHS/NWTEC representation (Dr. Weiser)
  - 4 subgroup areas- Implementation, Communication, Marijuana and Substantive Issues
  - Oregon Guideline follows the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain
  - Emphasizes limiting strength and duration of opioid prescriptions, use of naloxone to prevent overdose deaths, improving data, use of the prescription Drug Monitoring Program to identify potential misuse or abuse.

State Steps- Washington

- First issued opioid prescribing guidelines for providers in WA in 2007.
  - Updated in 2010 and 2015, ahead of CDC guidelines
- The 2016 WA State Interagency Opioid Working Plan includes four priority goals:

1. Prevent opioid misuse and abuse.
2. Treat opioid abuse and dependence.
3. Prevent deaths from overdose.
4. Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

Available at: http://stopoverdose.org/

Oregon Resolution

"The Oregon Opioid Prescribing Guidelines Task Force adopts the *CDC Guideline for Prescribing Opioids for Chronic Pain* as the foundation for opioid prescribing for Oregon. The Task Force further encourages more discussion at state, regional and organizational levels regarding how the guidelines will be disseminated, communicated to patients and providers, and implemented."

Approved June 3, 2016

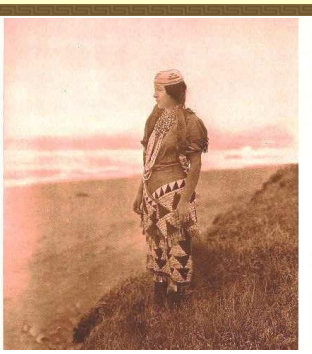
Next steps

- Request NPAIHB consider a resolution to endorse the efforts of Oregon and Washington States and IHS to address the prescription opioid overdose epidemic
- Consider further actions that NPAIHB can take to assist Tribes dealing with the prescription opioid epidemic

Thank You!

Northwest Tribal Comprehensive Cancer Program

October Quarterly Board Meeting 2016
Kerri Lopez



NTCCP Trainings/Activities

- Clinical Cancer Update
  - 29 participants (2016)
  - CEU accreditation
- Tribal Tobacco Summit
  - 50 participants (2016)
- Tobacco Cessation
  - Basic Tobacco Intervention Skills for AI/AN

- Tribal BRFSS
- Inflatable Colon "Kiki"
  - Supporting NW Tribal CRC Education Activities
- Tribal Cancer Plan Implementation Funding
- Tribal site visits
  - Cancer 101
  - Development tribal action plan
  - Participation in tribal prevention, screening and education activity
- Technical assistance
- Dissemination of resources

Tribal BRFSS– 6 tribes

Complete

- Two Oregon
  1. Randomized phone
  2. Census phone
- Two Washington
  - Door to door

In progress

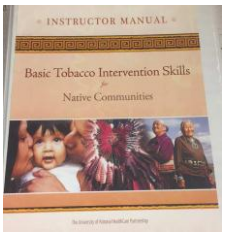
- One Oregon
  - Census phone

One Oregon

- Tribal resolution
- Development of survey materials and IRB application

Tobacco Cessation

- Basic Tobacco Intervention Skills Training (BTIST) for Native Communities
- 5A's model
- 6 Modules topics



Tribal Implementation

Clinic Integration

- From train - trainers
- 3 month time
- 50 clinic/admin staff were trained in the 5A's BTIST
- Of 50 staff participants 31 staff formed 4 teams
  - With the goal to increase referrals

Results

- 41 web-base referrals to the quit-line, 366% increase
- 51 commercial tobacco users agreed to stop smoking
- 26 clinical staff members level of knowledge increased

Other Implementation

- 1 on 1 cessation counseling
- Group classes
- Referrals to another resource for tobacco cessation
- All clinic staff training (from receptionist to the IT person)

NTCCP Coalition Meeting Navigation and Communication

- Topics
- Communication with patients
- Resources for Survivors
- Tobacco Cessation
- Lung cancer screening

- Other resources:
  - Housing
  - Financial assistance
  - Transportation

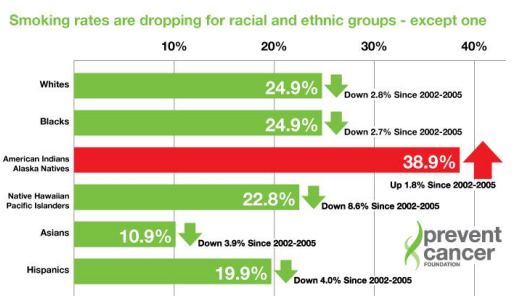
Resource Fair:

- Organizations sharing information with tribes (6)

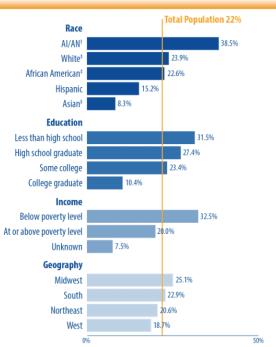
Youth tobacco training

- Tobacco Facts
- Tobacco 101 presentation
- Tobacco vs. Candy
- Environmental Scan Tool
- Group discussion

YIKES



Current cigarette smoking prevalence among adults 18 and older



Rates AI/AN Women

- **32.5%** of AI/AN women smoke
- **18%** of AI/AN women smoke during pregnancy nationally. **** 2003 data
- **26%** of AI/AN women smoke during their last 3 months of pregnancy.
- **22.3%** of AI/AN women in Oregon smoke during pregnancy, in the last 3 months of pregnancy 16.2%

Tobacco Use in Adults

Group	Use	Year	Source
AI/AN Adults	**N/A**	**N/A**	**N/A Idaho BRFSS**
All Adults	15.9%	2014	Idaho BRFSS
AI/AN Adults	**35.3%**	**2013**	**Oregon BRFSS**
NHW Adults	21.4%	2013	Oregon BRFSS
AI/AN Pregnant Women	**35.7%**	**2000-2001**	**2009 Oregon PRAMS Analysis**
NHW Pregnant Women	18.5%	2000-2001	2009 Oregon PRAMS Analysis
AI/AN Adults	**36.6%**	**2012-2014**	**Washington BRFSS**
NHW Adults	16.6%	2012-2014	Washington BRFSS

Tobacco Use in Youth

Group	Use	Year	Source
AI/AN 11th Grade Students	**N/A**	**N/A**	**N/A Idaho High School YBRS**
All 11th Grade Students	10.4%	2015	Idaho High School YBRS
AI/AN 8th Grade Students	**21.9%**	**2015**	**Oregon Healthy Teens Survey**
NHW 8th Grade Students	11.3%	2015	Oregon Healthy Teens Survey
AI/AN 11th Grade Students	**40.2%**	**2015**	**Oregon Healthy Teens Survey**
NHW 11th Grade Students	24.8%	2015	Oregon Healthy Teens Survey
AI/AN 10th Grade Students	**14.1%**	**2014**	**Washington Healthy Youth Survey**
NHW 10th Grade Students	7.7%	2014	Washington Healthy Youth Survey

Tobacco Related Cancer Disparities Oregon Incidence 2007-2012

Cancer Site	AI/AN Age adjusted rate per 100,000 (95% CI)	NHW Age adjusted rate per 100,000 (95% CI)
Lung & Bronchus*	84.561 (71.694, 99.424)	60.6 (59.2, 62.0)
Esophagus	8.8 (5.0, 14.9)	5.248 (4.8, 5.7)
Colorectal	45.7 (36.7, 56.7)	37.8 (36.7, 38.9)
Liver & IBD*	12.7 (8.8,18.4)	6.7 (6.3, 7.2)
Stomach	6.5 (3.4, 11.8)	4.9 (4.5, 5.2)
Pancreas	13.1 (8.4, 20)	11.7 (11.0, 12.3)
Kidney & Renal Pelvis	16.3 (11.7, 22.7)	14.6 (13.9, 15.3)

Colorectal Cancer Disparities

CRC Screening 2012 (ID, OR, WA)[1]

- AI/AN 36.0% (50-75 yo)

CRC Distant Staging 2003-2007 (ID, OR, WA)[2]

- AI/AN 23.9%
- NHW 18.1%

CRC 5 yr Survival 1998-2007 (ID, OR, WA)[3]

- AI/AN 0.4727 (0.4190, 0.5338)
- NHW 0.5627 (0.5627, 0.5825

[1] Indian Health Service: 2012 GPRA results
[2] Northwest Portland Area Indian Health Board. Cancer Among Northwest American Indians and Alaska Natives. Portland, OR: Northwest Tribal Epidemiology Center, 2011.
[3] Petersen, P. S. Colorectal Cancer Survival Among American Indian and Alaska Native People in the Pacific Northwest: A Thesis. Oregon Health & Science University, Portland, OR, 2011.

E-cigarettes

Myths

- Safe than conventional cigarettes
- Healthy alternative
- Does not cause death
- E-cigarette aerosol is harmless "water vapor" and is as safe as clean air
- No second hand smoke
- Little to no nicotine in e-liquid
- Fun, Cool, Sexy
- Cannot overdose on nicotine from e-liquids

Facts

- No FDA approved
- Currently no sufficient evidence to conclude that e-cigarettes are an effective smoking cessation tool.
- E-cigarette aerosol can contain heavy metals and cancer causing agents
- E-liquid contains insufficient amount of nicotine levels
- Most adults who use e-cigarettes also smoke conventional cigarettes, referred as "dual use"
- Marketing to youth using Big Tobacco tactics and fun flavors
- Gateway to smoking or using other tobacco products

Youth E-Cigarette use

Current use in Oregon 2015

	NHW	AI/AN
8th grade	8.6%	13.0%
11th Grade	17.9%	27.0%

From: Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention section. Current tobacco use and related topics among 8th and 11th graders by race and ethnicity, Oregon 2015. https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/DataReports/Pages/YouthData.aspx.

Adult E-Cigarette use

Current use in USA 2014

	NHW	AI/AN
ever tried	14.8%	20.2%
currently use	4.6%	10.7%

From: Nguyen KH, Marshall L, Brown S, Neff L. State-Specific Prevalence of Current Cigarette Smoking and Smokeless Tobacco Use Among Adults — United States, 2014. MMWR Morb Mortal Wkly Rep 2016;65:1045–1051. DOI: http://dx.doi.org/10.15585/mmwr.mm6539a1

Current Policy Work in Tribal Communities

- Tribal Admin-Community Campus
- Health Clinic
- Education
- Gathering Space
- Events & Gatherings
- Tribally Run Businesses
- Tribal Housing
- External Partners

Cancer Challenges - Multifaceted

- High need for Cancer Resources in AI/AN communities
  - Geographic Isolation
  - Independent Healthcare Systems
  - Low Health Literacy
  - Patient – Provider Communication
- Screening - referrals
- Screening rates for paps and mams going down
- After care for cancer survivors in tribal community
- Economic Impact

NTCCP Tools and Resources

- Twenty Year Northwest Tribal Comprehensive Cancer Control Plan
- Northwest Tribal Cancer Resource Guide
- Cancer 101
- Cancer Fact Sheets
- Appointment Companion
- Tribal Cancer Action Planning

Evaluation of Cancer 101: An Educational Program for Native Settings. Hill TG, Briant KJ, Bowen D, Boerner V, Vu T, Lopez K, Vinson E. J Cancer Educ. 2010 Feb 10.

The past, present, and future of comprehensive cancer control from the state and tribal perspective. Miller SE, Hager P, Lopez K, Salinas J, Shepherd WL. Prev Chronic Dis. 2009 Oct;6(4):A112.

Cancer Care of American Indians and Alaska Natives and Other Racial Groups Enrolled in Public and Private Insurance Plans. Ramsey S, Zeliadt S, Blough D, Lopez K, Buchwald D. Poverty & Public Policy. 2010 Vol. 2: Iss. 1, Article 3.

Tools and Resources Cont.

- Tribal Tobacco Policy Workbook
- Northwest Tribal Colorectal Cancer Screening Toolkit
- Second Wind Curriculum
- NPAIHB Tribal Profiles
  - State level
- Multiple Presentations
  - E-Cigarettes, Pregnancy & smoking, Cancer Resources, Cancer Survivor support group support and Cancer Action Planning
- Multiple factsheets
  - HPV, Tobacco, SHS, E-cigarettes, Smoke-free Homes, etc.

NTCCP Staff

- Kerri Lopez;
  - NTCCP Project Director
- Eric Vinson;
  - NCCP Coordinator
- Antoinette Aguirre;
  - Cancer Prevention Coordinator
- Ryan Sealy;
  - WEAVE NW Tobacco Specialist

Zika Virus Update

CAPT THOMAS WEISER, MD, MPH
MEDICAL EPIDEMIOLOGIST
PORTLAND AREA INDIAN HEALTH SERVICE
NORTHWEST TRIBAL EPIDEMIOLOGY CENTER

Background

- What is Zika virus? How is it transmitted?
- What are the health effects of Zika virus infection?
- What precautions should we take in the Pacific Northwest?

What is Zika Virus?

- Flavivirus- similar to dengue, yellow fever and West Nile virus
- Vector-borne disease- *Aedes egypti* and *Aedes albopictus* mosquitos are the primary vectors

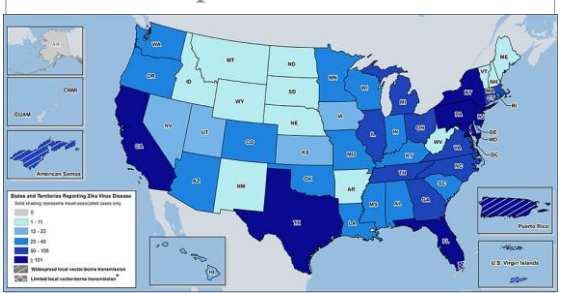
Non-Mosquito Transmission of Zika Virus

- Mother to fetus
- Sexual transmission- more information is being learned about sexual transmission of the virus
  - Transmission primarily from men to women or other men
  - 1 documented case of transmission from woman to man
  - The virus was cultured from semen as long as 90 days after infection
  - The virus has also been found in vaginal mucous in primates
- Other body fluids- blood, urine, amniotic fluid, cerebrospinal fluid

Health Effects of Zika Virus Infection

- Acute Zika virus infection: fever, rash, joint pain, or conjunctivitis; less common: muscle pain, headache
- Guillain-Barré Syndrome: post-infectious autoimmune disorder characterized by bilateral flaccid limb weakness attributable to peripheral nerve damage
- Congenital Zika Syndrome: microcephaly, intracranial calcifications or other brain anomalies, or eye anomalies

Zika Cases Reported in the United States



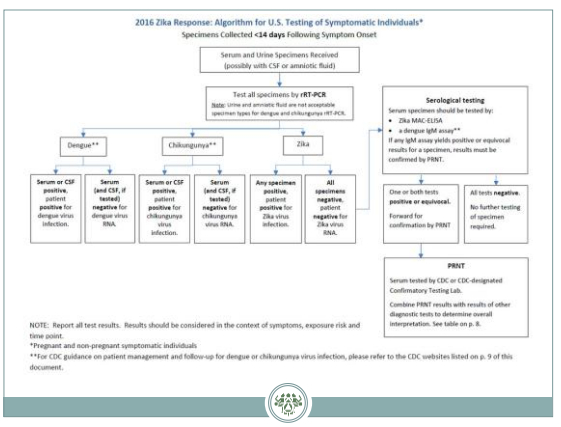
Laboratory-confirmed Zika virus disease cases reported to ArboNET by state or territory (as of October 5, 2016)

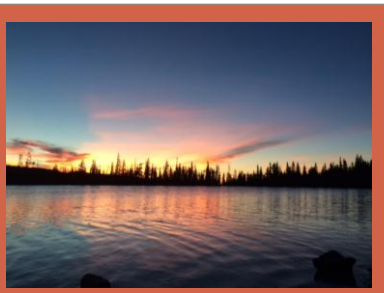
Prevention Steps

- Mosquito transmission of Zika virus has not been documented in the Pacific Northwest. The following prevention recommendations are only **for those who travel to areas with known Zika virus transmission or those who have contact with someone who has traveled in these areas:**
- Prevent exposure to mosquitos
  - CDC recommends the use of window screens, bed nets and EPA-registered mosquito repellents
  - Mosquito larvacide to treat standing water and reduce mosquito burden near homes
  - Permethrin spray to treat bed nets, clothing
- Prevent exposure through sexual contact
  - Condoms to prevent exposure
- Prevent pregnancy if exposed
  - Long-acting reversible contraception to prevent pregnancy if exposure is likely to occur or have already occurred

Recommendations

- CDC recommends Zika virus testing for potentially exposed persons with signs or symptoms consistent with Zika virus disease, and recommends that health care providers offer testing to asymptomatic pregnant women within 12 weeks of exposure.
- For couples planning to conceive who do not live in areas with active Zika virus transmission:
  - Couples in which the female partner may have been exposed to Zika virus should wait at least 8 weeks before trying to conceive
  - Couples in which the male partner may have been exposed to Zika virus should wait at least 6 months before trying to conceive





Thank You!

Legislative & Policy Update

NW Portland Area Indian Health Board

Quarterly Board Meeting

Hosted by the Suquamish Tribe

October 19, 2016

Report Overview

1. Status of FY 2017 IHS Budget
2. Contract Support Costs
3. Veteran's Administration
4. Community Health Aide Program (CHAP) Expansion
5. Tribal Premium Sponsorship
6. Catastrophic Health Emergency Fund
7. Other Policy Updates
8. STAC Meeting Update
9. MMPC CMS TTAG Update
10. Litigation Impacting Indian Health
11. Legislative Issues 114th Congress
12. Important Dates

Status of FY 2017 IHS Budget

- Congress enacted a continuing resolution through December 9, 2016 – funding pro rated and at FY 2016 level.
- Senate and House Committees' Interior, Environment and Related Agencies appropriation bills reflect differences (detailed on next slide)- to be negotiated.
- 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 and discussed during the September 15-16, 2016 CSC Workgroup meeting.
  - IHS will finalize by the end of October.

Veteran's Administration

- On September 12, 2016, the Veteran's Administration issued a Dear Tribal Leader Letter (DTLL)
- In October, 2015, VA submitted a Plan to Congress to Consolidate Programs of the Department of Veterans Affairs and conducted Tribal Consultations.
- As part of implementation of this Plan, tribal consultation is being sought on tribal health programs participation in the core provider network and potentially transitioning from the current reimbursement agreement structure to a model under which tribal health programs deliver care to all those eligible for services.
- In person consultation:
  - September 28, 2016 at 9:00am-11:00am at the Smithsonian National Museum of the American Indian (NMAI)
- Written comments are due on November 5, 2016 and can be sent to: tribalgovernmentconsultation@va.gov

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 are 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
- Comments are due on October 31.

Other Policies

- IHS Re-alignment of IHS Headquarters
  - All Tribes Call on 9/29/16 and in person discussion at NCAI on October 9.
  - Comments due November 5
- SAMSHA's Draft Tribal Behavioral Health Agenda (TBHA)
  - Sets forth a framework, priorities and strategies to address behavioral health issues in Indian country.
  - Comments due on October 31.
- CMS MACRA MIPS & APM
  - Final Rule issued on October 14.

Other Policies-cont'd

- CMS Medicare Expansion of Diabetes Prevention Program Proposed Rule
  - Proposed to expand the Medicare Diabetes Prevention Program beginning 1/1/2018.
  - Tribal consultation has been requested before final rule issued.
- CMS Managed Care Final Rules
  - All Tribes Call on 10/5/17.
  - CMS will provide an overview of Indian specific provisions and comments on an Indian health addendum
  - Effective 7/1/17; CHIP provisions effective 7/1/18
- CMS 100% FMAP -- CMS issued a letter to State Health Officials on 2/26/16 re-interpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:
  - CMS to issue a FAQ on new policy – still pending.

STAC Meeting Update

- Last meeting was September 13-14; next meeting is December 7-8
- Tribal leaders have made several requests to Secretary Burwell, including:
  - Quality of Care Issues at the Indian Health Service
  - Tribal Budget Formulation Workgroup's Recommendations for the FY 2018 IHS Budget
  - Office for AI/AN Programs at the Office of Management and Budget
  - Advocacy on the Veterans' Administration Memorandum of Understanding
  - Senior Level HHS Position Dedicated to Coordinating Tribal Policies at ACF
  - Indian Child Welfare Act Implementation
  - 1115 Waiver Approval
  - Transition Plan for the Next Administration

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee (MMPC) next face-to-face meeting on November 2.
  - Priority List
- CMS TTAG conference call and face-to-face meetings on October 12 and November 3-4, respectively.

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 in favor of Manilaaq.
  - IHS did not appeal the Final Order.

Indian Legislative Issues 114th Congress

- Employer Mandate Bills (S. 1771 & H.R. 3080)
- Indian Health Service Reform Bills (S. 2953 & H.R. 5406)

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 Committee; House bill passed Ways and Means Committee.

Indian Legislative Bills in 114th Congress

- Senate and House Bills Reforming the Indian Health Service in response to issues in the Great Plains region.
  - S. 2953 -- The Indian Health Service Accountability Act of 2016 was introduced by Sen. Barrasso (R-WY) on 5/19/16.
  - H.R. 5406 – The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare Act was introduced by Rep. Kristi Noem (R-SD) on 6/8/16.
  - Senate bill referred to Finance; House bill reported favorably out of House Ways and Mean on 6/15/16.
  - Both bills were amended and then approved in their respective committees on 9/21/16.

Indian Legislative Issues 114th Congress

Other pending legislation:

- Advance Appropriations (H.R. 395)
- Tribal Programs Exemption from Sequestration (S. 1497/H.R. 3063)
- Department of Interior Tribal Self-Governance Act of 2015 (2. 286)
- Family Stability and Family Kinship Act of 2015 (S. 1964)
- Native American Suicide Prevention Act of 2015 (H.R. 3166)
- Correct Inconsistencies in the ACA/IHCIA (S. 2114)

Important Dates

- Several comments are due in the next 3 weeks.
- Portland Area Budget Formulation Meeting – November 29, 2016.
  - Location: Portland, OR
- NCAI Transition Plan Submissions
  - Due: Wednesday, October 19, 2016
  - Submit to: Nicole Hallingstad, Director of Operations, NCAI, nhallingstad@ncai.org

Discussion?

Part 6 - Services To Tribal Governments And Organizations
Chapter 3 - Contract Support Costs

Manual Exhibit	Description
Manual Exhibit 6-3-A	Title 25, Chapter 14, Miscellaneous, Subchapter II, Indian Self-Determination and Education Assistance, Part A "Indian Self-Determination," Section 5325 and Section 5326
Manual Exhibit 6-3-B	Calculating IDC Associated with Tribal Shares and the Contract Support Costs Amount Based on a Detailed Analysis
Manual Exhibit 6-3-C	Calculating IDC Associated with Tribal Shares and the Contract Support Costs Amount Using the 80/20 Method
Manual Exhibit 6-3-D	Calculating IDC Associated with Recurring Service Unit Shares and the Contract Support Costs Amount Based on a Detailed Analysis
Manual Exhibit 6-3-E	Calculating IDC Associated with Recurring Service Unit Shares and the Contract Support Costs Amount Based on the 97/3 Method
Manual Exhibit 6-3-F	Contract Support Costs Negotiation Template
Manual Exhibit 6-3-G	Standards for Review and Approval of Contract Support Costs in the Indian Health Service

Author
Comment [1]: CHANGE #1: updated reference

Author
Deleted: 450j-1

Author
Deleted: 450j-2

6-3.1 INTRODUCTION

A. **Purpose.** This Chapter of the Indian Health Manual (Chapter) provides guidance to both Tribal and Agency personnel in the preparation, negotiation, determination, payment, and reconciliation of contract support costs (CSC) funding in support of new, expanded, and/or ongoing Indian Self-Determination and Education Assistance Act (ISDEAA), as amended, codified at 25 United States Code (U.S.C.) Section (§) 5301 et seq., contracts and compacts. The Chapter provides instructional guidance on the following:

1. determination of amounts of pre-award, startup, direct, and indirect CSC funding;
2. payment of CSC funding to awardees;
3. reconciliation of CSC payments to awardees; and
4. reporting by IHS to all Tribes and to Congress.

These instructions are not regulations establishing program requirements and are issued consistent with 25 Code of Federal Regulations (C.F.R.) § 900.5, which states:

> Except as specifically provided in the [ISDEAA], or as specified in subpart J, an Indian tribe or tribal organization is not required to abide by any unpublished requirements such as program guidelines, manuals, or policy directives of the Secretary, unless otherwise agreed to by the Indian tribe or tribal organization and the Secretary, or otherwise required by law.

The development of this Chapter has involved the active participation of representatives from American Indian and Alaska Native Tribes. The procedures discussed here will be applied to contracts and compacts awarded pursuant to Title I and Title V, respectively, of the ISDEAA.

B. **Guiding Principles.** This Chapter was drafted in accordance with the following guiding principles:

1. The process should be simple and efficient.
2. The Chapter assumes full funding of CSC.
3. To the maximum extent practicable, the Chapter should align with the Bureau of Indian Affair's (BIA) CSC policy.
4. The Chapter is designed to assure that the perfect does not become the enemy of the good.
5. The Chapter assures accountability.
6. The Chapter is intended to minimize future litigation.
7. The Chapter avoids putting at risk past CSC settlements.
8. The Chapter assures that post year-end reconciliation will not take several years.

Author
Deleted: 450

9. The Chapter has been developed and will be implemented in accordance with the government-to-government relationship.
10. The Chapter provided needed certainty for the Agency and Tribes and Tribal organizations.
11. The Chapter has received broad support across Tribes and Tribal organizations.
12. The Chapter is designed to minimize burdens imposed upon Tribes and IHS.
13. The Chapter is designed to assure consistency.
14. The Chapter is designed to assure transparency.
15. The Chapter is designed to assure integrity in the government-to-government relationship.
16. The Chapter has been built on trust amongst the IHS, Tribes, and Tribal organizations.
17. The Chapter will be supplemented with regular training for IHS and Tribal personnel to assure consistency in its application.
18. The Chapter will be reassessed on a regular basis.

C. **Supremacy of the ISDEAA.**

Nothing in this Chapter is intended to limit an ISDEAA contractor/compactor's right to be paid the full CSC amount under the ISDEAA. If a contractor/compactor believes that it has not been fully paid, it may request additional CSC funding from IHS and, if agreement cannot be reached, must invoke the remedies available in 25 U.S.C. § 5331.

Author
Deleted: 450m-1

Nothing in this Chapter is intended to alter, in any way, IHS's obligations or authority under the ISDEAA. In the event of any apparent conflict, the ISDEAA supersedes this Chapter.

D. **Background.** All policies and circulars concerning the administration of CSC by IHS have been developed and revised through coordination and consultation with Tribes. The CSC policies and circulars developed and revised to date include:

1. Indian Self-Determination Memorandum No. 92-02, "Contract Support Cost Policy," signed by Dr. Everett Rhodes, February 27, 1992.

2. Indian Health Circular No. 96-04, "Contract Support Costs," signed by Dr. Michael Trujillo, April 12, 1996.

3. Indian Health Circular No. 2000-01, "Contract Support Costs," signed by Dr. Michael Trujillo, January 20, 2000.

4. Indian Health Circular No. 2001-05, "Contract Support Costs," signed by Dr. Michael Trujillo (Michael E. Lincoln. for), July 6, 2001.

5. Indian Health Circular No. 2004-03, "Contract Support Costs," signed by Dr. Charles W. Grim, September 1, 2004.

6. Indian Health Service Manual, Part 6, Chapter 3, "Contract Support Costs," signed by Dr. Charles W. Grim, April 6, 2007.

This version of the Chapter is the successor to the same Chapter implemented on April 6, 2007. The changes in this successor version of the Chapter are provided to streamline and simplify the processes for the determination, payment, and reconciliation of full CSC funding under the ISDEAA. The IHS will continue to reassess the Chapter on a regular basis, and further changes will only be implemented after Tribal consultation. This Chapter replaces and supersedes all previous versions of the CSC policy, including previous versions of this Chapter.

E. **Policy.** The IHS will provide for a uniform and equitable system of determining, paying, and reconciling CSC funds for new, expanded, and ongoing ISDEAA compacts and contracts and preserve and support each awardee's right to contract/compact under the ISDEAA.

F. **Authorizing Legislation.**

1. Transfer Act, 42 U.S.C. § 2001

2. Title I of the ISDEAA, 25 U.S.C. §§ 5301-5332

3. Title V of the ISDEAA, 25 U.S.C. §§ 5381-45399

G. **Definitions.**

1. **Award.** An agreement authorized under Title I (contract) or Title V (compact) of the ISDEAA, including the associated annual funding agreement (AFA) or funding agreement (FA).

2. **Awardee.** A Tribe or Tribal organization that receives an ISDEAA award as defined above. *See also* Contractor.

3. **Annual CSC Report to Congress.** Report provided to Congress from the IHS Director pursuant to 25 U.S.C. § 5325(c), including "an accounting of any deficiency in funds needed to provide required contract support costs to all contractors for the fiscal year for which the report is being submitted."

4. **Buy-Back Services**. Services contracted by an awardee but that the awardee "buys back" from IHS and, accordingly, IHS provides pursuant to a full-cost reimbursement agreement with the Tribe. Costs of buy-back services may be included in the direct cost base, depending upon the Tribe's indirect cost (IDC) rate agreement.

5. **Contract Proposal.** A proposal for programs, functions, services, or activities (PFSA or PSFA) that the Secretary, Department of Health and Human Services

Author
Deleted: 450

Author
Deleted: 450n

Author
Deleted: 458aaa

Author
Deleted: 58aaa-18

Author
Deleted: 450j-1

(HHS), is authorized to perform, but which a Tribe or Tribal organization is not currently carrying out. The requirements of a Self-Determination contract proposal are found in 25 C.F.R. § 900.8.

6. **Cognizant Agency.** The Federal agency responsible for reviewing, negotiating, and approving cost allocation plans or IDC proposals developed under 2 C.F.R. Part 200 on behalf of all Federal agencies. The cognizant agency for IDC is not necessarily the same as the cognizant agency for audit purposes. For assignments of cognizant agencies see 2 C.F.R. Part 200.

7. **Contract Support Costs Awarded.** Total CSC funding allocated to an awardee.

8. **Contract Support Costs Need or Requirement.** The full amount of CSC funding for new, expanded, and ongoing contracts or compacts, as determined under this Chapter pursuant to 25 U.S.C. § 5325(a).

Author
Deleted: 450j-1

9. **Contractor.** A Tribe or Tribal organization that receives an ISDEAA award as defined above. *See also* Awardee.

10. **Direct Cost Base**. The accumulated direct costs (normally either total direct salaries and wages or total direct costs exclusive of any extraordinary or distorting expenditures) used to distribute IDC to individual Federal awards. The direct cost base for each year is determined by a negotiation between each awardee and its cognizant Federal agency.

11. **Direct CSC (DCSC).** Direct program expenses for the operation of the ISDEAA Programs that are the subject of the award, that otherwise meet the definition of CSC in 25 U.S.C. § 5325(a).

Author
Deleted: 450j-1

12. **Exclusions**. Direct expenditures excluded from the direct costs in order to calculate the direct cost base to which the IDC rate is applied. These types of expenditures vary by awardee and are defined in the IDC rate agreement.

13. **Expanded PSFA.** Expansion of a PSFA through the assumption of additional PSFAs previously operated by IHS, the assumption of programs previously operated under awards to other awardees, the assumption of a new facility (such as increased staff associated with a joint venture agreement), and increases due to new appropriations (excluding general program increases and increases for inflation, pay costs, population growth, and the Indian Health Care Improvement Fund).

14. **Indirect Costs.** Costs that have been incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified with a particular final cost objective without effort disproportionate to the results achieved.

15. **Indirect CSC.** Administrative or other expenses related to the overhead incurred by a contractor in connection with the operation of ISDEAA programs pursuant to the contract and that otherwise meet the definition of CSC in 25 U.S.C. § 5325(a)(2)-(3).

16. **Ineligible Funding.** Categories of funding not eligible for inclusion in the calculation of CSC funding because the related activities are not PSFA transferred and funded under 25 U.S.C. § 5325(a)(1).

17. **Indian Self-Determination Programs (ISDEAA Programs).** The PSFAs associated with an ISDEAA award that are eligible for CSC funding in accordance with this Chapter.

18. **ISDEAA.** The Indian Self-Determination and Education Assistance Act, as amended, codified at 25 U.S.C. §§ 5301-5399.

19. **New PSFA.** ISDEAA Programs that are being assumed by the awardee and transferred by IHS for the first time in the current contract period, including new PSFA available due to new appropriations (excluding general program increases and increases for inflation, pay costs, population growth, and the Indian Health Care Improvement Fund).

20. **Non-Indian Self-Determination Programs.** All awardee-operated programs, exclusive of PSFAs associated with an ISDEAA award, which are not eligible for CSC funding.

21. **Non-Recurring Funds.** Funds that require an annual justification. Some types of non-recurring funds provided for ISDEAA programs are included in the direct cost base.

22. **Ongoing Programs.** All awardee-operated PSFA that were assumed by the awardee prior to the current contract period.

23. **Pass-Through Expenditures.** Similar to exclusions in that pass-through expenditures may be excluded from the direct cost base to which the IDC rate is typically applied, though such expenditures also may be assigned a lower nominal IDC rate. The IDC rate(s) should be applied to such expenditures consistent with the IDC rate agreement.

24. **Pre-award Costs.** Costs incurred before the initial year that an award is in effect. CSC funding is authorized for pre-award costs only if such costs meet the definition in the ISDEAA in 25 U.S.C. § 5325(a)(2)-(3), (6), and the Secretary receives a written notification of the nature and extent of the costs prior to the date on which such costs are incurred.

25. **Programs, Services, Functions, and Activities.** Those PSFA that are contractible under the ISDEAA, including those administrative activities that support such PSFA

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450

Author
Deleted: 458aaa-18

Author
Deleted: 450j-1

and that are otherwise contractible, without regard to the organizational level within the HHS that carries out such functions (as authorized under 25 U.S.C. § 5301 et seq.).

26. **Reconciliation**. Review by IHS and an awardee of the awardee's total CSC requirement and payments made by IHS, including during the course of the contract year and for the purpose of issuing a final contract amendment.

27. **Recurring Funds.** Contract or compact funds that do not require annual justification to the Secretary are recurring funds. Annual increases may be provided through congressional increases or other resource allocation methodologies applicable to the respective funding category of the award.

28. **Retained Services.** Funding which is eligible to be contracted but for which the awardee has chosen not to contract, and thus, for which the IHS has retained associated funding.

29. **Secretarial, or 106(a)(1), Amount.** The amount of funds provided for the PSFA transferred under the award, per 25 U.S.C. § 5325(a)(1).

30. **Self-Governance Request.** A self-governance request is any one of the following requests from a Tribe or Tribal organization. A request:

    a. to enter into the Self-Governance Program for the first time, including Title V; or

    b. to join an existing Self-Governance compact; or

    c. to negotiate for new or expanded programs in a subsequent year's compact or FA from a Tribe with an existing self-governance agreement.

31. **Service Unit Shares.** For the purposes of this Chapter, refers to an awardee's equitable share of PSFA associated with Service Unit resources.

32. **Startup Costs.** Costs incurred on a one-time basis during the initial year that an award is in effect that may be eligible for CSC funding. CSC funding is authorized for startup costs only if the costs meet the definition of CSC in 25 U.S.C. § 5325(a)(2)-(3), (5).

33. **Total CSC Shortfall or Overpayment.** The difference between the total CSC requirement and the total CSC paid to the awardee.

34. **Total Health Care Program.** The health care program operated by the awardee from all resources, including but not limited to IHS, other Federal and State agencies, Tribal contributions, and collections from Medicare, Medicaid, and private insurance.

Author
Deleted: 450

Author
Deleted: 450j-1

Author
Deleted: 450j-1

35. **Tribal Shares.** For the purposes of this Chapter, refers only to an awardee's equitable share of PSFA associated with Area Office or Headquarters resources (including Tribal shares of discretionary IHS grants), notwithstanding the definition of Tribal shares set forth in 25 U.S.C. § 5381(a)(8).

Author
Deleted: 458aaa

6-3.2 DETERMINING CSC AMOUNTS[1]

A. **Categories of ISDEAA Funding: Secretarial Amount, Pre-award, Startup, DCSC, and Indirect CSC**.

The ISDEAA, 25 U.S.C. § 5325(a)(1)-(3), (5), (6), authorizes funding of an award, including the Secretarial amount and CSC. 25 U.S.C. § 5325(a)(1) provides for the Secretarial amount:

Author
Deleted: 450j-1

Author
Deleted: 450j-1

> The amount of funds provided under the terms of self-determination contracts entered into pursuant to this [Act] shall not be less than the appropriate Secretary would have otherwise provided for the operation of the programs or portions thereof for the period covered by the contract, without regard to any organizational level within the Department of the Interior or the Department of Health and Human

[1] IHS and Tribal members of the CSC Workgroup have differing interpretations of what costs are eligible to be paid as CSC under the ISDEAA. This footnote summarizes the differing interpretations and clarifies that any changes to language from the prior version of this Chapter or the Exhibits are not to be construed as a change in the IHS or Tribal position on this issue. The IHS position is that the plain language of the ISDEAA makes it clear that, to be eligible for CSC funding, a cost and the underlying activity must meet the definition of CSC in 25 U.S.C. § 5325(a)(2), which requires (among other things) that the underlying activity is one that IHS does not normally carry on or provided from resources not transferred in the contract. Accordingly, under the IHS position, activities performed by a Tribe that are also activities IHS normally carries on and provides from resources transferred in the contract are not eligible for CSC funding. The IHS position is that the statute cannot be construed in any other manner and that reliance on legislative history is unnecessary given the plain meaning of the statute. Therefore, reference to legislative history is not necessary under the IHS position, though the IHS refers to Senate Reports 100-274 and 103-374, as well as 140 Cong Rec. H11140-01, as affirming this interpretation of the statute's clear requirements. Tribal representatives' position is that the plain language of the ISDEAA, including 25 U.S.C. § 5325(a)(3), expressly defines CSC to include both funds required for administrative and other overhead expenses and "direct" type expenses of program operation, and that in the event the Secretarial amount for a particular function, activity or cost proves to be insufficient in light of a contractor's needs for prudent management of the contract, CSC funding is to be available to supplement such sums so that health services do not have to be reduced in order to pay for the insufficiency. Tribal representatives' position is that the plain meaning of this language is supported by the legislative history adding § 5325(a)(3) to the ISDEAA, *see* Senate Report 103-374, at 8-9; 140 Cong. Rec. 28,631 (1994). Tribal representatives also note that the ISDEAA also requires that "[e]ach provision of the [statute] and each provision of [the] Contract shall be liberally construed for the benefit of the Contractor[.]." § 5329(c) (Model Agreement Section 1(a)(2)).

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450(*l*)

Services, as appropriate, at which the program, function, service, or activity or portion thereof, including supportive administrative functions that are otherwise contractible, is operated.

In addition, 25 U.S.C. § 5325(a)(2) authorizes CSC funding:

There shall be added to the amount required by paragraph (1) contract support costs which shall consist of an amount for the reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract and prudent management, but which--

A. normally are not carried on by the respective Secretary in his [or her] direct operation of the program; or
B. are provided by the Secretary in support of the contracted program from resources other than those under contract.

The statute further identifies four categories of CSC funding. DCSC and indirect CSC are defined in 25 U.S.C. § 5325(a)(3):

(A) The contract support costs that are eligible costs for the purposes of receiving funding under this [Act] shall include the costs of reimbursing each tribal contractor for reasonable and allowable costs of--

i. direct program expenses for the operation of the Federal program that is the subject of the contract, and

ii. any additional administrative or other expense related to the overhead incurred by the tribal contractor in connection with the operation of the Federal program, function, service, or activity pursuant to the contract,

except that such funding shall not duplicate any funding provided under [25 U.S.C. § 5325(a)(1)].

(B) On an annual basis, during such period as a tribe or tribal organization operates a Federal program, function, service, or activity pursuant to a contract entered into under this [Act], the tribe or tribal organization shall have the option to negotiate with the Secretary the amount of funds that the tribe or tribal organization is entitled to receive under such contract pursuant to this paragraph.

The ISDEAA also defines startup and pre-award costs in 25 U.S.C. § 5325(a)(5)-(6):

(5) Subject to paragraph (6), during the initial year that a self-determination contract is in effect, the amount required to be paid

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

under paragraph (2) shall include startup costs consisting of the reasonable costs that have been incurred or will be incurred on a one-time basis pursuant to the contract necessary –

(A) to plan, prepare for, and assume operation of the [PFSA] that is the subject of the contract; and

(B) to ensure compliance with the terms of the contract and prudent management.

(6) Costs incurred before the initial year that a self-determination contract is in effect may not be included in the amount required to be paid under paragraph (2) if the Secretary does not receive written notification of the nature and extent of the costs prior to the date on which such costs are incurred.

B. **Determining CSC Requirements – Statutory Factors that Determine Eligible Costs.**

The definition of CSC in 25 U.S.C. § 5325(a)(2)-(3), establishes certain statutory criteria for determining which costs are eligible for any category of CSC funding.

Since awardees often operate more than one program, many of the costs incurred by the awardee are paid through an IDC allocation process, usually negotiated by the "cognizant agency" as identified under the applicable Office of Management and Budget (OMB) regulations at 2 C.F.R. Part 200 and the HHS regulations at 45 C.F.R. Part 75. In the case of ISDEAA awards, both the Secretarial amount and CSC funding include funding for both direct and indirect costs.

25 U.S.C. § 5325(a)(3) authorizes awardees to be paid CSC funding for eligible costs, whether they are "indirect" in nature (benefitting multiple programs) or additional costs associated with operating a single program, subject to all of the requirements for CSC funding in 25 U.S.C. § 5325(a).

IHS and the awardee will review a CSC request to ensure that all costs are eligible under 25 U.S.C. § 5325(a) and to identify duplication, if any, between pre-award, startup, DCSC, and indirect CSC funding.

The procedures outlined in this Chapter are intended to ensure that CSC requirements are accurately identified based on the statutory definition of which costs are eligible for CSC funding, as provided in 25 U.S.C. § 5325(a)(2)-(3), (5)-(6).

Duplication, if any, between pre-award, startup, DCSC, and indirect CSC funding will be assessed after first considering each cost proposed by the awardee to determine whether it is eligible for CSC funding under 25 U.S.C. § 5325(a). Examples of pre-award, startup, and DCSC are discussed in the standards in Manual Exhibit 6-3-G.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

When awardees choose to use sub-awards with Tribes or Tribal organizations (that in all respects meet the requirements to contract directly with the IHS, but choose, through Tribal resolution, to subcontract to carry out IHS PSFA), to carry out all or part of the PSFA transferred, the eligible costs of the Tribal sub-awardee may also be included in the CSC requirement of the awardee. For CSC on sub-awards, the costs and amounts requested for the sub-awardee will be analyzed and negotiated. Amounts may be considered duplicative to the extent that CSC funding for these costs has already been included in the CSC requirement of the awardee.

C. **Startup and Pre-Award Costs.**

The amount of CSC funding to be awarded for startup and pre-award costs shall be negotiated consistent with the requirements of 25 U.S.C. § 5325(a)(2)-(3), (5)-(6). Depending on the nature of the costs as direct or indirect, the amount of CSC funding also will be negotiated consistent with the guidance below on DCSC and indirect CSC funding. NOTE: Examples of startup and pre-award costs are described in the standards for the review and approval of CSC in Manual Exhibit 6-3-G.

Author
Deleted: 450j-1

Startup costs for PSFA will only be provided to an awardee on a one-time basis, during the initial 12-month period that the award is in effect. Within 90 days after the end of the initial 12-month period of the agreement, the awardee will certify to IHS that it has fully obligated the startup costs funding on the negotiated startup activities. If the awardee's obligations were less than the negotiated amount, the awardee shall either repay any overpayment or agree with IHS to apply the overpayment to the subsequent year's CSC requirement. If the awardee has obligations for the negotiated startup activities in excess of the amounts funded by IHS, the awardee will provide documentation of these costs and the additional amounts will be subject to negotiation between the parties. No additional startup costs will be justified for that awardee if the PSFA is subsequently transferred to a sub-awardee.

Pursuant to 25 U.S.C. § 5325(a)(6) of the ISDEAA, notification from awardees for pre-award costs must clearly indicate the nature and extent of the costs to be incurred and such notification must be received by IHS in writing before any of the costs are actually incurred. Tribes must provide a pre-award notice to the appropriate IHS Area Director as soon as they anticipate contracting or compacting a PSFA, and before they incur any of the costs. If such a notice is received by any other IHS Area Office, it should be immediately forwarded to the appropriate IHS Area Director. Upon receipt by the appropriate Area Director, the IHS will send a letter within 10 days acknowledging the date of receipt of the letter.

Author
Deleted: 450j-1

The review of pre-award and startup costs by Area Office staff should ensure that the costs meet the CSC requirements in the ISDEAA, 25 U.S.C. § 5325(a)(2)-(3), (5)-(6), and there is no duplication of other CSC funding or of any costs funded under a Tribal management grant. *See also* Manual Exhibit 6-3-G for Sample Pre-Award letters.

Author
Deleted: 450j-1

Author
Formatted: Font:Italic

D. **DCSC.**

Direct costs eligible for CSC funding, pursuant to 25 U.S.C. § 5325(a)(2)-(3), may be incurred directly by the awardee or by an eligible sub-awardee. DCSC amounts are generally awarded on a recurring basis.

1. Examples of DCSC are described in the standards for the review and approval of CSC in Manual Exhibit 6-3-G. These may include, but are not limited to:
    a. unemployment taxes on salaries funded in the Secretarial amount;
    b. workers compensation insurance on salaries funded in the Secretarial amount;
    c. cost of retirement for converted civil service and United States Public Health Service Commissioned Corps Officer salaries;
    d. insurance, but only for coverage not included in the IDC pool (or indirect-type-costs budget) and not covered by the Federal Tort Claims Act;
    e. facility support costs to the extent not already made available;
    f. training required to maintain certification of direct program personnel to the extent not already made available; and
    g. any other item of cost that meets the definition of CSC at 25 U.S.C. § 5325(a)(2)-(3), but is not included in the awardee's IDC pool (or indirect-type-costs budget) or the 25 U.S.C. § 5325(a)(1) amount.

2. Funds for DCSC need not be recalculated each year and will be provided to the awardee on a recurring basis, except for in the following instances:
    a. If an awardee submits a proposal or request and renegotiates DCSC.
    b. If a cost that has previously been funded as DCSC is moved to the Tribe's IDC pool (See Section 6-3.2E).
    c. In the case of a withdrawal as outlined in Section 6-3.3A.
    d. To add amounts in connection with IPA or MOA employees who have converted after the effective date of the preceding DCSC negotiation. This shall not require a renegotiation of ongoing DCSC amounts.

Renegotiated DCSC requirements become effective for the contract period covered by the DCSC request and are awarded on a recurring basis. IHS will provide technical assistance at the request of the Tribe.

3. Unless a negotiation occurs under the preceding subparagraph, the amount of each awardee's ongoing DCSC need shall be adjusted at the end of the first quarter of the

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Federal fiscal year by the most recent OMB non-medical inflation rate in order to account for the normal increased DCSC need.[2]

4. Unless otherwise requested by the awardee, DCSC calculated on new PSFA and expanded PSFA shall not require a recalculation of DCSC on ongoing PSFAs, as long as the additional DCSC is allocable only to the new or expanded PSFA being awarded.

E. **Indirect CSC.**

Guidelines for the Principles Involved in Negotiating Indirect and Indirect-Type Costs. A plan for the allocation of IDC is required to support the distribution of any IDC related to the awardee's program and the determination of which IDC are eligible for indirect CSC funding. All IDC included in the plan are required to be supported by accounting records that substantiate the propriety of the IDC and establish the costs as either: (a) funded in the Secretarial amount; or (b) eligible for indirect CSC funding. The allocation plan should cover all IDC of the awardee and contain, but not necessarily be limited to, the nature and extent of services provided and their relevance to the awardee's program; the item of expense to be included in the IDC pool; and the methods to be used in distributing costs.

Title 2 C.F.R. Part 200 establishes principles and standards for determining IDC applicable to the awardee and the negotiation of IDC rates with the awardee's cognizant agency. 25 U.S.C. § 5325(k) has made modifications to the OMB cost principles otherwise applicable to awardees. Once these principles are applied to identify an awardee's total IDC, the costs must be analyzed to ensure they meet the definition of CSC in 25 U.S.C. § 5325(a)(2)-(3). See also the standards for the review and approval of CSC in Manual Exhibit 6-3-G.

In determining the amount of CSC funding required in relation to the awardee's IDC, Areas should review the awardee's cost allocation plan, its associated IDC proposal, its approved IDC negotiation agreement, and the requirements of 25 U.S.C. § 5325(a)(2)-(3). The allowable IDC of an eligible sub-awardee may be included in the indirect CSC requirement of the awardee when the sub-awards are excluded from the IDC base of the awardee, or are subject to a pass-through IDC rate. The awardee shall be responsible for providing documentation of these costs to the IHS.

1. **Use of Negotiated IDC Rates.** The amount of IDC expected to be incurred by awardees using rates negotiated with the cognizant Federal agency will be estimated annually by applying the most recent negotiated IDC rate(s) to

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[2] Tribes have requested the CPI-U medical inflation rate. HHS is exploring a policy change in the inflation rate used by IHS. If IHS determines a medical inflation rate is appropriate for application in the future, the change will be implemented automatically.

the appropriate direct cost base amount, as discussed below in this paragraph and subject to paragraphs 6-3.2E(3)-(4).

The amount determined as the awardee's CSC requirement will be consistent with the individual awardee's IDC rate agreement and reflect any exclusions required by the IDC rate agreement.

If an awardee's IDC rate is applicable to a fiscal year (FY) that is more than three years old, IHS will not provide IDC associated with the application of that IDC rate. In these cases, the Area will negotiate "indirect-type costs" with the awardee (*see* paragraph 6-3.2E(2) that follows). The rate applicable to the current FY is considered current, and the rate applicable to the previous FY shall be considered one year old. Thus, for example, in FY2016 a rate agreement for FY2013 is the oldest rate that will be used in these calculations.

Based on these principles, IHS will apply the IDC rate to determine a Tribe's IDC need (which shall be adjusted consistent with 25 U.S.C. § 5325(a)(2)-(3), as discussed below, to determine the indirect CSC need) as follows:

Author
Deleted: 450j-1

a. Estimate of Indirect CSC Need and Funding Prior to the Contract Year

In advance of the contract year, IHS and the awardee will negotiate an estimate of the awardee's IDC need using the awardee's most recent (no more than three years old) negotiated IDC rate agreement.

1) Total direct costs will be used based on either:
   a) The eligible funding in the Secretarial amount plus the DCSC funding (or the salaries (or salaries and fringe) for those awardees that use a salary (or salaries and fringe) base), if the total direct costs of the total health care program reflected in the IDC rate agreement or other documentation of prior-year expenditures demonstrate that amount;[3] or
   b) The total direct costs of the total health care program operated by the awardee, if those costs as reflected in the IDC rate agreement are less than the eligible funding in the Secretarial amount plus the DCSC funding.
2) The IDC transferred in the Secretarial amount, negotiated pursuant to 25 U.S.C. § 5325(a)(2)-(3) and this Chapter, shall be deducted from the total direct costs determined in (a)(1).
3) The pass-through and exclusion amount will be determined consistent with the awardee's IDC rate proposal. This amount will be deducted from the total direct costs determined in (a)(1), less the amount determined in (a)(2), if any, to determine the direct cost base.

Author
Deleted: 450j-1

[3] Based on current data as of the publication of this Chapter, IHS believes that the substantial majority of awardees' total direct costs will be calculated pursuant to this subsection.

4) Application of IDC rate: the IDC rate will be applied to the direct cost base determined in paragraphs (a)(1)-(3) to estimate the total amount of IDC applicable to the IHS-funded program.
5) The amount identified in (a)(2), if any, shall be deducted from the total IDC amount determined in paragraph (a)(4) to determine the amount of indirect CSC need and funding to be paid.

b. Determination of Final Amount for Indirect CSC Need and Funding

After the end of the contract funding period IHS and the awardee will negotiate the final amount of indirect CSC as follows.

1) Total direct costs will be based on the amount negotiated pursuant to paragraph (a)(1) above, without further information being required of the awardee, except that:
   a) Increases in eligible funding in the Secretarial amount or DCSC funding awarded during the contract year will be added, to the extent the new total direct costs of the total health care program reflected in the IDC rate agreement or other documentation of prior year expenditures demonstrate that amount;
   b) The awardee may propose to increase the amount for:
      i. Expenditures of prior-year Secretarial funding for which IHS did not pay CSC funding in the year awarded and that the awardee carried over and expended in the current year; and
      ii. Increases in expenditures of Secretarial funding above the amount estimated;
   c) Reductions to the Secretarial amount shall be subtracted.
   d) Reductions to DCSC, if any, as specified in section 6-3.2D(2) shall be subtracted.
2) The IDC transferred in the Secretarial amount, negotiated pursuant to 25 U.S.C. § 5325(a)(2)-(3) and this Chapter, shall be deducted from the total direct costs determined in (b)(1).
3) Pass-through and exclusion amounts will be based on the amounts negotiated pursuant to paragraph (a)(3) above, without further information being required of the awardee, though the awardee may propose adjustments based on expenditures throughout the year and the amounts may need to be adjusted if the awardee proposes increases pursuant to paragraph (b)(1).
4) Application of IDC rate: the applicable IDC rate – i.e., either the fixed carryforward rate or the final rate applicable to the contract funding year– will be applied to the direct cost base to determine the amount of IDC. If the IDC rate applicable to the contract year is not available within 90 days after the end of the performance period, at the awardee's request IHS shall apply the fixed carryforward rate for the funding year or one year prior, or the final rate for the funding year or

Author
Deleted: 450j-1

Author
Deleted: (

two years prior.[4] The final IDC amount will not be determined until the awardee has received an IDC rate that meets the requirements of this subparagraph.

5) The amount, if any, identified pursuant to paragraph (b)(2) shall be deducted from the total IDC amount determined in paragraph (b)(4) to determine the amount of indirect CSC need and any additional funding to be paid.
6) Once final reconciliation is complete and both parties agree on the amount of indirect CSC funding, the parties shall enter into a bilateral amendment/modification setting forth the amount as the indirect CSC funding required under the ISDEAA for the award. If any amount is still owed, IHS will make payment according to the payment provisions of the award. If the awardee was overpaid, the awardee will have the option to either: (a) reimburse IHS for the overpayment; or (b) agree that IHS will apply the overpayment to the awardee's CSC need in the subsequent year.

Author
Deleted: it will

Author
Comment [2]: CHANGE #2: WG agreed to recommended change

2. **Negotiating Indirect-Type Costs.** A lump sum amount for "indirect-type costs" may be negotiated with awardees that do not have negotiated IDC agreements with their cognizant agency or that request such a negotiation, even if they have a negotiated rate. This annual lump-sum amount may be calculated by negotiating a fixed amount for "indirect-type costs." Categories of costs often considered "overhead" or "indirect-type" are generally in the categories of:

Management and Administration; Facilities and Facilities Equipment; and General Services and Expenses. More specific examples of indirect and indirect-type costs include but are not necessarily limited to the following:

Management and Administration	Facilities and Facilities Equipment	General Services and Expenses
Governing Body	Building Rent/Lease/Cost Recovery	Insurance and Bonding
Management and Planning	Utilities	Legal Services
Financial Management	Housekeeping/Janitorial	Audit
Personnel Management	Building and Grounds	General Support Services
Property Management	Repairs and Maintenance	Interest
Records Management	Equipment	Depreciation/Use Fees
Data Processing	__	__
Office Services	__	__

[4] For 2014-2017 agreements IHS agrees to a transitional period, in which it will use an IDC rate up to 3 years old.

As with all IDC, however, the negotiation of indirect-type CSC funding must ensure the amounts are consistent with the definition of CSC in 25 U.S.C. § 5325(a)(2)-(3).

Indirect-type costs must be renegotiated not less than once every three years, but they can be renegotiated more frequently at the awardee's option.

3. **Alternative Methods for Calculating IDC Associated With Recurring Service Unit Shares.** The provisions of this section E(3) shall apply to the negotiation of indirect CSC funding in or after FY 2016 and to the calculation of duplication under 25 U.S.C. § 5325(a)(3), when: i) an awardee assumes a new or expanded PFSA or added staff associated with a joint venture (in which case the review is limited to those new or expanded PFSA or those additional staff); ii) an awardee includes new types of costs not previously included in the IDC pool that is associated with IHS programs, resulting in a change of more than 5% in the value of the IDC pool (in which case the review will be conducted under Alternative A and will be limited to those new types of costs); or iii) an awardee proposes and renegotiates the amount.

Pursuant to the above circumstances, the awardee shall elect the method for determining the amount of IDC associated with the Service Unit shares and the remaining IDC that may be eligible for CSC funding, to identify duplication, if any, pursuant to 25 U.S.C. § 5325(a)(3), in one of two options listed below.

a) **Alternative A**. The awardee and the Area Director or his or her designee shall conduct a case-by-case detailed analysis (Manual Exhibit 6-3-D) of Agency Service Unit share expenditures to identify any IDC transferred in the Secretarial amount. The IDC funded in the Service Unit shares will be deducted from the awardee's direct costs and total IDC, not to exceed the amount included for that same cost in the awardee's IDC pool that would be allocable to IHS under the IDC rate, to avoid duplication under 25 U.S.C. § 5325(a)(3) when determining the indirect CSC funding amount as described above in 6-3.2E(1).

b) **Alternative B.** The awardee and the Area Director or his or her designee will apply the following "split" of total Service Unit shares, the 97/3 method (Manual Exhibit 6-3-E):

   i. 97% of the Service Unit shares amounts will be considered as part of the awardee's direct cost base.
   ii. 3% of the Service Unit shares amounts will be considered as IDC funding.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Comment [3]: This left parenthesis was left out.

Author
Deleted: 2

Author
Comment [4]: CHANGE #3: WG agreed to recommended change

Author
Deleted: 450j-1

Author
Deleted: 450j-1

If the amount considered IDC funding (3 percent) exceeds the awardee's negotiated CSC requirements, the awardee shall retain the excess funds for direct costs.

Once these 97/3 amounts are computed, they will be used in accordance with the terms of the IDC rate agreement (or alternative method provided herein) for calculating the CSC requirement. The remaining IDC need associated with the IHS PSFA will be eligible for payment as indirect CSC, as provided in this Chapter and 25 U.S.C. § 5325(a)(2)-(3). Manual Exhibit 6-3-D illustrates how Alternative A (a detailed analysis) is calculated and Manual Exhibit 6-3-E illustrates how Alternative B (the 97/3 method) is calculated.

4. **Alternative Methods for Calculating IDC Associated With Tribal Shares.** Pursuant to the above circumstances, if an awardee's contract includes Tribal shares, the awardee shall elect the method for determining the amount of IDC associated with Tribal shares and the remaining IDC that may be eligible for CSC funding, to identify duplication, if any, pursuant to 25 U.S.C. § 5325(a)(3), in one of two options listed below.

a. **Alternative A.** The awardee and the Area Director or his or her designee shall conduct a case-by-case detailed analysis (Manual Exhibit 6-3-B) of Agency Tribal share expenditures to identify any IDC transferred in the Secretarial amount. The IDC funded in the Tribal shares will be deducted from the awardee's direct costs and total IDC, not to exceed the amount included for that same cost in the awardee's IDC pool that would be allocable to IHS under the IDC rate, to avoid duplication under 25 U.S.C. § 5325(a)(3) when determining the indirect CSC funding amount as described above in 6-3.2E(1).

b. **Alternative B.** The awardee and the Area Director or his or her designee will apply the following "split" of total Tribal shares, the 80/20 method (Manual Exhibit 6-3-C):

   i. 80% of the Tribal shares amounts will be considered as part of the awardee's direct cost base.
   ii. 20% of the Tribal shares amounts will be considered as IDC funding.
   If the amount considered IDC funding (20 percent) exceeds the awardee's negotiated CSC requirements, the awardee shall retain the excess funds for direct costs.

Once these 80/20 amounts are computed, they will be used in accordance with the terms of the rate agreement (or alternative method provided herein) for calculating the CSC requirement. The remaining IDC need associated with the IHS PSFA will be eligible for payment as indirect CSC, as provided in this Chapter and 25 U.S.C. § 5325(a)(2)-(3). Manual Exhibit 6-3-B illustrates how Alternative A (a detailed analysis) is

Author
Comment [5]: CHANGE #4: WG agreed to recommended change

Author
Deleted: If the 3% percent that is considered IDC funding exceeds the awardee's total negotiated indirect CSC requirements, the awardee shall retain the excess funds for direct costs.

Author
Deleted:

Author
Deleted:

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Comment [6]: CHANGE #5: WG agreed to recommended change

Author
Deleted: If the 20% that is considered IDC funding exceeds the awardee's total negotiated indirect CSC requirements, the awardee shall retain the excess funds for direct costs.

Author
Deleted:

Author
Deleted: 450j-1

calculated and Manual Exhibit 6-3-C illustrates how Alternative B (the 80/20 method) is calculated.

6-3.3 CSC PAYMENTS

Awards will include payment of the full amount of CSC funding negotiated in accordance with the ISDEAA and section 6-3.2 of this Chapter.

A. **Withdrawal.**

When an awardee withdraws a PSFA from an existing award between the IHS and a second awardee, who has been operating that PSFA on behalf of the first awardee, the existing DCSC is subject to reallocation between the two awardees. The DCSC is directly associated with the direct program funds and should be reallocated proportionately between the awardees on the same basis as the Secretarial amount is reallocated.

Any overpayment of CSC funding to the second awardee must either: i) be returned to IHS for allocation to the first awardee; or ii) offset against the second awardee's CSC need in the subsequent year.

B. **Initial Funding Period—New and Expanded Contracts.**

All requests for CSC funding associated with new or expanded PSFA that are submitted independently of a contract proposal or a final offer must be reviewed within the time provided by the ISDEAA at 25 U.S.C. §§ 5321(a), 5387(b).

Author
Deleted: 450f

Negotiated amounts for CSC funding for new and expanded PSFA will be paid along with the award of any 25 U.S.C. § 5325(a)(1) funds. This includes pre-award, startup, DCSC, and indirect CSC funding.

Author
Deleted: 458aaa-6

If an awardee proposes to start a new or expanded activity for less than a full year, an annual amount for CSC may be determined consistent with the methodologies included in this Chapter; however, DCSC and indirect CSC funding will be pro-rated in the first award period. Startup and pre-award costs will be non-recurring, and the negotiated amount will be paid entirely in the first year of the award period.

Author
Deleted: 450j-1

C. **Ongoing Awards.**

Negotiated amounts for DCSC and indirect CSC funding for ongoing awards will be paid along with the initial payment of the 25 U.S.C. § 5325(a)(1) funding.

Author
Deleted: 450j-1

Subsequent payments may be made if a new amount is negotiated during the contract year, e.g., due to updates to the awardee's IDC rate, consistent with the determination of CSC in section 6-3.2.

6-3.4 ROLES AND RESPONSIBILITIES

Awardees and IHS staff have distinct roles and responsibilities in facilitating the determination of Tribal CSC requirements and in the allocation of CSC resources. This section will describe the roles and responsibilities associated with the determination of initial Tribal CSC (new and expanded) requirements; the determination of ongoing CSC requirements; and some of the ancillary CSC activities carried out by the IHS.

A. **Overview - New and Expanded CSC Requests.** Awardees must provide a detailed CSC request to the Area Director or his or her designee. IHS has developed sample request letters for that purpose, at the option of the awardee to use to submit their requests (see sample letters in Manual Exhibit 6-3-G and the Annual CSC Calculation (ACC) tool in Manual Exhibit 6-3-F). The request must include a clear description of the requested CSC funding to be negotiated (as specified at 25 C.F.R. § 900.8) along with supporting justification, the date that the PSFA are to be assumed, and an identification of the Secretarial amount to be transferred. Additionally, the awardee is encouraged to provide a detailed line item Tribal budget for the 25 U.S.C. § 5325(a)(1) amount to facilitate CSC negotiations. The Area Director or his or her designee will provide a copy of the proposal to the Headquarters Office of Direct Service and Contracting Tribes (ODSCT) and a copy of the final negotiated request to the IHS Headquarters Office of Finance and Accounting (OFA), and a copy to the Office of Tribal Self-Governance (OTSG) in the case of a Title V compactor.

Author
Deleted: 450j-1

B. **New and Expanded CSC Negotiations.** The Area Director or his or her designee (or the Agency Lead Negotiator in the case of a Title V Self-Governance award) has the primary responsibility for negotiating the new and expanded CSC request with the awardee and forwarding the proposal to the Headquarters ODSCT (or OTSG), as well as the final approved request to the Headquarters OFA for funding to be released for payment. If the Area Director or his or her designee and the awardee do not agree on an item(s) of cost, the Area Director or designee shall issue a partial declination of the awardee's contract proposal or final offer in accordance with the ISDEAA and with 25 C.F.R. §§ 900.20-900.33 and 42 C.F.R. §§ 137.140-137.48. The declination or final offer rejection must be issued within the time required by the ISDEAA unless the awardee has provided written consent to an extension in accordance with 25 C.F.R. § 900.17 or 42 C.F.R. § 137.135. In the event CSC negotiations are unresolved at the time a program transfer or expansion goes into effect, the finally-determined CSC amounts shall be effective for the entire contract funding period starting from the date of the transfer or expansion.

C. **Ongoing Awards.**

The Area Director or his or her designee (or the Agency Lead Negotiator in the case of a Title V Self-Governance award) will provide a completed ACC tool during negotiations of successor AFA or FA, in order to assist the parties in determining the amount of CSC funding to be added to the contract. (Consistent with Section 6-3.2.)

D. **Other CSC Responsibilities.**

1. **Disputes.** Disputes over CSC should be resolved as either a formal declination or final offer rejection appeal or as a claim under the Contract Disputes Act (CDA), 41 U.S.C. § 7101 et seq. An informal conference (25 C.F.R. § 900.153) or other alternative dispute mechanism (25 C.F.R. § 900.217) may also be useful in resolving disagreements over CSC. When it is unclear whether a dispute should be resolved as a declination or a CDA claim, the Associate Director of Self-Determination Services, ODSCT, should be contacted for possible referral to the IHS Headquarters Leadership Team.

2. **Pre-Award Declination Appeals.** Declination appeals may arise from a pre-award decision to decline a proposal, in whole or in part; a pre-award decision to decline a proposed amendment to an award; or any of the other reasons cited at 25 C.F.R. § 900.150. Declination appeals are most likely to occur as a result of disagreements over an awardee's new or expanded CSC request (Section 6-3.3B). Declination appeals must be processed pursuant to 25 C.F.R. §§ 900.150-900.177.

3. **Appeals of Rejections of Final Offers.** Final Offer appeals may arise out of a pre-award decision by the IHS to reject, in whole or in part, a Final Offer submitted by a compactor when it is unable to reach agreement with the IHS on the terms of a compact or FA, including funding levels. Final Offer appeals must be processed pursuant to 25 U.S.C. § 5387(c)(1) and any regulations promulgated thereunder.

4. **Post-Award CDA Claims.** All post-award disputes regarding an awarding official's decision related to an ISDEAA award, including post-award disputes over CSC funding, must be addressed under the CDA. Post-award contract disputes generally occur as a result of the parties' failure to agree concerning the amount of DCSC due (Section 6-3.2D) or the amount of indirect CSC funding due (Section 6-3.2E). Post-award contract disputes must be handled pursuant to the CDA and 25 C.F.R. §§ 900.215-900.230.

5. **Pilot Projects.** The IHS may adopt pilot projects to incorporate innovative approaches to CSC funding issues. The IHS Director may approve these pilot projects without requiring revisions in this Chapter. Pilot projects must be optional for awardees and of limited duration. Upon the completion and evaluation of these projects, this Chapter may be amended following Tribal consultation to incorporate new provisions implementing these projects on a permanent basis.

6. **CSC Budget Projections.** Each Area Director or his or her designee shall survey Tribes and Tribal organizations within that Area to develop accurate projections of CSC need at the end of the second and fourth quarter. This will include identification of the amounts required for any new and expanded projects as well as projections for the total ongoing CSC requirement for the following FY and estimates for the next two FYs. The information will be consolidated by the IHS Headquarters OFA and

Author
Deleted: 458aaa-6

provided to Tribes and Tribal organizations as expeditiously as possible. The information will also be generated in the "Contract Support Costs Budget Projections (for the appropriate FY)," and submitted to the Director, Headquarters OFA, on or before September 30 of each FY and will be used by the IHS in conjunction with the Agency's budget formulation process.

7. **Common Language.** The IHS may from time to time propose common language for AFA and FA regarding CSC. This common language may be considered as an option for negotiations by the awardees and IHS negotiators. Awardees and IHS negotiators should be made aware that specific CSC language in contracts, compacts, AFA, and FA is negotiable and cannot be imposed on awardees as a condition of contracting.

6-3.5 CSC REPORTS

A. **Reporting and Documenting Amounts of CSC Available, Needed, and Requested.** The Area Director or his or her designee shall maintain a historical record of funds negotiated and awarded in each of the categories listed below. Final reports can be found at http://www.ihs.gov/newsroom/index.cfm/reportstocongress/.

1. Secretarial amount
2. Pre-award costs
3. Startup costs
4. DCSC funding
5. Indirect CSC funding for those awardees that use an IDC rate
6. Indirect CSC funding for those awardees that negotiate indirect-type costs
7. IDC rates
8. Types of bases
9. Pass-through/exclusions
10. Total direct cost base
11. DCSC requirements (including the unduplicated DCSC requirement associated with sub-awards)

12. Indirect CSC requirements (including the unduplicated indirect CSC requirement associated with sub-awards)

B. **Annual CSC Funding Report to Tribes and Tribal Organizations.** Area Directors shall provide a report to the Director, OFA, no later than March 1 of each FY that includes those data elements identified above on an awardee-by-awardee basis for the previous FY ending on September 30. Before the report is submitted, the amounts included in the report shall be certified as accurate by the IHS Area Finance Management Officer (FMO) and the Area Director or his or her designee.

1. A copy of the Area Director's report inclusive of all Area-wide CSC funding information shall be provided by the Area Director or his or her designee to the awardees within that Area no later than January 31. Any corrections or changes to the data resulting from an awardee review must be certified by the Area FMO and a [revised / corrected] final Area Director's report shall be submitted to the IHS Headquarters OFA through the Area Director or his or her designee no later than March 1. A copy of this report shall also be provided by the Area Director or his or her designee to the awardees within that Area no later than May 30.

2. The IHS Headquarters Director, OFA, shall consolidate all Area reports into the "IHS CSC Funding Report to Tribes." In doing so, the IHS Headquarters Director, OFA, shall, in consultation with the Director, ODSCT, and the Director, OTSG, provide a projection of the full CSC requirement for the current and subsequent FY.

3. The IHS Headquarters Director, OFA, shall finalize the "IHS CSC Funding Report to Tribes," obtain concurrence from the Director, ODSCT, and the Director, OTSG, and transmit the report to the Director, IHS, for approval no later than April 1.

After the "IHS CSC Funding Report to Tribes" is approved by the Director, IHS, the Headquarters Director, OFA, will provide copies to each Area Director or his or her designee, who shall then be responsible for promptly providing a copy of the IHS CSC Funding Report to Tribes to all awardees compacting or contracting within that Area. The IHS CSC Funding Report shall be furnished to all awardees on or before May 30 of the year following the close of the fiscal year that is the subject of the Report. The timing for delivery of the IHS CSC Funding Report to awardees is not dependent upon finalization and/or clearance of the report referenced in Section 6-3.5C below.

C. **Annual CSC Report to Congress**. IHS also has a responsibility pursuant to 25 U.S.C. § 5325(c)1-5 to provide a report to Congress on the implementation of the ISDEAA and its administration of CSC, including "an accounting of any deficiency in funds needed to provide required contract support costs to all contractors for the fiscal year for which the report is being submitted."

Author
Deleted: 450j-1

The Director, IHS or his/her designee shall also provide each awardee with a copy of the CSC Report to Congress, once that report has been cleared by the Administration for submission to Congress.

Part 6, Chapter 3: Manual Exhibits

Manual Exhibit	Description
Exhibit 6-3-A	United States Code, Title 25, Chapter 14, Miscellaneous, Subchapter II, Indian Self-Determination and Education Assistance, Part A "Indian Self-Determination," Section 5325 and Section 5326
Exhibit 6-3-B	Calculating IDC Associated with Tribal Shares and the Contract Support Costs Amount Based on a Detailed Analysis
Exhibit 6-3-C	Calculating IDC Associated with Tribal Shares and the Contract Support Costs Amount Using the 80/20 Method
Exhibit 6-3-D	Calculating IDC Associated with Recurring Service Unit Shares and the Contract Support Costs Amount Based on a Detailed Analysis
Exhibit 6-3-E	Calculating IDC Associated with Recurring Service Unit Shares and the Contract Support Costs Amount Using the 97/3 Method
Exhibit 6-3-F	Contract Support Costs Negotiation Template
Exhibit 6-3-G	Standards for Review and Approval of Contract Support Costs in the Indian Health Service

Author
Deleted: 450j-1

Author
Deleted: 450j-2

Part 6, Chapter 3: Manual Exhibits

Manual Exhibit 6-3-A

United States Code, Title 25, Chapter 14, Miscellaneous, Subchapter II, Indian Self-Determination and Education Assistance, Part A "Indian Self-Determination," Section 5325 and Section 5326

§5325. Contract funding and indirect costs

(a) Amount of funds provided

(1) The amount of funds provided under the terms of self-determination contracts entered into pursuant to this subchapter shall not be less than the appropriate Secretary would have otherwise provided for the operation of the programs or portions thereof for the period covered by the contract, without regard to any organizational level within the Department of the Interior or the Department of Health and Human Services, as appropriate, at which the program, function, service, or activity or portion thereof, including supportive administrative functions that are otherwise contractable, is operated.

(2) There shall be added to the amount required by paragraph (1) contract support costs which shall consist of an amount for the reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract and prudent management, but which—

(A) normally are not carried on by the respective Secretary in his direct operation of the program; or

(B) are provided by the Secretary in support of the contracted program from resources other than those under contract.

(3)(A) The contract support costs that are eligible costs for the purposes of receiving funding under this subchapter shall include the costs of reimbursing each tribal contractor for reasonable and allowable costs of—

(i) direct program expenses for the operation of the Federal program that is the subject of the contract, and

(ii) any additional administrative or other expense related to the overhead incurred by the tribal contractor in connection with the operation of the Federal program, function, service, or activity pursuant to the contract,

except that such funding shall not duplicate any funding provided under subsection (a)(1).

(B) On an annual basis, during such period as a tribe or tribal organization operates a Federal program, function, service, or activity pursuant to a contract entered into under this subchapter, the tribe or tribal organization shall have the option to negotiate with the Secretary the amount of funds that the tribe or tribal organization is entitled to receive under such contract pursuant to this paragraph.

Author
Deleted: 450j-1

Author
Deleted: 450j-2

Author
Deleted: 450j–1

(4) For each fiscal year during which a self-determination contract is in effect, any savings attributable to the operation of a Federal program, function, service, or activity under a self-determination contract by a tribe or tribal organization (including a cost reimbursement construction contract) shall-

(A) be used to provide additional services or benefits under the contract; or

(B) be expended by the tribe or tribal organization in the succeeding fiscal year, as provided in section 13a of this title.

(5) Subject to paragraph (6), during the initial year that a self-determination contract is in effect, the amount required to be paid under paragraph (2) shall include startup costs consisting of the reasonable costs that have been incurred or will be incurred on a one-time basis pursuant to the contract necessary-

(A) to plan, prepare for, and assume operation of the program, function, service, or activity that is the subject of the contract; and

(B) to ensure compliance with the terms of the contract and prudent management.

(6) Costs incurred before the initial year that a self-determination contract is in effect may not be included in the amount required to be paid under paragraph (2) if the Secretary does not receive a written notification of the nature and extent of the costs prior to the date on which such costs are incurred.

(b) Reductions and increases in amount of funds provided

The amount of funds required by subsection (a)—

(1) shall not be reduced to make funding available for contract monitoring or administration by the Secretary;

(2) shall not be reduced by the Secretary in subsequent years except pursuant to—

(A) a reduction in appropriations from the previous fiscal year for the program or function to be contracted;

(B) a directive in the statement of the managers accompanying a conference report on an appropriation bill or continuing resolution;

(C) a tribal authorization;

(D) a change in the amount of pass-through funds needed under a contract; or

(E) completion of a contracted project, activity, or program;

(3) shall not be reduced by the Secretary to pay for Federal functions, including, but not limited to, Federal pay costs, Federal employee retirement benefits, automated data processing, contract technical assistance or contract monitoring;

(4) shall not be reduced by the Secretary to pay for the costs of Federal personnel displaced by a self-determination contract; and

(5) may, at the request of the tribal organization, be increased by the Secretary if necessary to carry out this subchapter or as provided in section 5324(c) of this title.

Author
Deleted: 450j

Notwithstanding any other provision in this subchapter, the provision of funds under this subchapter is subject to the availability of appropriations and the Secretary is not required to reduce funding for programs, projects, or activities serving a tribe to make funds available to another tribe or tribal organization under this subchapter.

(c) Annual reports

Not later than May 15 of each year, the Secretary shall prepare and submit to Congress an annual report on the implementation of this subchapter. Such report shall include—

(1) an accounting of the total amounts of funds provided for each program and the budget activity for direct program costs and contract support costs of tribal organizations under self-determination;

(2) an accounting of any deficiency in funds needed to provide required contract support costs to all contractors for the fiscal year for which the report is being submitted;

(3) the indirect cost rate and type of rate for each tribal organization that has been negotiated with the appropriate Secretary;

(4) the direct cost base and type of base from which the indirect cost rate is determined for each tribal organization;

(5) the indirect cost pool amounts and the types of costs included in the indirect cost pool; and

(6) an accounting of any deficiency in funds needed to maintain the preexisting level of services to any Indian tribes affected by contracting activities under this subchapter, and a statement of the amount of funds needed for transitional purposes to enable contractors to convert from a Federal fiscal year accounting cycle, as authorized by section 5324(d) of this title.

Author
Deleted: 450j

(d) Treatment of shortfalls in indirect cost recoveries

(1) Where a tribal organization's allowable indirect cost recoveries are below the level of indirect costs that the tribal organizations should have received for any given year pursuant to its approved indirect cost rate, and such shortfall is the result of lack of full indirect cost funding by any Federal, State, or other agency, such shortfall in recoveries shall not form the basis for any theoretical over-recovery or other adverse adjustment to any future years' indirect cost rate or amount for such tribal organization, nor shall any agency seek to collect such shortfall from the tribal organization.

(2) Nothing in this subsection shall be construed to authorize the Secretary to fund less than the full amount of need for indirect costs associated with a self-determination contract.

(e) Liability for indebtedness incurred before fiscal year 1992

Indian tribes and tribal organizations shall not be held liable for amounts of indebtedness attributable to theoretical or actual under-recoveries or theoretical over-recoveries of indirect costs, as defined in Office of Management and Budget Circular A–87, incurred for fiscal years prior to fiscal year 1992.

(f) Limitation on remedies relating to cost disallowances

Any right of action or other remedy (other than those relating to a criminal offense) relating to any disallowance of costs shall be barred unless the Secretary has given notice of any such disallowance within three hundred and sixty-five days of receiving any required annual single agency audit report or, for any period covered by law or regulation in force prior to October 19, 1984, any other required final audit report. Such notice shall set forth the right of appeal and hearing to the board of contract appeals pursuant to section 5331 of this title. For the purpose of determining the 365-day period specified in this paragraph, an audit report shall be deemed to have been received on the date of actual receipt by the Secretary, if, within 60 days after receiving the report, the Secretary does not give notice of a determination by the Secretary to reject the single-agency report as insufficient due to noncompliance with chapter 75 of title 31 or noncompliance with any other applicable law. Nothing in this subsection shall be deemed to enlarge the rights of the Secretary with respect to section 476 of this title.

Author
Deleted: 450m–1

(g) Addition to contract of full amount contractor entitled; adjustment

Upon the approval of a self-determination contract, the Secretary shall add to the contract the full amount of funds to which the contractor is entitled under subsection (a), subject to adjustments for each subsequent year that such tribe or tribal organization administers a Federal program, function, service, or activity under such contract.

(h) Indirect costs for contracts for construction programs

In calculating the indirect costs associated with a self-determination contract for a construction program, the Secretary shall take into consideration only those costs associated with the administration of the contract and shall not take into consideration those moneys actually passed on by the tribal organization to construction contractors and subcontractors.

(i) Indian Health Service and Bureau of Indian Affairs budget consultations

On an annual basis, the Secretary shall consult with, and solicit the participation of, Indian tribes and tribal organizations in the development of the budget for the Indian

Health Service and the Bureau of Indian Affairs (including participation of Indian tribes and tribal organizations in formulating annual budget requests that the Secretary submits to the President for submission to Congress pursuant to section 1105 of title 31).

(j) Use of funds for matching or cost participation requirements

Notwithstanding any other provision of law, a tribal organization may use funds provided under a self-determination contract to meet matching or cost participation requirements under other Federal and non-Federal programs.

(k) Allowable uses of funds without approval of Secretary

Without intending any limitation, a tribal organization may, without the approval of the Secretary, expend funds provided under a self-determination contract for the following purposes, to the extent that the expenditure of the funds is supportive of a contracted program:

(1) Depreciation and use allowances not otherwise specifically prohibited by law, including the depreciation of facilities owned by the tribe or tribal organization.

(2) Publication and printing costs.

(3) Building, realty, and facilities costs, including rental costs or mortgage expenses.

(4) Automated data processing and similar equipment or services.

(5) Costs for capital assets and repairs.

(6) Management studies.

(7) Professional services, other than services provided in connection with judicial proceedings by or against the United States.

(8) Insurance and indemnification, including insurance covering the risk of loss of or damage to property used in connection with the contract without regard to the ownership of such property.

(9) Costs incurred to raise funds or contributions from non-Federal sources for the purpose of furthering the goals and objectives of the self-determination contract.

(10) Interest expenses paid on capital expenditures such as buildings, building renovation, or acquisition or fabrication of capital equipment, and interest expenses on loans necessitated due to delays by the Secretary in providing funds under a contract.

(11) Expenses of a governing body of a tribal organization that are attributable to the management or operation of programs under this subchapter.

(12) Costs associated with the management of pension funds, self-insurance funds, and other funds of the tribal organization that provide for participation by the Federal Government.

(l) Suspension, withholding, or delay in payment of funds

(1) The Secretary may only suspend, withhold, or delay the payment of funds for a period of 30 days beginning on the date the Secretary makes a determination under this paragraph to a tribal organization under a self-determination contract, if the Secretary determines that the tribal organization has failed to substantially carry out the contract without good cause. In any such case, the Secretary shall provide the tribal organization with reasonable advance written notice, technical assistance (subject to available resources) to assist the tribal organization, a hearing on the record not later than 10 days after the date of such determination or such later date as the tribal organization shall approve, and promptly release any funds withheld upon subsequent compliance.

(2) With respect to any hearing or appeal conducted pursuant to this subsection, the Secretary shall have the burden of proof to establish by clearly demonstrating the validity of the grounds for suspending, withholding, or delaying payment of funds.

(m) Use of program income earned

The program income earned by a tribal organization in the course of carrying out a self-determination contract—

(1) shall be used by the tribal organization to further the general purposes of the contract; and

(2) shall not be a basis for reducing the amount of funds otherwise obligated to the contract.

(n) Reduction of administrative or other responsibilities of Secretary; use of savings

To the extent that programs, functions, services, or activities carried out by tribal organizations pursuant to contracts entered into under this subchapter reduce the administrative or other responsibilities of the Secretary with respect to the operation of Indian programs and result in savings that have not otherwise been included in the amount of contract funds determined under subsection (a), the Secretary shall make such savings available for the provision of additional services to program beneficiaries, either directly or through contractors, in a manner equitable to both direct and contracted programs.

(o) Rebudgeting by tribal organization

Notwithstanding any other provision of law (including any regulation), a tribal organization that carries out a self-determination contract may, with respect to allocations within the approved budget of the contract, rebudget to meet contract requirements, if such rebudgeting would not have an adverse effect on the performance of the contract.

§ 5326. Indian Health Service: availability of funds for Indian self-determination or self-governance contract or grant support costs

Before, on, and after October 21, 1998, and notwithstanding any other provision of law, funds available to the Indian Health Service in this Act or any other Act for Indian self-determination or self-governance contract or grant support costs may be expended only for costs directly attributable to contracts, grants and compacts pursuant to the Indian Self-Determination Act [25 U.S.C. 5321 et seq.] and no funds appropriated by this or any other Act shall be available for any contract support costs or indirect costs associated with any contract, grant, cooperative agreement, self-governance compact, or funding agreement entered into between an Indian tribe or tribal organization and any entity other than the Indian Health Service.

Reference: the United States Code, Office of the Law Revision Counsel, 25 U.S.C. § 5325 and 25 U.S.C. § 5326 (laws renumbered on September 1, 2016), available at http://uscode.house.gov/browse.xhtml.

Author
Deleted: 450j–2

Author
Deleted: 450f

Author
Comment [7]: CHANGE #6: IHS corrected the date

Author
Deleted: 450j-1

Author
Deleted: 450j-2

Author
Deleted: in effect as of March 2, 2016, and

Manual Exhibit 6-3-B

Calculating Indirect Costs (IDC) Associated with Tribal Shares and the Contract Support Costs Amount Based On A Detailed Analysis (This Exhibit does not cover DCSC.[1])

Assumptions:

1. Tribe A has $100,000 in Area and Headquarters Tribal Shares
2. Based on a detailed analysis, IHS and the Tribe agree that $10,000 of Tribal shares are associated with IDC in Tribe A's IDC pool, pursuant to Section 6-3.2.E.4.a. of this Chapter
3. No pass-through or exclusions
4. Indirect cost rate = 30%

Table 1. IDC Calculation

Tribal Shares amount	$100,000
Less agreed-upon Tribal Shares amount associated with costs in the IDC pool	($10,000)
Sub-total of Tribal Shares for direct costs	$90,000
Less Pass-through & Exclusions	$0
Total of direct cost base for Tribal Shares	$90,000
x 30% IDC rate to determine total IDC need for Tribal Shares	$27,000

Table 2. Indirect CSC Calculation

Total IDC need for Tribal Shares	$27,000
Less agreed-upon Tribal Shares amount associated with costs in the IDC pool	($10,000)
Indirect CSC amount	$17,000

Tribe A would receive $100,000 from Tribal Shares and $17,000 would be funded for indirect CSC.

[1] See Indian Health Manual Section 6-3.2.E.

Manual Exhibit 6-3-C

Calculating Indirect Costs (IDC) Associated with Tribal Shares and the Contract Support Costs Amount Using The 80/20 Method (This Exhibit does not cover DCSC.[1])

Assumptions:

1. Tribe B has $100,000 in Area and Headquarters Tribal Shares
2. The Area and Tribe apply the "80/20 Split" pursuant to Section 6-3.2.E.4.b of this Chapter
3. No Pass-through & Exclusions
4. Indirect cost rate = 30%

Table 1. IDC Calculation

Tribal Shares amount	$100,000
Less 80/20 split	($20,000)
Sub-total Tribal Shares for direct costs	$80,000
Less Pass-through & Exclusions	$0
Total of direct cost base for Tribal Shares	$80,000
x 30% IDC rate to determine total IDC need for Tribal Shares	$24,000

Table 2. Indirect CSC Calculation

Total IDC need for Tribal Shares	$24,000
Less 80/20 split	($20,000)
Indirect CSC amount	$4,000

Tribe B would receive $100,000 from Tribal shares and $4,000 would be funded for indirect CSC.

[1] See Indian Health Manual Section 6-3.2.E.

Manual Exhibit 6-3-D

Calculating Indirect Costs (IDC) Associated with Recurring Service Unit Shares and the Contract Support Costs Amount Based On A Detailed Analysis (This Exhibit does not cover DCSC.[1])

Assumptions:

1. Tribe A has $600,000 in Recurring Service Unit Shares
2. Based on a detailed analysis, IHS and the Tribe agree that $15,000 of Recurring Service Unit Shares are associated with IDC in Tribe A's IDC pool, pursuant to Section 6-3.2.E.3.a. of this Chapter
3. Pass-through & Exclusions = $80,000
4. Indirect cost rate = 30%

Table 1. IDC Calculation

Recurring Service Unit Shares amount	$600,000
Less agreed-upon Recurring Service Unit Shares amount associated with costs in the IDC pool	($15,000)
Sub-total Recurring Service Unit Shares for direct costs	$585,000
Less Pass-through & Exclusions	$(80,000)
Total of direct cost base for Recurring Service Unit Shares	$505,000
x 30% IDC rate to determine total IDC need for Recurring Service Unit Shares	$151,500

Table 2. CSC Calculation

Total IDC need for Recurring Service Unit Shares	$151,500
Less agreed-upon Recurring Service Unit Shares amount associated with costs in the IDC pool	($15,000)
Indirect CSC amount	$136,500

Tribe A would receive $600,000 from Recurring Service Unit Shares and $136,500 would be funded for indirect CSC.

[1] See Indian Health Manual Section 6-3.2.E.

Manual Exhibit 6-3-E

Calculating Indirect Costs (IDC) Associated with Recurring Service Unit Shares and the Contract Support Costs Amount Using The 97/3 Method (This Exhibit does not cover DCSC.[8])

Assumptions:

1. Tribe B has $600,000 in Recurring Service Unit Shares
2. The Area and Tribe apply the "97/3 Split" pursuant to Section 6-3.2.E.3.b of this Chapter
3. Pass-through & Exclusions = $80,000
4. Indirect cost rate = 30%

Table 1. IDC Calculation

Recurring Service Unit Shares amount	$600,000
Less 97/3 split	($18,000)
Sub-total Recurring Service Unit Shares for direct costs	$582,000
Less Pass-through & Exclusions	$(80,000)
Total of direct cost base for Recurring Service Unit Shares	$502,000
x 30% IDC rate to determine total IDC need for Recurring Service Unit Shares	$150,600

Table 2. CSC Calculation

Total IDC need for Recurring Service Unit Shares	$150,600
Less 97/3 split	($18,000)
Indirect CSC amount	$132,600

Tribe B would receive $600,000 from Recurring Service Unit Shares and $132,600 would be funded for indirect CSC.

[8] See Indian Health Manual Section 6-3.2.E.

Manual Exhibit 6-3-F

Contract Support Costs (CSC) Negotiation Template (Fiscal Year 20XX)[9]

Check one box: ☐ **Estimate of CSC Need** ☐ **Final CSC Reconciliation**	
Check one box: **FA Amendment #** **FA Cumulative Funding Report (CFR) #**	_____ _____
Date Completed:	_____
Tribe/Tribal Organization (T/TO):	**Example T/TO**

	Funding/Costs	Subtotals	Totals	Source of Inputs
A	Program (Service Unit) Funding	$655,943.00		Recurring and non-recurring eligible funding for the T/TO's programs, functions, services, or activities (PFSA) at the Service Unit level. Depending upon the structure of an awardee's indirect cost (IDC) rate, this may include buy-backs.
A.1	Expenditures from Carryover Funds (for which CSC was not funded previously), Net of Pass-throughs and Exclusions	$0.00		Pursuant to Section 6-3.2.E.1.b.1.b.i. This is determined by whether the parties included the funds in the CSC calculation in the year awarded and not by how the T/TO allocates funding in its accounting records.
B	Total Area Tribal Shares	$25,000.00		Recurring and non-recurring eligible funding for the T/TO's PFSA at the Area Level (Area Office Tribal Shares, or AOTS).
C	Total Headquarters Tribal Shares	$10,000.00		Recurring and non-recurring eligible funding for the T/TO's PFSA at the Headquarters Level (Headquarters Tribal Shares, or HQTS).
D	Total Secretarial Amount	$690,943.00		Items A + B + C (Total recurring and non-recurring eligible funding awarded under the Secretarial Amount.)

[9] This Template is a tool used by the Indian Health Service (IHS) for calculating and negotiating CSC. Neither this Template nor any other negotiation documents creates a contractual obligation on behalf of either IHS or a T/TO. The CSC amount that the parties agree is required under any Indian Self-Determination and Education Assistance Act (ISDEAA) agreement will be identified in the agreement itself.

Author
Comment [8]: CHANGE #7: Changes reflect WG agreement

Author
Deleted: (or 450j-15325(a)(1))

Author
Deleted: 450j-15325(a)(1)

Author
Deleted: of the ISDEAA

	Funding/Costs	Subtotals	Totals	Source of Inputs
E.1	IDC Associated With –Recurring Service Unit Shares	$0.00		Negotiated and calculated pursuant to Section 6-3.2.E.3 either: (a) case-by-case analysis, or (b) 97-3 method.
E.2	IDC Associated With Tribal Shares	$7,000.00		Negotiated and calculated pursuant to Section 6-3.2.E.4, either: (a) case-by-case analysis, or (b) 80-20 method.
E.3	Total IDC Identified As Associated With the Secretarial Amount	$7,000.00		This represents PFSA funded in the Secretarial amount determined to be duplicative of costs in the T/TO's IDC pool.
F	Direct Costs Funded through the Secretarial Amount		$683,943.00	Item D - E.3
G	Prior Year Direct CSC (DCSC) Need	$76,390.00		Per prior-year agreement.
H	Inflation Factor	1.6%		To be provided by IHS when final inflation rate for previous year becomes available (usually in November). Final rate would be used to update this amount and award T/TO inflation on DCSC at the end of IHS's first quarter. See Section 6-3.2.D.3, including footnote 3.
I.1	Current Year DCSC Need	$77,612.24		Incorporate either the prior-year DCSC need or, if there is a current-year renegotiation, the renegotiated amount.
I.2		$0.00	$77,612.24	
I.3	Startup and Pre-Award Need		$450.00	Summarizes the negotiation for non-recurring Pre-Award and Startup costs for new or expanded PSFA's in the upcoming year.
J	Total Direct Costs		$762,005.24	Items F + I, but subject to Section 6-3.2, Paragraphs E.1.a, Estimate of Indirect CSC Need and Funding Prior to the Contract Year and E.1.b, Determination of Final Amount for Indirect CSC Need and Funding.
K	Less: Pass-throughs and Exclusions		$14,262.29	The amount of pass-throughs and exclusions funded by IHS.
L	Direct Cost Base		$747,742.95	Item J - K
M	Most Current IDC Rate		25.12%	Current IDC rate. If T/TO has multiple IDC rates, enter blended rate and submit detailed calculation of the blended rate.

Author
Deleted: Identified

Author
Deleted: 450j-15325(a)(1)

Author
Deleted: 450j-15325(a)(1)

Author
Deleted: 450j-15325(a)(1)

	Funding/Costs	Subtotals	Totals	Source of Inputs
N	IDC Need (Non-Recurring) Based on IDC Rate		$187,833.03	Item L * M (Direct Cost Base x IDC Rate)
O	Credit for IDC Associated with the Secretarial Amount		$7,000.00	Equals Item E.3 if the T/TO has higher than a 25.00% IDC rate; if T/TO has a rate of 25.00% or lower the credit in Item O is based on the total IDC need for Tribal Shares generated by the T/TO's rate plus the IDC Associated with Recurring Service Unit Shares (Item E.1)
P	Current-Year Indirect CSC Need		$180,833.03	Item N - O (Total IDC need less IDC associated with the Secretarial Amount.
Q	IDC-Type Costs		$0.00	As negotiated pursuant to Section 6-3.2.E.2; see also Exhibit G, footnote 5. Enter $0 if the T/TO negotiates indirect CSC solely based on its IDC rate.
R	Current-Year Total CSC Need		$258,445.27	Items I.2 + I.3 + P +Q (Total need for DCSC and indirect CSC)

S	Current-Year DCSC Need		$77,612.24	Item I.2
T	Total DCSC Paid Year-to-Date		$0.00	Total DCSC funding paid to the T/TO year-to-date.

U	Current-Year Indirect CSC Need		$180,833.03	Items P + Q
V	Total Indirect CSC Paid Year-to-Date		$100,000.00	Total indirect CSC funding paid to the T/TO year-to-date.

W	Current-Year Startup and Pre-Award Need		$450.00	Item I.3
X	Total Startup and Pre-Award CSC Paid Year-to-Date		$0.00	Total Startup and Pre-Award CSC funding paid to the T/TO year-to-date.

Author
Deleted: 450j-15325(a)(1)

Author
Deleted: Item E

Author
Deleted: 450j-15325(a)(1).

Author
Comment [9]: The formula on the Excel Worksheet shared by the IHS incorrectly omits Line I.3 in the formula to include Startup and Pre-Award Need.

Author
Comment [10]: Description incorrectly omitted Line Q – IDC-Type Costs.

	Funding/Costs	Subtotals	Totals	Source of Inputs
Note Regarding Sub-Awards: The Template awards CSC on the direct cost base incurred by the T/TO. If the T/TO has an agreement(s) with a sub-awardee whose costs are eligible to be considered in the CSC need of the T/TO and the T/TO treats sub-awards as a pass-through cost when determining its direct cost base, the total CSC negotiated can be adjusted to incorporate eligible costs specifically identified for each sub-awardee (while recognizing sub-awardee pass-throughs and exclusions and the sub-awardee's IDC rate).				

Exhibit	Description
Manual Exhibit 6-3-G	Standards for Review and Approval of Contract Support Costs by the Indian Health Service

Manual Exhibit 6-3-G

Standards for the Review and Approval of Contract Support Costs by the Indian Health Service[10]

Section A. Guidelines for Proposal Preparation and Cost Analysis of Tribal Requests for Contract Support Costs Funding

1. **Introduction.** The Indian Health Service (IHS) has developed its contract support costs (CSC) policy with the active participation of Indian Tribes and interested Tribal representatives. The IHS has sought to maintain an openness concerning CSC issues and has provided information, guidance, and technical assistance to Tribes in their development of CSC proposals. The following documents are intended to clarify CSC.

   Tribes have requested that the IHS develop standards for CSC to be used in the review and approval of CSC requests. The Office of Management and Budget (OMB) has also supported the development of CSC standards as a means of ensuring consistency in the review of Tribal CSC requests. In order to help Tribes understand the Agency's rationale for approving or disapproving Tribal CSC requests, it has become necessary to develop a set of consistent standards. In fiscal year (FY) 2001, the IHS initiated the process of developing standards for CSC by creating a joint Tribal/Federal workgroup and making this part of the ongoing IHS/Tribal CSC Workgroup's charge. The IHS and Tribes revisited and updated these standards in FY 2016. Consensus with Tribal representatives has been achieved on most of the standards in this Exhibit. On issues that have not been resolved, the Federal position is incorporated into the document, and the tribal position, if different, is referenced.

[10] IHS and Tribal members of the CSC Workgroup have differing interpretations of what costs are eligible to be paid as CSC under the ISDEAA. This footnote summarizes the differing interpretations and clarifies that any changes to language from the prior version of this Chapter or the Exhibits are not to be construed as a change in the IHS or Tribal position on this issue. The IHS position is that the plain language of the ISDEAA makes it clear that, to be eligible for CSC funding, a cost and the underlying activity must meet the definition of CSC in 25 U.S.C. § 5325(a)(2), which requires (among other things) that the underlying activity is one that IHS does not normally carry on or provided from resources not transferred in the contract. Accordingly, under the IHS position, activities performed by a Tribe that are also activities IHS normally carries on and provides from resources transferred in the contract are not eligible for CSC funding. The IHS position is that the statute cannot be construed in any other manner and that reliance on legislative history is unnecessary given the plain meaning of the statute. Therefore, reference to legislative history is not necessary under the IHS position, though the IHS refers to Senate Reports 100-274 and 103-374, as well as 140 Cong Rec. H11140-01, as affirming this interpretation of the statute's clear requirements. Tribal representatives' position is that the plain language of the ISDEAA, including 25 U.S.C. § 5325(a)(3), expressly defines CSC to include both funds required for administrative and other overhead expenses and "direct" type expenses of program operation, and that in the event the Secretarial amount for a particular function, activity or cost proves to be insufficient in light of a contractor's needs for prudent management of the contract, CSC funding is to be available to supplement such sums so that health services do not have to be reduced in order to pay for the insufficiency. Tribal representatives' position is that the plain meaning of this language is supported by the legislative history adding § 5325(a)(3) to the ISDEAA, *see* Senate Report 103-374, at 8-9; 140 Cong. Rec. 28,631 (1994). Tribal representatives also note that the ISDEAA also requires that "[e]ach provision of the [statute] and each provision of [the] Contract shall be liberally construed for the benefit of the Contractor[.]." § 5329(c) (Model Agreement Section 1(a)(2)).

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450(*l*)

Adoption and dissemination of these standards are prerequisites for any delegation of CSC negotiation responsibilities to IHS Area Offices. Area negotiators will also require some training in the application of these standards to ensure broad acceptance and consistent application of the standards.

2. **Statutory Background.** See Exhibit 6-3-A.

   A. **Direct CSC.** Direct CSC (DCSC) are both non-recurring and recurring.

      1. Non-recurring DCSC are those costs generally required for the contractor/compactor to begin operations when a program, function, service, and/or activity (PFSA) is first transferred. These costs are also referred to as startup or pre-award costs. Costs for these activities are not contained in either the indirect cost pool or the amount computed pursuant to Section 5325(a)(1).

      2. Recurring DCSC are those costs eligible pursuant to 25 U.S.C. § 5325(a)(2)-(3) that are associated directly with the ongoing operation of the PFSA.

   B. **Indirect Costs.** Indirect costs (IDC) are those costs that the contractor/compactor does not treat as direct costs but rather incorporates into the indirect cost allocation plan as negotiated annually with the cognizant Federal agency. IDC, which may be eligible for indirect CSC pursuant to 25 U.S.C. § 5325(a)(2)-(3), are:

      1. incurred for a common or joint purpose benefiting more than one cost objective, or

      2. not readily assignable to the cost objective specifically benefited without effort disproportionate to the results achieved.

   C. **Negotiating Indirect-Type Costs.**[11] For contractors/compactors without negotiated IDC rates or that request to do so, IHS and the contractor/compactor will negotiate a lump-sum amount for indirect-type costs that consists of those categories of costs that normally are found in IDC pools of contractors with rates and that are consistent with the requirements of 25 U.S.C. § 5325(a)(2)-(3). Both indirect and indirect-type costs are awarded as non-recurring, as indirect amounts must be negotiated on an annual basis. IDC generally fall into one of the following three categories:

      1. management and administration,

      2. facilities and equipment, and

      3. general services and expenses.

3. **OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awardees, 2 C.F.R. Part 200.** OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awardees contains cost principles for State, local, and Tribal governments. 2 C.F.R. Part 200. The Department of Health and Human Services' implementing regulations are available at 45 C.F.R. Part 75. The regulations are useful as they define the allowability of costs under Federal awards by applying the following three criteria to costs: (1) allowable, (2) reasonable, and (3) allocable. These criteria are incorporated herein and should be considered in terms of the allowability of CSC under IHS contracts and compacts. The following applies to all ISDEAA contracts and compacts:

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[11] Such lump-sum agreements can also be negotiated to supplement an IDC rate where eligible costs are not included in the contractor's/compactor's IDC pool.

A. Factors affecting allowability of costs. Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards:

1. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

2. Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

3. Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

4. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.

5. Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

6. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federally-financed program in either the current or a prior period. See also § 200.306 Cost sharing or matching paragraph (b).

7. Be adequately documented. See also § 200.300 Statutory and national policy requirements through § 200.309 Period of performance of this part.

B. Reasonable Costs. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The question of reasonableness is particularly important when the non-Federal entity is predominantly Federally-funded. In determining reasonableness of a given cost, consideration must be given to:

1. Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the non-Federal entity or the proper and efficient performance of the Federal award.

2. The restraints or requirements imposed by such factors as: sound business practices; arm's-length bargaining; Federal, state, local, tribal, and other laws and regulations; and terms and conditions of the Federal award.

3. Market prices for comparable goods or services for the geographic area.

4. Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the non-Federal entity, its employees, where applicable its students or membership, the public at large, and the Federal Government.

5. Whether the non-Federal entity significantly deviates from its established practices and policies regarding the incurrence of costs, which may unjustifiably increase the Federal award's cost.

C. Allocable Costs.

1. A cost is allocable to a particular Federal award or other cost objective if the goods or services involved are chargeable or assignable to that Federal award or cost objective in accordance with relative benefits received. This standard is met if the cost:

a. Is incurred specifically for the Federal award;

b. Benefits both the Federal award and other work of the non-Federal entity and can be distributed in proportions that may be approximated using reasonable methods; and

c. Is necessary to the overall operation of the non-Federal entity and is assignable in part to the Federal award in accordance with the principles in this subpart.

2. All activities which benefit from the non-Federal entity's IDC (facilities and administration, or F&A), including unallowable activities and donated services by the non-Federal entity or third parties, will receive an appropriate allocation of IDC.

3. Any cost allocable to a particular Federal award under the principles provided for in this part may not be charged to other Federal awards to overcome fund deficiencies, to avoid restrictions imposed by Federal statutes, regulations, or terms and conditions of the Federal awards, or for other reasons. However, this prohibition would not preclude the non-Federal entity from shifting costs that are allowable under two or more Federal awards in accordance with existing Federal statutes, regulations, or the terms and conditions of the Federal awards.

4. Direct cost allocation principles. If a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then, notwithstanding paragraph (3) of this section, the costs may be allocated or transferred to benefitted projects on any reasonable documented basis. Where the purchase of equipment or other capital asset is specifically authorized under a Federal award, the costs are assignable to the Federal award regardless of the use that may be made of the equipment or other capital asset involved when no longer needed for the purpose for which it was originally required.

5. If the contract is subject to Cost Accounting Standards (CAS), costs must be allocated to the contract pursuant to the Cost Accounting Standards. To the extent that CAS is applicable, the allocation of costs in accordance with CAS takes precedence over the allocation provisions in this part.

4. **Conclusion.** In an effort to make CSC more understandable, the IHS is providing the following guidelines (standards) for CSC proposal development. These are the standards that the IHS will use in reviewing Tribal CSC requests. The guidelines are not intended to be read as regulations dictating allowable Tribal CSC. The guidelines should be interpreted in such a way as to be consistent with the ISDEAA, its implementing regulations, and IHS CSC policy.

Section B. Guidelines for Proposal Preparation and Cost Analysis of Tribal Requests for Pre-Award and Startup CSC Funding

Pre-award and Startup Costs: Both pre-award and startup costs are one-time costs incurred to plan, prepare for, and assume the operation of a PFSA and that otherwise meet the definition of CSC in 25 U.S.C. §§ 5325(a)(2)-(3), (5)-(6). Both categories are for similar types of costs, except pre-award costs are costs incurred prior to the award date of the contract, and startup costs are costs that are incurred after the award date but during the initial year of operation of the PFSA. Neither type of cost is considered to be recurring CSC in the ongoing operation of the PFSA.

Startup and pre-award costs usually represent a total of between 20 percent to 40 percent of the entire negotiated CSC funding requirement for awardees in the first year of operation of the PFSA. These costs are usually higher for new organizations or Tribes assuming Federal PFSA for the first time. Because these costs are non-recurring, however, they represent a very small portion of any one year's total CSC need. In addition, startup and pre-award costs can vary significantly from program to program depending on the existing capacity of the awardee and the size and scope of the proposed award.

Pre-award and startup costs must be reasonable and necessary and pay for activities that are not provided in the amount computed pursuant to Section 5325(a)(1) or in the recurring direct or indirect CSC.

With regard to startup costs, section 5325(a)(5) of the ISDEAA states:

> [D]uring the initial year that a self-determination contract is in effect, the amount required to be paid under [Section 5325(a)(2)] shall include startup costs consisting of the reasonable costs that have been incurred or will be incurred on a one-time basis pursuant to the contract necessary— (A) to plan, prepare for, and assume operation of the program, function, service, or activity that is the subject of the contract; and (B) to ensure compliance with the terms of the contract and prudent management.

Startup costs are costs that occur after the award of the contract.

With regard to pre-award costs that occur prior to the contract/compact start date covered by the award, section 5325(a)(6) of the ISDEAA states:

> Costs incurred before the initial year that a self-determination contract is in effect may not be included in the amount required to be paid under [Section 5325(a)(2)] if the Secretary does not receive a written notification of the nature and extent of the costs prior to the date on which such costs are incurred.

Pre-award costs are computed on the basis of actual expended costs (i.e., they are reimbursed). An estimated amount for startup costs is negotiated and awarded on the basis of a budget for costs submitted and negotiated with the Agency, though the amount will be reconciled at the end of the initial 12-month period of the agreement and the awardee will certify to IHS that it has fully obligated the startup costs funding on the negotiated startup activities.

The Agency only becomes liable to reimburse the pre-award costs and estimated startup costs when the ISDEAA contract or compact for the contemplated PFSA is actually awarded. There is a risk to the Tribe that costs will be incurred in preparing for the contract that may not be reimbursed as pre-award costs if any of the following apply:

1. The Tribe fails to notify the Agency in writing of the nature and extent of the pre-award costs before they are incurred.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

2. The Tribe expends funds for activities or items that are not included in the description of the "nature" of the costs in the pre-award letter.

3. The Tribe cannot provide documentation of the costs.

4. The requested costs exceed the "extent" of the costs included in the pre-award letter or are found not to be reasonable and necessary by the Agency after they are incurred and submitted for reimbursement.

5. The ISDEAA contract proposal for which the costs are incurred is not awarded.

6. The costs being requested have been provided to a Tribe in the assumption of a service unit or other program Section 5325(a)(1) amount or have been paid under a Tribal management grant or other existing IHS grant or contract.

Author
Deleted: 450j-1

Tribes can reduce the risk associated with incurring pre-award costs by ensuring that a pre-award letter is received by the Agency before the costs are incurred, maintaining close communication with the Area Office regarding the reasonableness and nature of the costs being incurred, and ensuring the estimated amount provided in the pre-award letter is sufficient to cover all the costs. Tribes should ensure that the description of the nature of the activities to be performed is inclusive enough to cover all potential activities needed to begin to operate the PFSA.

Two sample pre-award letters are attached. These can be used as templates to assist Tribes in preparing their own pre-award letters. A pre-award letter (see sample letter No.1) should address the unique needs of each Tribe as it contemplates what it will require in the planning, preparation, and assumption of the contract. Tribes should provide additional letters if circumstances change or additional costs are anticipated (see sample letter No. 2).

The development of a proposal for pre-award and startup costs, and the evaluation guidelines for typical types of costs, are outlined on the following pages. The guidelines are for the development and evaluation of a proposal under normal circumstances. Some proposals will have unique circumstances that do not fit the criteria in these guidelines. In such cases, one must review the statutory intent and the IHS CSC Policy to determine if other costs will be allowed. In all circumstances, however, the awardee should expect to be requested to provide thorough documentation of the amounts and justification for the amounts to reviewers at all levels of the Agency.

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)

Author
Deleted: 450j-1

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
PRE-AWARD COSTS (Section 5325(a)(6) letter)	Pursuant to 25 U.S.C. §§ 5325(a)(2)-(3), (6) of the ISDEAA, costs incurred before the initial year that a self-determination contract is in effect are allowable only when the Secretary has been provided written notification of the nature and extent of the costs prior to the date on which such costs are incurred. Tribes are encouraged to estimate their costs accurately. Actual costs claimed in excess of the amount provided in the pre-award letter should be allowable to the extent they are otherwise found to be reasonable and necessary for the operation of the PFSA to be awarded and will not be disallowed in the event the costs exceed the initial estimate.	For all pre-award costs, the Tribe or Tribal organization must provide to the Area Office written notification of the general nature of the types of costs the Tribe expects to incur and an estimate of such costs before they are incurred. When including costs as a part of a CSC request, the Tribe or Tribal organization must provide documentation that indicates the date the liability was incurred for any goods or services up to the date of negotiations and an estimate of the costs to be incurred up to the date of the proposed award of the contract. The Tribe must show that the cost was reasonable and necessary to plan, prepare for, or assume operation of the PFSA.	The Area Office, as the Agency representative, will review each pre-award letter from a Tribe or Tribal organization and will acknowledge receipt of each such request within 10 days. Costs included in a CSC request will only be allowable to the extent such a notification is received and the costs requested meet the statutory requirements for CSC at Sections 5325(a)(2), (3), (5), and (6) of the Act. ****See SAMPLE pre-award letters, copies attached.****
PRE-AWARD COSTS (No Award)	Pre-award costs are only awarded when an award of the PFSA is made.	Same as pre-award costs above.	No pre-award costs are awarded in the event the Tribe and IHS do not enter into a contract or compact for any of the PFSA proposed.
PRE-AWARD COSTS (Partial Award)	Pre-award costs are only awardable when an award of a PFSA is made. Costs directly attributable to a specific PFSA are allowable only when the specific PFSA is actually awarded.	Same as pre-award costs above.	Pre-award costs will be awarded, except for those pre-award costs that are demonstrated to benefit a PFSA that was not actually awarded.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
STARTUP COSTS	Startup costs are authorized pursuant to 25 U.S.C. §§ 5325(a)(2)-(3), (5). They are costs that are incurred within the first year (12 months) that the contract/compact is in effect and are necessary to plan, prepare for, or assume operation of the contract/compact. Startup costs are generally provided to support the Tribe's administrative unit, which in turn supports the PFSA to be contracted or compacted. Like all CSC, startup costs must meet the CSC requirements in 25 U.S.C. §§ 5325(a)(2)-(3).	Varies based on the type of cost claimed.	Review to determine that the cost is allowable pursuant to Sections 5325(a)(2)-(3), and (5) and not duplicative of DCSC or IDC amounts or of costs associated with the Secretarial amount. Startup costs are not to be used for costs otherwise provided for within the Secretarial amount or for expanding PFSA.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
PERSONNEL COSTS			
Pre-award costs are allowable for personnel to plan, prepare for, and assume operation of the PFSA.	Generally pre-award costs are allowable for these activities whether carried out by consultants or Tribal employees, such as a Tribal administrator or planner (to the extent not included in the Tribe's IDC pool) who assists with the planning and negotiations for assumption of the PFSA.	Costs incurred prior to the award of the contract/compact must be covered by the nature and extent references in the Tribe's pre-award letter. The Tribe must also provide documentation that the costs were incurred and the date when they were incurred, or careful estimates of the costs to be incurred when they have not yet been incurred. Tribes should keep careful financial records of these costs. Types of data needed for review are: dates of service, hourly rate, estimated or actual number of hours billed, and purpose of the service.	All costs must be reasonable and necessary to plan, prepare for, or assume operation of the proposed contract. All pre-award costs must be incurred after notification and before the contract starts. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.
Startup costs for personnel are allowable for Tribal employees in the first year (12 months) of operation, if the employee is assigned to activities necessary to plan, prepare for, or begin operation of the PFSA under contract.	These costs are allowable for an administrator, planner, or other Tribal employee who is assigned to develop or improve management systems.	Tribes must provide a budget and budget justification or a description of costs that are reasonable and necessary to plan, prepare for, and assume operation of the contact and that otherwise meet the requirements of 25 U.S.C. §§ 5325(a)(2), (3), and (5).	Startup costs must be reasonable and necessary to plan, prepare for, or assume operation of the PFSA and must be incurred after the award date but during the initial year of the contract (i.e., all startup costs must be incurred in the first 12 months of operation). Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
SUPPLIES			
Pre-award supply costs are allowable.	This means supplies needed to support the activities necessary to plan, prepare for, and assume operation of the PFSA. Costs necessary to develop inventories of medical supplies, drugs, and other supplies for the PFSA transferred have not generally been allowed.	Costs incurred prior to the award of the contract/compact must be covered by the nature and extent references in the Tribe's pre-award letter. The Tribe must also provide documentation that the costs were incurred and the date when they were incurred, or careful estimates of the costs to be incurred when they have not yet been incurred. Tribes should keep careful financial records of these costs. A Tribe should provide documentation showing what was purchased, when it was purchased, the total cost, and how it was needed to plan, prepare for, and assume operation of the PFSA.	All costs must be reasonable and necessary to plan, prepare for, or assume the proposed contract. All pre-award costs must be incurred after notification and before the contract starts. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.
Startup costs for supplies are allowable to support the startup activities only.	The costs of software or supplies necessary to support the implementation of the systems developed with startup resources are allowable. Costs necessary to develop inventories of medical supplies, drugs, and other supplies for the PFSA transferred have generally not been allowed, unless the contract divides a PFSA and the inventory is not transferred with the PFSA, requiring the Tribe to build up an inventory of supplies for the PFSA (including drugs).	Tribes must provide a budget and budget justification or a description of costs that are reasonable and necessary to plan, prepare for, and assume operation of the contract.	All startup costs must be incurred in the first 12 months of operation. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.

Author
Deleted: 450j-1

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
TRAVEL			
Pre-award travel costs are allowable for Tribal board members, Tribal personnel, and consultants to plan, prepare for, and assume operation of the PFSA.	This includes travel costs for staff, board members, and consultants to attend meetings and negotiations in preparation for PFSA assumption. Travel costs for education and orientation of new or existing Tribal staff may be allowable.	Costs incurred prior to the award of the contract/compact must be covered by the nature and extent references in the Tribe's pre-award letter. The Tribe must provide documentation of the expenditures including the name or position of the traveler, the purpose of the travel, and the costs and duration of the trip.	All costs must be reasonable and necessary to plan for, prepare for, or to assume the proposed contract. All pre-award costs must be incurred after notification and before the contract starts. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.
Startup travel costs for personnel are allowable.	Startup travel costs may be allowable for education, training, and developmental activities for either board members or Tribal employees.	Tribes must provide a budget and budget justification or a description of costs that are reasonable and necessary to plan, prepare for, and assume operation of the contract, including the position of the traveler, the purpose of the travel, and the costs and duration of the trip.	All startup costs must be incurred in the initial 12 months of operation. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.

Author
Deleted: 450j-1

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
EQUIPMENT			
Pre-award - Costs of equipment to support the administrative unit of the Tribe are allowable as pre-award costs.	Costs of equipment must meet the CSC definition and support the administrative unit of the Tribe to be allowable as a pre-award costs. The costs of administrative equipment that support the Tribe to plan, prepare for, and assume operation of the PFSA are allowable. The cost of equipment needed to carry out the PFSA transferred under the contract/compact have generally not been allowed.	Costs incurred prior to the award of the contract/compact must be covered by the nature and extent references in the Tribe's pre-award letter. A Tribe should provide documentation showing what was purchased, when it was purchased, the total cost, the end user of the equipment, and how it was needed to plan, prepare for, and assume operation of the PFSA.	All costs must be reasonable and necessary to plan for, prepare for, or assume operation under the proposed contract. All pre-award costs must be incurred after notification and before the contract starts. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.
Startup - Costs of equipment to support the administrative unit of the Tribe are allowable as startup costs.	Costs of equipment must meet the CSC definition and support the administrative unit of the Tribe to be allowable as startup costs. Costs necessary to support the implementation of the systems developed with startup resources are allowable. Costs of PFSA equipment needed to carry out the contract/compact have generally not been allowed, unless the contract divides a PFSA and the equipment is not transferred with the PFSA, requiring the Tribe to purchase equipment.	Tribes must provide a budget and budget justification or a description of costs that are reasonable and necessary to plan, prepare for, and assume operation of the contract. This should include an identification of the equipment's end user.	All costs must be reasonable and necessary to start up the proposed contract. All startup costs must be incurred during the initial year of the contract/compact. Costs supporting the central administrative unit of the Tribe are allowable. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.

Author
Deleted: 450j-1

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
CONSULTANTS			
Pre-award costs are allowable for consultants needed to plan, prepare for, and assume operation of the PFSA.	Consultant activities are allowable for proposal planning, preparation, and assumption of the ISDEAA contract/compact, including for proposal development, negotiations, board training, management systems development, etc.	Costs incurred prior to the award of the contract/compact must be covered by the nature and extent references in the Tribe's pre-award letter. Documentation of actual costs for consultants, including the service to be performed, hourly rate, number of hours, and date cost was incurred, are required for all pre-award costs.	All costs must be reasonable and necessary to plan for, prepare for, or assume operation of the proposed contract. All pre-award costs must be incurred after notification and before the contract starts. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.
Startup costs are allowable when needed to ensure compliance with the terms of the contract in the first 12 months of operation.	Startup activities are allowable for board training, management systems development, etc.	Budget and budget justification are required in the CSC proposal, including estimates or bids from consultants for the work to be performed. Estimates should include the rate and time involved for each task to be performed.	All startup costs must be incurred in the first 12 months of operation. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.

Author
Deleted: 450j-1

Line Items	GENERAL GUIDELINES Examples of Allowable Pre-Award and Startup Costs	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
OTHER			
Pre-award costs are allowable for other types of costs if those costs are necessary to support the activities needed to plan, prepare for, and assume operation of the PFSA and otherwise meet the requirements of 25 U.S.C. §§ 5325(a)(2)-(3), and (6).	Tribes may incur other costs necessary to support the activities needed to plan for, prepare for, and assume operation of the contract.	Costs incurred prior to the award of the contract/compact must be covered by the nature and extent references in the Tribe's pre-award letter. Documentation is required in support of actual costs and that the costs meet the requirements of 25 U.S.C. §§ 5325(a)(2)-(3), and (6). The date the cost was incurred is required for all pre-award costs. These costs should be documented with a detailed description of the type, quantity, and unit cost of the items and the justification for the costs.	All costs must be reasonable and necessary to plan for, prepare for, or assume operation of the proposed contract and not duplicate costs associated with the Secretarial amount or funded in the indirect CSC or DCSC amounts. Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.
Startup costs are allowable when needed to plan for, prepare for, and implement activities necessary to assume the contract and when the costs otherwise meet the requirements of 25 U.S.C. §§ 5325(a)(2)-(3), and (5).	Tribes may incur other costs necessary to support the activities needed to plan for, prepare for, and assume operation of the contract.	Budget and budget justification is required in the CSC proposal, including estimates of the reasonable and necessary costs needed to support the Tribe and an explanation of how the costs meet the requirements of 25 U.S.C. §§ 5325(a)(2)-(3), and (5). These costs should be documented with a detailed description of the type, quantity, and unit cost of the items and the justification for the costs.	Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under a Tribal Management Grant or other existing IHS grant or contract.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Section C. Guidelines for Proposal Preparation and Cost Analysis of Tribal Requests for DCSC Funding

DCSC is one of four types of CSC. DCSC funding covers ongoing activities that are not contained in either the amount computed pursuant to Section 5325(a)(1) or the IDC pool or an "indirect-type" cost budget. DCSC amounts are awarded on a recurring basis based on the initial CSC proposal and negotiation.

The determination and payment of DCSC requires a proposal from the awardee. To the extent an awardee needs assistance in preparing a proposal, IHS will provide technical assistance. A DCSC proposal requires adequate detail and documentation for the IHS to determine if the costs requested are allowable as DCSC under Sections 5325(a)(2)-(3) and are not duplicated in the Section 5325(a)(1) amount or in the indirect CSC amounts requested. For a DCSC proposal, this documentation normally includes the salary of the Federal employees transferred and the Federal fringe benefits paid on those salaries by fringe-benefit category. In addition the awardee must provide the personnel budget of the tribally-operated PFSA and the detailed fringe-benefit costs of the awardee's benefit package. The awardee must also provide justification for costs in other budget categories for which DCSC is requested.

To compute the DCSC requirement, the awardee and the IHS must negotiate the total cost to the awardee of the activities to be supported with CSC. After this requirement is determined, the Agency will deduct any funds that may have been provided to the awardee in the Secretarial amount for this activity to avoid duplication of costs. The amount provided in support of these PFSA included in the Secretarial amount is determined by the past expenditures of the Agency for the activities included in the DCSC that are provided in support of the PFSA to be transferred. In cases where the expenditures of the prior year do not represent the amount the Secretary would have expended due to one-time distortions in expenditures, a multi-year average of past expenditures may be used. In circumstances where the Agency has never operated the PFSA, such as new programs or new appropriations for expanded programs, the Agency will compute the amount the Secretary would have provided for the DCSC activities from a "profile" developed from other, similar Agency PFSA. To prepare the DCSC proposal, the awardee should request the amounts the Agency has provided in support of the PFSA to be transferred. In cases where the PFSA has not been operated by the Agency, the awardee should request the cost "profile" from the Agency to determine what the Secretarial amount would have been.

The majority of DCSC is usually composed of certain fringe benefit costs on Federal employees that are not received in the Section 5325(a)(1) amount.[12] These costs continue to be paid by the Federal Government on employees working under an Intergovernmental Personnel Act (IPA) agreement or a Memorandum of Agreement (MOA), and DCSC for these employees are not due until the employee or position transfers to direct Tribal hire. Awardees should carefully maintain historical data on IPA/MOA transfers. These positions become eligible for DCSC as they become vacant and are not expected to be replaced with another IPA/MOA employee. The awardee must submit a CSC request or renegotiate the DCSC to ensure these costs are included in the DCSC requirement.

The Agency is required to determine that amounts requested in the DCSC proposal are consistent with the requirements of 25 U.S.C. §§ 5325(a)(2)-(3).

On a national basis, based on data from the 2012 Report to Congress on Funding Needs for CSC of Self-Determination Awards (2012 Report to Congress), the total DCSC requirement averages about 7 percent

[12] Tribal representatives take the position that CSC funding is due on all Federal funds used to carry out a contract/compact and that Federal funds include funds paid by Medicaid, Medicare, and other third-party payors. The IHS position is that, to be eligible for CSC, an awardee's costs must be related to the PFSA transferred and supported directly from Federally-appropriated dollars transferred in the Section 5325(a)(1) amount. For example, in the Agency's view, fringe benefit costs for employees supported with Medicaid, Medicare, and other third-party resources are not eligible for DCSC.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

of the total Section 5325(a)(1) amount under contract. Based on the 2012 Report to Congress, DCSC represents about 22 percent of the entire negotiated CSC requirement for Tribes and Tribal organizations. DCSC can vary significantly depending on the type of service and service delivery modality selected by the Tribe. In general, DCSC is composed mostly of costs computed on the salaries of the directly-hired Tribal employees. Therefore, contracts that do not have large personnel components (like Purchased/Referred Care) or contracts operated primarily with IPA/MOA employees normally require smaller amounts of DCSC when calculated as a percentage of the total award. Fringe benefit costs continue to make up the majority of the approved DCSC requirement.

In addition to certain fringe benefit costs, the IHS has approved some other costs as DCSC. Reasonable costs for legal fees and general liability insurance (when not included in the IDC pool) are additional examples of costs that have been found to be allowable, as these are costs that the Agency either does not pay or are paid from resources other than those under contract. Allowable tribal health insurance costs may include employer shared responsibility payments and any other associated employer costs under the ACA

The development of a DCSC proposal and the evaluation guidelines for the typical types of costs are outlined in the following pages. The guidelines are meant for the development and evaluation of a DCSC proposal under normal circumstances. Some DCSC proposals will have unique circumstances that do not fit the guidelines. In these cases, one must review the statutory intent and the IHS CSC Policy to determine if other DCSC will be required. In these circumstances, however, the awardee should expect to be requested to provide thorough documentation of the amounts and reasons for the amounts to reviewers at all levels within the Agency.

Author
Deleted: 450j-1

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
SALARIES In general, salaries[13] and wages for personnel have been completely disallowed for DCSC. Budgets for direct-salary costs are required for most DCSC proposals to accurately compute the requested fringe-benefit costs, as discussed below.	Salaries associated with the PFSA transferred in the Secretarial amount are never allowable as DCSC. Awardees with or without IDC rates can be paid direct-salary costs for administrative employees as part of CSC; however, these costs should be categorized and negotiated as "indirect-type costs," not DCSC, even though they are treated as direct costs and are not incorporated in the Tribe's IDC pool.[14] Although costs for direct salaries are generally disallowed, costs for certain fringe benefits on direct salaries are the primary components of DCSC, as discussed below.	Direct salary costs of employees are generally not allowed as DCSC. Tribal budgets are required from awardees with a detailed salary listing for each position funded from the Section 5325(a)(1) amount.	For DCSC, the Agency has considered all salary requests a duplication or expansion of Section 5325(a)(1) and not allowable under the ISDEAA.[15]

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[13] Tribal representatives take the position that direct salaries may be included in DCSC in situations where the salaries would be allowable as an indirect-type cost but the awardee has an IDC allocation plan that specifically excludes these costs from the IDC pool. It has not, however, been the Agency's practice to allow salary costs as DCSC.

[14] The total lump-sum amount for these indirect-type costs will include the lump-sum amount plus the amount determined by applying the IDC rate to that lump sum amount.

[15] Tribal representatives take the position that, to the extent that Tribes and Tribal Organizations are required to pay higher salaries than IHS pays to operate the PFSA, the difference in salary should also be eligible for DCSC. Tribal representatives take the position that Tribes and Tribal Organizations must sometimes pay higher salaries than IHS pays due to the value attributed to Federal employment, including the value attributed to Federal retirement and other associated benefit programs.

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
FRINGE BENEFITS			
- Federal Insurance Contributions Act (FICA) and Medicare tax - Life, Health, and Disability Insurance - Retirement (401k, 403b, etc.)	Fringe benefits have historically constituted the majority of all DCSC. The Agency reviews the documented amounts requested by the awardee and deducts the amount provided as part of the Section 5325(a)(1) amount to the awardee. The awardees should request that the Agency provide a detailed breakout of each fringe amount when providing the total Section 5325(a)(1) amount available for the PFSA to be contracted.	Documentation of fringe benefits should include the awardee's rate for each type of fringe benefit for which DCSC is requested. The awardee must provide sufficient salary detail to determine if the fringe-benefit costs requested are reasonable and necessary. For a new awardee, written quotes for costs should be provided to support the costs claimed.	The Agency totals the amount provided in the Section 5325(a)(1) amount for FICA, Medicare tax, health, life, and disability insurance, and retirement. To the extent the budgeted Tribal costs are determined to be reasonable and necessary and these costs exceed the amounts the Agency provides for these costs in the Section 5325(a)(1) amount, the difference is allowed as a DCSC requirement for the PFSA transferred.
Workers' compensation insurance	Funding for workers' compensation costs is not transferred as part of the Section 5325(a)(1) amount.	Awardees should provide documentation for workers' compensation costs.	Costs of workers' compensation insurance are allowed as a DCSC requirement.
Unemployment insurance	Funding for unemployment insurance is not provided as part of the Section 5325(a)(1) amount.	Awardees should provide documentation of state unemployment insurance costs.	Costs of state unemployment insurance are allowed as a DCSC requirement.[16]

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[16] The Internal Revenue Service (IRS) has determined that Tribes and Tribal instrumentalities are not subject to Federal Unemployment Tax. Therefore, this cost will not be allowed.

Example of the fringe benefits calculation:

FRINGE ITEM	TRIBAL AMOUNT	IHS AMOUNT	DIFFERENCE (DCSC AMOUNT)
FICA and Medicare Tax	$1,000	$900	---
Retirement	$2,000	$1,250	---
Insurance (Life, Health, Disability)	$750	$1,000	---
Sub-Totals	$3,750	$3,150	$600
Workers Comp.	$200	---	$200
Unemployment	$400	---	$400
TOTALS	$4,350	$3,150	$1,200

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
TRAVEL/VEHICLE LEASE	These are generally not provided as allowable DCSC. Again, travel costs in support of administrative functions normally included in an IDC pool (such as board of directors' travel cost) can be paid directly to the Tribe when the Tribe or Tribal organization does not have an IDC rate. In this situation, however, these types of costs are categorized as "indirect type costs."	Travel costs are not generally allowed by the Agency as a DCSC requirement.	The Agency has considered most requests for travel duplicative of the Section 5325(a)(1) or as a PFSA that normally would be carried on by the Agency in the direct operation of the PFSA.[17]

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[17] As noted in footnote 1, Tribal representatives are of the view that no category of costs is per se duplicative and unallowable as DCSC, so long as the additional amount is necessary and reasonable for the Tribe or tribal organization to prudently operate the PFSA under contract. As also noted in footnote 1, the IHS position is that "duplication" is not the only assessment to determine whether a cost is eligible for CSC pursuant to Section 5325(a).

Author
Deleted: 450j-1

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
SUPPLIES AND DRUGS	These are generally not allowable DCSC.	Supply costs are not generally allowed by the Agency as a DCSC requirement.	The Agency has considered most requests for supplies and drugs duplicative of the Section 5325(a)(1) or as a PFSA that normally would be carried on by the Agency in the direct operation of the PFSA.[18]
INSURANCE General Insurance (property, fire, general liability)	The Government is self-insured under the Federal Tort Claims Act (FTCA). Activities of Tribes that the FTCA does not cover, such as property insurance on buildings and vehicles and general liability insurance (i.e., wraparound insurance) supplemental to FTCA coverage, can be considered allowable.	A detailed estimate of costs of insurance for property, vehicles, and general liability is to be provided. It is important to document that the costs are not included in the IDC pool where an IDC rate is used.	The Agency reviews insurance coverage to determine that it is not included in the Tribe's IDC pool or indirect-type cost agreement and that it does not cover risks covered by the FTCA. Insurance activities that are covered in the Tribe's negotiated IDC rate, indirect-type cost agreement, or would be covered by FTCA are duplicative.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[18] *See* footnotes 1 and 8.

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
MALPRACTICE LIABILITY INSURANCE Professional Liability Insurance	Malpractice liability insurance is allowable only to the extent that it does not duplicate FTCA coverage. Medical malpractice insurance covering the employees of a Tribe or Tribal organization (including those assigned under IPA or MOA status) when performing duties is authorized under a contract/compact pursuant to the ISDEAA is not necessary due to the applicability of the FTCA to contracting/compacting Tribes and Tribal organizations. Malpractice liability insurance is allowable, however, in the case of personal service contractors carrying out the terms of a contract/compact when operating outside of an IHS facility. Malpractice liability insurance may also be allowable to cover torts brought in Tribal courts that may not be covered in the FTCA. General liability wraparound insurance is allowable.	Because malpractice liability insurance is allowable only to the extent that it does not duplicate coverage provided by the FTCA, awardees will be required to provide a written quote or cost estimate from an insurance broker and must indicate that the insurance costs claimed do not duplicate coverage provided by the FTCA.	Malpractice liability insurance is allowable to the extent that it does not duplicate FTCA coverage.

Author
Deleted: 450j-1

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
POSTAGE[19]	This cost is borne by IHS in the general course of doing business. Funds for these costs have been transferred to Area Offices, and this cost is not allowable as DCSC unless IHS did not transfer the resources it used in the Tribe's Secretarial amount and is not included in the IDC pool or the Tribe's indirect-type costs.	For PFSA assumed prior to implementation of the IHS Director's May 10, 2002, decision, DCSC negotiations may include postage costs but only in instances where IHS did not transfer the resources it used in the Tribe's Secretarial amount.	Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under other existing IHS grants or contracts. Except in rare circumstances, this will be considered duplicative of the Section 5325(a)(1) amount.[20]

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[19] In the past, DCSC has included postage, communications, and printing costs in some cases. These costs were approved in the past because the IHS centrally-managed the costs, and the funds were not transferred to Tribal contractors in the Section 5325(a)(1) amount. These costs were then transferred to the Area Offices and should now be available for inclusion in the Section 5325(a)(1) amount. Accordingly, these costs are no longer being approved by the IHS as DCSC, except in the rare circumstances noted in these tables. As noted in footnote 1, Tribal representatives are of the view that no category of costs is per se duplicative and unallowable as DCSC, so long as the additional amount is necessary and reasonable for the Tribe or tribal organization to prudently operate the PFSA under contract. As also noted in footnote 1, the IHS position is that "duplication" is not the only assessment to determine whether a cost is eligible for CSC pursuant to Section 5325(a).

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[20] *See* footnotes 1 and 8.

Author
Deleted: 450j-1

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
PRINTING AND DUPLICATION[21]	This is generally not included in the DCSC requirement.	This is not generally allowed by the Agency.	Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under other existing IHS grants or contracts. This generally will be considered to be duplicative of the Section 5325(a)(1) amount.[22]
COMMUNICATIONS[23]	Long-distance phone charges and/or leased data-line charges are costs that are borne by IHS in the general course of doing business. Funds for these costs have been transferred to Area Offices, and this cost is not allowable as DCSC unless IHS did not transfer the resources it used in the Tribe's Secretarial amount and is not included in the IDC pool or the Tribe's indirect-type costs.	For PFSA assumed prior to implementation of the IHS Director's May 10, 2002, decision, DCSC negotiations may include communication costs but only in instances where IHS did not transfer the resources it used in the Tribe's Secretarial amount.	Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under other existing IHS grants or contracts. Except in rare circumstances, this will be considered duplicative of the Section 5325(a)(1) amount.[24]

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[21] See footnote xx.

[22] *See* footnotes 1 and 8.

[23] See footnote xx.

[24] *See* footnotes 1 and 8.

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
TRAINING	This is generally included in the DCSC requirement to the extent the awardee must provide training to comply with requirements not applicable to the Federal Government and, therefore, not transferred in the Section 5325(a)(1) amount.[25]	Awardees should provide details on the cost and purpose of the training.	Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under other existing IHS grants or contracts. This likely will be considered duplicative of the Section 5325(a)(1) amount.[26]
EQUIPMENT PURCHASE AND MAINTENANCE	This generally is not included in the DCSC requirement. Funds for equipment purchases are included in the Section 5325(a)(1) amount or in the startup or pre-award amount for administrative equipment.	Not applicable.	Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under other existing IHS grants or contracts. This is considered duplicative of the Section 5325(a)(1) amount and may also be duplicative of costs covered in the IDC pool.[27]

[25] The IHS made available all Federal dollars supporting long-term career training costs in the Section 5325(a)(1) amount. Federal sites provide for long-term training from within their operational budgets. IHS takes the position that no additional CSC funds are made available for this cost, which is duplicative of the Section 5325(a)(1) amount. As noted in footnote 1, Tribal representatives are of the view that no category of costs is per se duplicative and unallowable as DCSC, so long as the additional amount is necessary and reasonable for the Tribe or tribal organization to prudently operate the PFSA under contract. As also noted in footnote 1, the IHS position is that "duplication" is not the only assessment to determine whether a cost is eligible for CSC pursuant to Section 5325(a).

[26] *See* footnotes 1 and 8.

[27] Tribal Representatives take the position, as indicated in the General Guidelines column for this line item, that there are circumstances in which these amounts have not been duplicated in any other funding provided to a Tribe or Tribal Organization. Therefore, upon Tribal request and justification the cost should be negotiated on a case-by-case basis.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

LINE ITEMS	GENERAL GUIDELINES Examples of Allowable DCSC	DOCUMENTATION REQUIRED FROM TRIBE	STANDARDS FOR REVIEW AND DUPLICATION UNDER 25 U.S.C. § 5325(a)(3)
RENT/UTILITIES	This generally is not included in the DCSC requirement. It has been allowed in extremely rare circumstances when the awardee did not receive the funds in the Section 5325(a)(1) amount because the facility in question continued to be used to operate IHS or other Tribally-operated programs.	This is allowable when a program is being divided and space currently used in the delivery of the program cannot be divided and provided to the awardee due to ownership or lease restrictions.	Duplication will be determined by reviewing: (a) the Secretarial amount provided to the Tribe for all PFSA transferred to the Tribe, and (b) amounts paid to the Tribe under other existing IHS grants or contracts. This is considered duplicative of the Section 5325(a)(1) amount absent these rare circumstances.[28]
OTHER DCSC	The IHS recognizes that Tribes differ in the types and extent of costs included within their IDC pools. The IHS will recognize as DCSC any item of cost that meets the definition of CSC at Sections 5325(a)(2)-(3) but is not already included in the awardee's IDC pool (or the Section 5325(a)(1) amount). CSC are not, however, to be considered as available to expand program activities.	Awardees are to provide a detailed description and justification of costs showing they should be allowable pursuant to Section 5325(a)(2)-(3). Documentation should show that the costs are included in neither the IDC pool nor the Section 5325(a)(1) amount.	Each cost must meet the definition of CSC at Sections 5325(a)(2)-(3), must not be included in the IDC pool or indirect-type costs of the Tribe, and must not be duplicative of the costs included in the Section 5325(a)(1) amount.

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

Author
Deleted: 450j-1

[28] *See* footnotes 1 and 8.

Section D. Guidelines for Proposal Preparation and Cost Analysis of Tribal Requests for Indirect CSC Funding

INDIRECT CSC. Most Tribes and Tribal organizations have IDC rates that are negotiated with their cognizant Federal agency. The cognizant Federal agency for most Tribes is the Interior Business Center at the Department of the Interior. For some Tribal organizations that primarily receive awards from the Department of Health and Human Services (HHS), their cognizant Federal agency for determining an IDC rate is HHS Cost Allocation Services. The respective addresses and phone numbers are as follows:

U.S. Department of the Interior Office of the Secretary Interior Business Center Acquisition and Property Management Indirect Cost Section Attn: Debra Moberly, IDC Coordinator 2180 Harvard Street, Suite 430 Sacramento, CA 95815 Phone (916) 566-7111 FAX (916) 566-7110 https://www.doi.gov/ibc/services/finance/indirect-cost-services	U.S. Department of Health and Human Services Cost Allocation Services Attn: Arif Karim, Director 90 – 7th Street, Suite 4-600 San Francisco, CA 94103-6705 Phone (415) 437-7820 http://rates.psc.gov/

Tribes are encouraged to refer to 2 C.F.R. Part 200 for guidance on IDC rates. This document is accessible on the Internet at:
www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl.

For assistance with indirect-type costs, please refer to the ISDEAA, the IHS CSC Policy, 2 C.F.R. Part 200, and 45 C.F.R. Part 75, and contact your local IHS Area Office.

Section E. Sample Letters

Sample Pre-Award Notification Letter # 1 – From Contractor/Compactor To Area Director

Dear Area Director:

Please accept this letter as notification that the ****Tribe**** will begin to incur pre-award costs necessary to plan, prepare for, and assume operation of the ****PFSA(s)****. We anticipate providing a proposal in accordance with the Indian Self-Determination and Education Assistance Act (ISDEAA) and the associated regulations at 25 C.F.R. Part 900 in the near future; however, we must first do some preliminary work in order to ensure a successful contracting effort.

The ****Tribe**** has reviewed the "Standards for the Review and Approval of Contract Support Costs by the Indian Health Service." We understand that this document provides guidance concerning the typical costs Tribes might expect to incur in undertaking contracting or compacting under the ISDEAA, but we do not believe that this document limits the types of costs we might expect to incur. Initially, we will incur costs associated with assessing the feasibility of contracting, developing the contract proposal and contract document, and negotiating the contract with the IHS. We anticipate incurring costs for consultants, attorneys, and other professional staff to assist us. The costs may also include the costs of special training or meetings of the governing board, travel by current Tribal staff and other costs incurred in developing the proposal and negotiating the contract award. The Tribe may also assign staff to this project to assist with this contracting effort.

The Tribe estimates the amounts necessary to complete the tasks needed to plan, prepare for, and assume the above PFSA to be **** fifty thousand ($50,000) **** dollars. We will monitor these costs, however, and we will notify the IHS if the costs can be expected to exceed this amount. It is our understanding that this amount is an estimate and does not limit the extent to which our costs might ultimately be found to be reasonable and necessary to assume operation of the contract.

Please confirm receipt of this letter and notify us of the date of your receipt of this pre-award letter. We look forward to working with the ****Area Office**** and to the successful contracting of the above PFSA(s). Thank you.

Sincerely,
****Authorized Tribal Signature****

Cc: Headquarters, ODSCT
Headquarters, OTSG (****when compacting under Title V****).

Sample Pre-Award Notification Letter # 2 – From Contractor/Compactor To Area Director

Dear Area Director:

On ****date of initial notification**** the ****Tribe**** notified you that we would begin incurring costs associated with the assumption of ****PFSA****. While planning and preparing that contracting effort, we realized we would need to ****improve our accounting and management systems**** in order to successfully administer the ****[additional] PFSA**** proposed. Therefore, we now anticipate incurring additional costs for ****the acquisition of IT equipment and systems and other management systems necessary**** to support the contract. Professional services necessary to implement these systems will also be required. The costs may also include the costs of special training of existing Tribal staff on the new systems. This is in addition to those costs identified in our earlier letter.

The Tribe estimates the amounts necessary for these additional costs to be **** one-hundred and twenty thousand ($120,000)**** dollars. Additionally, our earlier letter estimated other pre-award costs at **** fifty thousand ($50,000)**** dollars; however, it appears that due to some unanticipated circumstances and the complexity of negotiations, this amount will probably be closer to **** eighty thousand ($80,000)**** dollars. Therefore total pre-award costs are now estimated at **** two hundred thousand ($200,000)**** dollars. As previously stated, this amount is an estimate and does not limit the extent to which our costs might ultimately be found to be reasonable and necessary to assume operation of the contract.

Please confirm receipt of this letter and notify us of the date of your receipt of this pre-award letter. We look forward to working with the ****Area Office**** and to the successful contracting of the above PFSA.

Thank you.
****Authorized Tribal Signature****

Cc: Headquarters, ODSCT
Headquarters, OTSG (****When compacting under Title V****)

Sample Pre-Award Acknowledgment Letter – From Area Director to Contractor/Compactor

[Insert Tribe or Tribal Organization Address]

Dear [Insert Name]:

This is to acknowledge receipt of the [Insert Tribe or Tribal Organization]'s letter, which was received on [Insert Date of Receipt], regarding its estimated pre-award costs necessary to [Describe Activity (e.g. enter into an agreement to assume additional PSFA, new PSFA, expand PSFA, etc.)] with the Indian Health Service (IHS). While we acknowledge receipt of your letter, this acknowledgement does not constitute a decision on or agreement with the estimated costs. The final amount will require negotiations, must be consistent with 25 U.S.C. § 5325(a), and is subject to an award being made by the IHS.

Author
Deleted: 450j-1

The [Identify IHS Area Office Point of Contact] will serve as the primary point of contact for the [Insert Tribe or Tribal Organization] during the planning process. Our staff is happy to assist and look forward to this new proposed endeavor of the [Insert Tribe or Tribal Organization].

If you have questions, please contact [Insert Point of Contact], by telephone at [Insert Telephone Number] or by e-mail at [Insert E-mail address].

Sincerely,

[IHS Area Director]

Friday, October 14, 2016 at 8:42:56 AM Pacific Daylight Time

Subject: CSC Workgroup policy recommendations
Date: Thursday, October 13, 2016 at 8:34:26 AM Pacific Daylight Time
From: Andy Joseph Jr.
To: Roselyn Tso
CC: rbdemaray@demarayconsulting.com, Laura Platero, Andy Joseph Jr.

Dear Ms. Tso:

I am writing to you as the Tribal Co-Chair of the IHS/Tribal CSC Workgroup on behalf of all the Tribal participants. We have reviewed the October 3rd, IHS final draft of the proposed IHS CSC Policy and have a few recommendations that we would like to share. The Tribal edits to the draft IHS CSC policy are as follows:

- We reviewed the new ISDA references throughout the document and these appear to be fine.
- In the definition section, the Manual defines the term "ISDEAA" and then purports to cite the entire act, but it actually only cites through the end of Title V. We think this is OK.
- On page 18, when making the corrections to the provision regarding the "value of the IDC pool" duplication trigger, it appears the left parenthesis (was left out before the words "in which."
- At the last CSC Workgroup meeting Tribes provided language related to employer costs associated with the Affordable Care Act. There was a recommendation to include the following sentence on page 58 of the draft policy: "Allowable tribal health insurance costs may include employer shared responsibility payments and any other associated employer costs under the ACA"

Additionally, the following corrections need to be made to the CSC Negotiation Template (Excel Workbook):

- Near the top of the table where you are to choose an FA Amendment or FA CFR as the source document by checking a box, there are no boxes to check. This was OK on the Excel spreadsheet that was sent out with the policy on Oct. 3rd, but not in the CSC Manual, MS Word document – Exhibit 6-3-F – Page 38.
- On both the Excel spreadsheet and in the CSC Manual – Page 40. In the "Source of Inputs" column for Item R, it should be the sum of I.2 + I.3 + P **+ Q**. Q was left out (Indirect-type costs).
- Also on the Excel spreadsheet that was sent out with the policy on Oct. 4, the formula for Item R in Excel cell E33, should be E22**+E24**+E31+E32. (E24 – Startup and Pre-Award Need, line I.3, was left out.)

Another draft of the CSC Policy with these comments incorporated is attached for your convenience. We thank you and the IHS Team for working with Tribal representatives. There remain several areas of disagreement embodied within the draft policy that will have to be worked out in individual Tribal negotiations but we believe this revised policy is long overdue. It represents a significant amount of work on all our parts. We trust that the IHS will implement it within the spirit of cooperation that went into its development.

Sincerely,

Andy Joseph, Jr.
Tribal Co-Chair, IHS CSC Workgroup

7C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

OCT 5 2016

Dear Tribal Leader:

As you know, at IHS we have engaged a very substantial number of strategies to improve our performance over the past seven months. Today I am writing to let you know about a proposed realignment of IHS Headquarters offices and a 30-day comment period that is open for you to provide input. The Indian Health Service (IHS or Agency) honors the government-to-government relationship with Tribes, and, in accordance with our consultation policy, we value the input from Tribal leaders.

When I accepted the position of Principal Deputy Director, I was directed to focus on further strengthening the IHS in order to deliver on the mission of the Agency. The IHS mission is to raise the health status of American Indians and Alaska Natives to the highest level. To accomplish that, we must use resources efficiently and effectively to consistently provide high quality health care to American Indians and Alaska Natives across the country. While we are hopeful that the President's fiscal year (FY) 2017 proposed budget for IHS will be fully funded, our commitment is to ensure that we meet these expectations. To that end, for the past several months, IHS has reviewed its structure and lines of accountability, particularly in Headquarters.

In addition, Office of Inspector General (OIG) and Government Accountability Office reports have noted a lack of systematic Agency-wide oversight for ensuring compliance with various standards and requirements. After taking this into account and to achieve improvements in the Agency's performance, there are a set of changes that I am considering to better realign the Agency's structure and processes. I appreciate the opportunity to provide an overview of this proposed realignment with you and to obtain your feedback.

First, this realignment is intended to impact how Headquarters operates and accomplishes its oversight responsibilities, with clearer and more transparent lines of accountability. To improve efficiency and effectiveness of program operations, the realignment also moves some Division level components under different senior staff leadership. Specific changes include:

- Clearer lines of IHS Senior Leadership responsibility for administrative and/or programmatic functions that are readily apparent on the Agency's organizational chart. The new organizational chart depicts the senior leadership team members connected to the offices and functions for which they have responsibility. This is in contrast to all Deputy Director positions currently displayed in a single box at the top of the chart without connection to areas of responsibility. I want to be clear that the new depiction does not reflect a demotion. The new depiction does reflect the Chief Operating Officer, Chief Medical Officer, and the Associate Directors along with the Director and Deputy Director continuing to comprise the Agency's senior leadership team.

- Realigning specific functions under oversight of the Associate Director for Quality. Even though the Deputy Director of Quality currently oversees all quality functions at IHS, this responsibility is not reflected on the current organizational chart. The new chart reflects the functions that are relevant for the Associate Director of Quality from the Chief Medical Officer to the Associate Director for Quality, such as national credentialing. Additionally, the chart reflects the establishment of a permanent home for the Quality Framework responsibilities, a set of responsibilities that are crucial to being executed in order to further improve and sustain our performance in the delivery of high quality care. Strengthening our quality infrastructure is critical as noted by a recent OIG report that clearly noted that IHS is "missing opportunities to identify and remediate quality problems in its hospitals because it performs limited oversight activities regarding quality care. . ."

- Creating an Associate Director for Healthcare Workforce Development and realigning the Scholarships and Loan Repayment programs under this senior staff member. Moreover, based on clear challenges in fielding sufficient health care providers, there is much more we need to do to develop lasting strategies to build a pathway for an adequately sized workforce. Consequently, this organizational component also has responsibility for workforce strategy to ensure we are taking advantage of every authority available to us and ensuring a cadre of candidates for IHS positions for both the field or for our administrative and management positions.

In addition to these organizational changes, we are making management process changes as well to improve procurement planning and budget monitoring. This focus is critically important. For example, currently, Headquarters has limited knowledge of planned contracts to purchase goods and services in the Area Offices and service units and yet organizational leadership is rightly held accountable for procurement and budget. Consequently, we are implementing a process for reporting to Headquarters all planned procurements that cost more than $25,000. This will also allow cross-Agency visibility into opportunities for better leveraging procurement expenditures.

There is a similar lack of visibility at the Headquarters level of service unit budget planning and monitoring. To improve fiscal accountability and promote efficient procurement across IHS, we are implementing a monitoring and reporting process in order for Headquarters to have comprehensive information about how funds are being spent at the Area and Service Unit levels. Neither of these new processes are intended to remove authority from the Area Directors, limit the Areas in what they can do, or create a roadblock for the Areas in accomplishing their work. Rather, these changes increase transparency, strengthen accountability and oversight and consequently will help IHS more effectively manage its limited resources.

Some tribal leaders have expressed concerns that these actions may have impacts on Tribes for example through impact Tribal shares funding and interactions with IHS. Let me assure you that the Headquarters budget as reflected on the Headquarters Tribal Shares tables is not impacted by this realignment and consequently does not change because of the realignment. Each Tribal

shares line will remain intact, though it may appropriately fall under the responsibility of a different senior leader.

While, some of you heard me describe this information on the realignment on an All Tribes conference call on Thursday, September 29, for those of you who were unable to participate, I appreciate the opportunity to share the features of this realignment with you through this letter. Once the realignment chart and functional statements are final, they will be published as a notice in the Federal Register with an effective date 30 days after the publication date.

To help with your review of this realignment, please find enclosed the current organizational chart and associated functional statements, as well as, the draft updated organizational chart and associated functional statements for the realignment. In addition, I included a copy of an interim organizational chart that depicts the realignment using current senior staff titles and Office names to show how existing organizational units are realigned in the new structure. Comments will be accepted through November 5.

In addition, an in-person session is scheduled on Sunday, October 9, from 5:00 – 6:00 p.m. in Room 102 AB at the Phoenix Convention Center located at 100 North 3rd Street, Phoenix, Arizona. This is the location of the National Congress of American Indians' 73rd Annual Convention & Marketplace.

Thank you for your interest in working with IHS in partnership to improve health care for Native Americans across the country, and I look forward to receiving your comments.

Sincerely,

/Mary Smith/

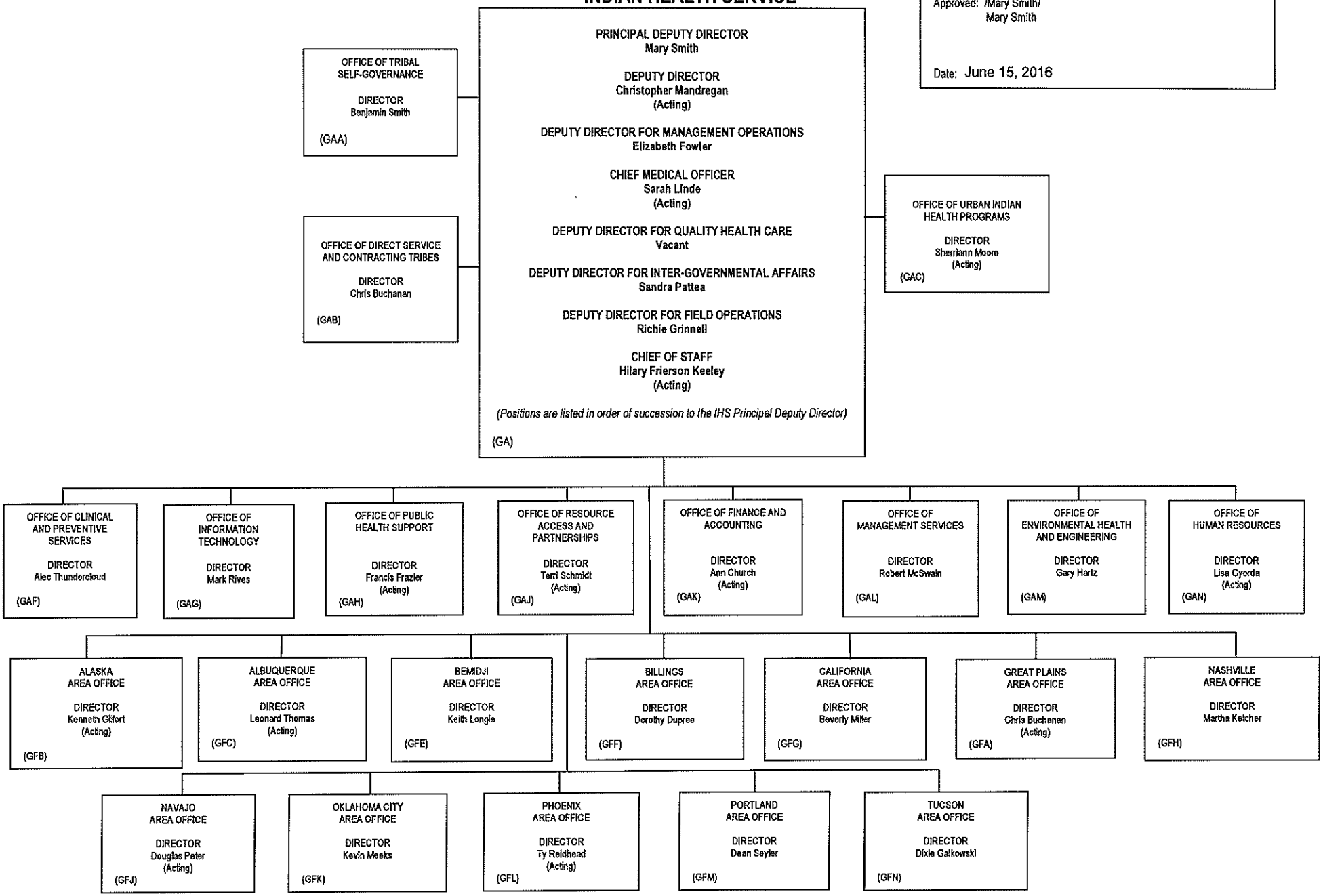
Mary L. Smith
Principal Deputy Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

Approved: /Mary Smith/
Mary Smith

Date: June 15, 2016



NOTE: THE STANDARD ADMINISTRATIVE CODE IS LOCATED IN THE LOWER LEFT HAND CORNER OF EACH BOX.

7C

Dated: October 11, 2005.

John Howard,

Director, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention.

[FR Doc. 05–20717 Filed 10–14–05; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Organization, Functions, and Delegations of Authority

Part G—Indian Health Service

Part G, of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (HHS), as amended at 52 FR 47053–67, December 11, 1987, as amended at 60 FR 56606, November 9, 1995, as amended at 61 FR 67048, December 19, 1996, as amended at 69 FR 41825 July 12, 2004, and most recently as amended at 70 FR 24087 May 6, 2005 is hereby amended to reflect a reorganization of the Indian Health Service (IHS) Headquarters (HQ). The goal of the reorganization is to demonstrate increased leadership and advocacy, while improving the Agency's responsibilities for oversight and accountability. We have considered the President's Management Agenda, the Secretary's Workforce Restructuring Plan and recommendations from the Indian Health Design Team and the IHS Restructuring Initiatives Workgroup. Delete the functional statements for the IHS Headquarters in their entirety and replace with the following:

Chapter GA—Office of the Director

Section GA–10, Indian Health Service—Organization

The IHS is an Operating Division within the Department of Health and Human Services (HHS) and is under the leadership and direction of a Director who is directly responsible to the Secretary of Health and Human Services. The IHS Headquarters consists of the following major components:

Office of the Director (GA), Office of Tribal Self-Governance (GAA), Office of Tribal Programs (GAB), Office of Urban Indian Health Programs (GAC), Policy Formulation and Communications Groups (GAE), Office of Clinical and Preventive Services (GAF), Office of Information Technology (GAG), Office of Public Health Support (GAH), Office of Resource Access and Partnerships (GAJ), Office of Finance and Accounting (GAK), Office of Management Services (GAL), Office of Management Services (GAL) and Office of Environmental Health and Engineering (GAM).

Section GA–20, Indian Health Service—Functions

Office of the Director (OD) (GA)

Provides overall direction and leadership for the IHS: (1) Establishes goals and objectives for the IHS consistent with the mission of the IHS and ensures Agency performance is managed through goals/objectives, achievements, and/or improved outcomes; (2) provides for the full participation of Indian Tribes in the programs and services provided by the Federal Government; (3) develops health care policy; (4) ensures the delivery of quality comprehensive health services; (5) advocates for the health needs and concerns of American Indians/Alaska Natives (AI/AN); (6) promotes the IHS programs at the local, State, national, and international levels; (7) develops and demonstrates alternative methods and techniques of health services management and delivery with maximum participation by Indian Tribes and Indian organizations; (8) supports the development of individual and Tribal capacities to participate in Indian health programs through means and modalities that they deem appropriate to their needs and circumstances; (9) the IHS will carry out the responsibilities of the United States to Indian Tribes and individual Indians; (10) affords Indian people an opportunity to enter a career in the IHS by applying Indian preference; and (11) ensures full application of the principles of Equal Employment Opportunity laws and the Civil Rights Act in managing the human resources of the IHS.

Office of Tribal Self-Governance (OTSG) (GAA)

Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS, under Title V of the Indian Self-Determination and Education Assistance Act, Public Law 93–638, as amended; (2) develops and recommends policies, administrative procedures, and guidelines for IHS Tribal self-governance activities, with maximum input from IHS staff and workgroups, Tribes and Tribal organizations, and the Tribal Self-Governance Advisory Committee; (3) advises the IHS Director on Agency compliance with self-governance policies, administrative procedures and guidelines and coordinates activities for resolution of problems with appropriate IHS and HHS staff; (4) provides resource and technical assistance to Tribes and Tribal organizations for the implementation of the Tribal Self-Governance Program (TSGP); (5) participates in the reviewing of proposals from Tribes for self-governance planning and negotiation grants and recommends approvals to the IHS Director; (6) determines eligibility for Tribes and Tribal organizations desiring to participate in the TSGP; (7) oversees the negotiation of self-governance compacts and annual funding agreements with participating Tribal governments; (8) identifies the amount of Headquarters managed funds necessary to implement the annual funding agreements and prepares annual budgets for available Tribal shares in conjunction with IHS Area and Headquarters components; (9) coordinates annual reconciliation of funding agreements with IHS Headquarters components, Area Offices, and participating Tribes; (10) serves as the principal IHS office for developing, releasing, and presenting information on behalf of the IHS Director related to the IHS Tribal self-governance activities to Tribes, Tribal organizations, HHS officials, IHS officials, and officials from other Federal agencies, State and local governmental agencies, and other agencies and organizations; (11) arranges national self-governance meetings to promote the participation by all AI/AN Tribes in IHS self-governance activities and program direction; (12) participates in meetings for Self-Governance Tribal delegations visiting IHS Headquarters; and (13) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolutions of audit findings as may be needed and appropriate.

Office of Tribal Programs (PT) (GAB)

(1) Assures that Indian Tribes and Tribal organizations are informed regarding pertinent health policy and program management issues; (2) assures that consultation and participation by Indian Tribes and organizations occurs during the development of IHS policy and decision making; (3) provides overall Agency leadership concerning functions and responsibilities associated with self-determination contracting (Title I of the Indian Self-Determination Act); (4) advises the IHS Director and senior management on activities and issues related to self-determination contracting; (5) monitors Agency compliance with self-determination policies, administrative procedures, and guidelines; (6) provides Agency

7C

leadership in planning and conducting a program of expert guidance, technical assistance, and support to Indian Tribes that continue to receive their health services directly from the IHS; (7) administers a national grant program designed to assist Tribes and Tribal organizations in beginning and/or expanding self-determination activities; (8) provides Agency leadership in the development of policy; (9) discharges operational responsibilities, with respect to the contract support cost (CSC) program administered by the IHS; (10) provides advice to the IHS Director and senior management on Tribal issues and concerns by acting as liaison with Tribal leaders, national Tribal organizations, inter-Tribal consortiums and Area health boards; (11) provides leadership in the management process of receiving visiting delegations of Tribal leaders and representatives to IHS Headquarters and provides staff assistance to the Office of the Director with respect to Tribal meetings at locations outside of Headquarters; (12) provides overall Agency leadership with respect to policy development and issues concerning the Federal recognition of new Tribes; (13) supports Tribes in managing health programs; (14) coordinates available support from other public and private agencies and organizations; (15) maintains a central database on relevant information to contact Tribal leaders, health programs, etc.; and (16) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Office of Urban Indian Health Programs (OUIHP) (GAC)

(1) Advises the IHS Director on the activities and issues related to the IHS' implementation of Title V, "Indian Health Care Improvement Act", as amended; (2) develops and recommends policies, administrative procedures, and guidelines for IHS services and activities for Urban Indian health programs and organizations; (3) assures that urban Indian health programs and organizations are informed of pertinent health policies; (4) ensures that consultation with urban Indian health programs and organizations occurs during the development of IHS policy to the extent allowed by law; (5) supports Urban Indian health programs and organizations in managing health programs; (6) coordinates support available from other public and private agencies and organizations; (7) advises the IHS Director on Agency compliance with Urban Indian health program policies, administrative procedures, and guidelines; (8) maintains relevant information on urban Indian health programs and organizations; (9) coordinates meetings and other communications with urban Indian health program representatives; and (10) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Policy Formulation and Communications Group (PFCG) (GAE)

(1) Analyzes policy-related issues; (2) provides recommendations for resolving policy conflicts; (3) evaluates policy options and forecasts their costs, benefits, and long-term results; (4) ensures consistency between and within public agency statements, external correspondence, legislative and regulatory positions and internal policy development; (5) disseminates information to IHS consumers, stakeholders, and the general public regarding the activities of the IHS and the health status of AI/AN people and communities; and (6) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Public Affairs Staff (PAS) (GAE1)

(1) Serves as the principal advisor for strategic planning on communications, media relations, and public affairs policy formulation and implementation; (2) ensures IHS policy is consistent with directives from the Assistant Secretary for Public Affairs; (3) provides leadership and advocacy to establish and implement policy for internal and external dissemination of Agency information intended for public release or employee and stakeholder information; (4) serves as the central office for technical guidance and assistance to IHS staff for the development of public affairs and media communication; (5) coordinates public affairs activities with other public and private sector organizations; (6) coordinates the clearance of IHS public relations activities, campaigns, and communications materials; (7) represents the IHS in discussions regarding policy and public affairs initiatives/implementation; (8) provides technical assistance and advice relative to the effect public affairs initiatives/implementation would have on the IHS; (9) collaborates with the Division of Regulatory Affairs, for review and response to media requests received under the Freedom of Information Act (FOIA) or the Privacy Act, and ensures the security of IHS documents used in such responses that contain sensitive and/or confidential information; and (10) serves as the IHS liaison office for press and public affairs with HHS, IHS Area Offices, media and other external organizations and representatives.

Diversity Management and Equal Employment Opportunity Staff (DMEEOS) (GAE2)

(1) Administers the IHS equal employment opportunity, civil rights, and affirmative action and alternative Dispute Resolution programs, in accordance with applicable laws, regulations, and HHS policies; (2) plans and oversees the implementation of IHS affirmative employment and special emphasis programs; (3) reviews data and advises IHS managers of possible discriminatory trends; (4) ensures immediate implementation of required actions on complaints of alleged sexual harassment or discrimination; (5) decides on accepting, for investigation, or dismissing discrimination complaints and evaluates accepted complaints for procedural sufficiency and investigates, adjudicates, and resolves such complaints; (6) evaluates accepted complaints for procedural sufficiency and investigates, adjudicates, and resolves such complaint; and (7) develops/administers equal employment opportunity education and training programs for IHS managers, supervisors, counselors, and employees.

Executive Secretariat Staff (ESS) (GAE3)

(1) Serves as the Agency's liaison with the Office of the Secretary's Executive Secretariat on IHS program, policy, and special matters; (2) reviews correspondence received by the IHS Director and assigns reply or follow-up action to appropriate IHS Headquarters program offices and IHS Area Offices; (3) ensures the quality (responsiveness, clarity, and substance) of IHS-generated correspondence prepared for the IHS Director's signature by coordinating the review of integrity and policy issues, and performing standard edits and revisions; (4) reviews and coordinates clearance of decision documents for the IHS Director's approval to ensure successful operations and policy-making within the Agency; (5) assists IHS officials as they prepare documents for the HHS Secretary's review, decision, and/or signature; (6) performs

special writing assignments for the IHS Director; (7) manages the flow of executive correspondence and related information to Tribes, Tribal organizations, heads of Federal departments and agencies, Congressional Staff offices, and members of Congress; (8) maintains official records for the IHS Director's correspondence and conducts topic research of files, as needed; (9) maintains an electronic document handling system to assist in managing the timely processing of internal and external executive correspondence; (10) conducts training to promote conformance by IHS Headquarters and Area staff to the IHS Executive Correspondence Guidelines and the electronic document handling system; and (11) tracks reports required by Congress.

Congressional and Legislative Affairs Staff (CLAS) (GAE4)

(1) Serves as the principal advisor to the IHS Director on all legislative and Congressional relations matters; (2) advises the IHS Director and other IHS officials on the need for changes in legislation and manages the development of IHS legislative initiatives; (3) serves as the IHS liaison office for Congressional and legislative affairs with Congressional offices, the HHS, the Office of Management and Budget (OMB), the White House, and other Federal agencies; (4) tracks all major legislative proposals in the Congress that would impact Indian health; (5) ensures that the IHS Director and appropriate IHS and HHS officials are briefed on the potential impact of proposed legislation; (6) represents the IHS in discussions regarding policy and legislative initiatives/implementation; (7) provides technical assistance and advice relative to the effect that initiatives/implementation would have on the IHS; (8) establishes collaborations with Headquarters Officers on programmatic and financial issues related to budget formulation; (9) conducts legislative analysis; (10) provides support and serves as liaison to the IHS Director relative to IHS appropriations efforts; (11) directs the development of IHS briefing materials for Congressional hearings, testimony, and bill reports; (12) analyzes legislation for necessary action within the IHS; (13) develops appropriate Legislative Implementation Plans; and (14) coordinates with IHS offices as appropriate to provide leadership, advocacy, and technical support to respond to requests from the public, including Tribal governments, Tribal organizations, and Indian community organizations regarding IHS legislative issues.

Policy Support Staff (PSS) (GAE5)

(1) Organizes, facilitates, and supports stakeholder task teams to advise the IHS Director on major policy issues; (2) represents the IHS Director in meetings with IHS employees and high-level management officials within the IHS, the HHS, or other Federal agencies, Tribes, and other organizations; (3) provides staff support to the IHS Director, including preparation of presentations and briefings; (4) provides staff support to senior managers, councils and groups; (5) completes special assignments for the IHS Director that may require coordination with other IHS offices or other Federal agencies, Tribes, or Tribal organizations; (6) serves as the IHS liaison for inter-governmental and private sector initiatives that impact health care services and management of the IHS; and (7) participates on inter-governmental task forces.

Office of Clinical and Preventive Services (OCPS) (GAF)

(1) Serves as the primary source of national advocacy, policy development, budget development and allocation for clinical, preventive, and public health programs for the IHS, Area Offices, and Service Units; (2) provides leadership in articulating the clinical, preventive, and public health needs of AI/AN, including consultation and technical support to clinical and public health programs; (3) develops, manages, and administers program functions that include, but are not limited to, alcohol and substance abuse, behavioral health, chronic diseases such as diabetes, asthma, dental services, medical services, Health Promotion/Disease Prevention, domestic violence, pharmacy and pharmaceutical acquisition, community health representatives, emergency medical services, health records, disabilities, Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome, maternal health, child health, clinical nursing, public health nursing, women's health, nutrition and dietetics, and elder care; (4) investigates service delivery and community prevention evidence-based and best practice models for dissemination to community service locations; (5) expands the availability of resources available for AI/AN health by working with public and private entities as well as Federal agencies within and outside the HHS; (6) coordinates development of staffing requirements for new or replacement health care facilities and approves Congressional budget requests for staffing, in collaboration with the Office of Environmental Health and Engineering; (7) provides program oversight and direction for the facilities planning and construction process; (8) develops and coordinates various Health Initiative and Nursing grant programs; (9) provides the national focus for recruitment and retention of health professionals and coordinates with the scholarship and loan repayment programs; (10) works with the Contract Health Services (CHS) program on CHS denial appeals to the IHS Director and in determining CHS medical priorities; (11) manages the clinical (medical, nursing, pharmacy, dental) features of medical tort claims against the IHS; (12) works with the Office of Management Services in managing the clinical aspects of the IHS workman's compensation claims; (13) oversees IHS efforts in a variety of quality assurance and improvement activities, including patient safety; (14) monitors approximately one-half of the IHS's Government Performance and Results Act (GPRA) indicators, overseeing indicator development, data collection, and reporting results; and (15) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, border health initiatives, Tribal delegation meetings, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Emergency Preparedness and Emergency Medical Services Staff (EPEMSS)

(1) Provides overall direction and leadership for the IHS in regard to establishing IHS goals and objectives consistent with those of the Department of Homeland Security and the HHS, addressing the mission critical elements of emergency preparedness; (2) provides leadership for the development of emergency preparedness plans, policies, and services, including the continuity of operations plans, deployment, public health infrastructure, and emergency medical services; (3) coordinates IHS activities and resources with the activities and available resources of other government and non-government programs for essential services related to homeland security and emergency preparedness; (4) advocates for the emergency preparedness needs and concerns of AI/AN and promotes these program activities at the local, State, national, and international levels; and (5) advocates and coordinates support for Tribal emergency medical services

programs, including training and equipment.

Division of Behavioral Health (DBH) (GAFA)

(1) Applies identified profession and program standards, monitors and evaluates community and Area-wide services provided through grants or contracts with AI/AN Tribes, villages, organizations, and direct IHS operations for mental health, social services, and alcohol/substance abuse; (2) coordinates AI/AN community behavioral health programs including alcohol/substance abuse prevention and treatment, mental health, and social work with program directors, division staff, Area staff, and other agencies and institutions; (3) coordinates contracts and grants for behavioral health services and monitors services provided; (4) makes program and policy changes using data analysis, recommendations from operational levels, research results, and coordinates resource allocation from program policies; (5) provides behavioral health program consultation to AI/AN groups and IHS staff; (6) provides leadership in the identification of behavioral change interventions and supports implementation at the community level; (7) coordinates with Federal, State, professional, private, and community organizations on alternate health care resources; (8) works with other Federal agencies and departments to provide additional Federal resources for AI/AN behavioral health programs; (9) provides financial resources and programmatic oversight for complying with the Americans With Disabilities Act through programs such as the Indian Children's Program, and for elders through partnerships with the Administration on Aging and the National Indian Council on Aging; (10) measures and evaluates the quality of behavioral health care services; and (11) prepares information on behavioral health for budgetary hearings and provides program evaluation results to the IHS Director, the Congress, and the Administration.

Division of Clinical and Community Services (DCCS) (GAFB)

(1) Manages, develops, and coordinates a comprehensive clinical, preventive and public health approach to clinical and community program focusing on maternal and child health, Indian children services including preventive health support services for Head Start and Early Head Start Health Programs, medicine, nutrition, HIV/AIDS, pharmacy, health records, health education, health promotion, and disease prevention; (2) develops objectives, priorities, and methodologies for the conduct and evaluation of clinical, preventive, and public health for community health-based programs; (3) provides, develops, and implements IHS guidelines, standards, policies, and procedures on clinical, preventive, and public health for community based programs and initiatives; (4) monitors, evaluates, and provides consultation to clinical and community programs; (5) plans jointly with other programs and divisions of the IHS and other agencies on research and coordination of services; (6) coordinates professional staff recruitment and training needs, and scholarship recipient assignments and development to meet Area Office, Service Unit, and Tribal health professional human resource needs; (7) coordinates and monitors contracts and grants with IHS programs and other entities, in collaboration with the Division of Acquisitions Policy and the Division of Grants Operations; (8) develops and disseminates information and materials to IHS facilities and to Tribes and Urban Indian health programs; (9) develops program budget materials for resource management, program data collection, administrative system integrity and accountability and responds to Congressional and Departmental inquiries; and (10) manages the Veterans Affairs Pharmaceutical Prime Vendor Contract and IHS National Core Formulary.

Division of Nursing Services (DNS) (GAFC)

(1) Plans, develops, coordinates, evaluates, manages and advocates for Clinical and public health Nursing Services, including acute care, ambulatory care, and public health nursing services, Women's Health, and Community Health Representative Programs (CHR); (2) identifies and establishes standards for these programs; (3) provides leadership, professional guidance, and staff development; (4) plans, develops, coordinates, manages, and evaluates nursing CHR education to better meet the needs of nursing and CHRs in Indian Health programs; (5) coordinates professional staff, including nursing recruitment, scholarship recipients, assignment and development to meet Area Office, Service Unit, and Tribal needs in accordance with IHS policies and procedures; (6) provides guidance in planning, developing, and maintaining management information systems that will benefit documentation and data collection by and for nurses and community health workers; and (7) prepares budgetary data, analysis and program evaluations and prepares information for program and budget presentations, as well as Congressional hearings.

Division of Oral Health (DOH) (GAFD)

(1) Plans, develops, coordinates, and evaluates dental health programs; (2) establishes staffing, procedural, facility, and dental contract standards; (3) coordinates professional recruitment, assignment, and staff development; (4) represents dental staff and Area Dental Programs in personnel matters, including the monitoring of personnel orders for both appointments and transfers, establishing promotion priority lists, processing special pay and retention bonus contracts, and serving as the HQ representative on adverse action cases; (5) improves effectiveness and efficiency of dental programs; (6) develops resource opportunities and monitors utilization of resources for dental health programs; (7) formulates, allocates and analyzes dental program budget and prepares information for program and budget presentations as well as Congressional inquiries; (8) advocates for oral health needs of the AI/AN population; (9) coordinates health promotion and disease prevention activities for the dental program; (10) monitors oral health status and treatment needs of the AI/AN population; (11) provides clinical and technical support to field staff by way of oral health surveys, provision of clinical trials, consultation on treatment cases, publication of quarterly newsletters and serving as liaison with public and private institutions, as well as major universities to evaluate new and existing strategies for addressing oral health problems in AI/AN; (12) serves as the IHS liaison for oral health issues with other Federal agencies; (13) serves as main source of information transfer to field staff via mediums including, but not limited to, teleconference hookups, electronics (email/listservs), conventional mail and meeting attendance; and (14) maintains and distributes information from the IHS centralized dental database, including workload, program resource directories and exploring the applicability of new health informatics technologies and systems.

Division of Diabetes Treatment and Prevention (DDTP) (GAFE)

(1) Plans, manages, coordinates, and evaluates a comprehensive clinical and community program focusing on type 2 diabetes in AI/AN communities; (2) plans, manages, develops, coordinates, and evaluates the Congressionally-mandated Special Diabetes Program for Indians, a large grant program focused

7C

on the prevention and treatment of diabetes; (3) coordinates and monitors contracts and grants with IHS, Tribal, Urban Indian health programs and other entities; (4) develops objectives, priorities and methodologies for the conduct of clinical and community diabetes programs; (5) monitors, evaluates, and provides consultation to clinical and community diabetes grant programs and other new initiatives; (6) provides leadership, professional guidance, and staff development to Area Diabetes Consultants, Model Diabetes Programs and IHS, Tribal, Urban diabetes program providers; (7) coordinates diabetes training needs for Area Offices, Service Units, and Tribes; (8) develops and implements IHS standards of care, clinical guidelines, policies, and procedures for diabetes and diabetes-related conditions; (9) coordinates model diabetes program sites; (10) develops and disseminates diabetes-related information and materials to IHS, Tribes and Urban Indian health programs; (11) is responsible for preparing budgetary data, analysis and program evaluations for budget presentations and Congressional hearings; and (12) coordinates a chronic disease strategic plan initiative for the IHS.

Office of Information Technology (OIT) (GAG)

(1) Provides Chief Information Officer (CIO) services and advises the IHS Director on all aspects of information resource management and technology ensuring Agency compliance with related Federal laws, regulations and policies; (2) directs the development, implementation, and maintenance of policies, procedures, standards, and architecture for information resource management, technology activities, and services in the IHS; (3) directs strategic planning and budgeting processes for information resources and technology; (4) leads IHS efforts in the development and implementation of information resource and technology management initiatives in IHS; (5) directs the design, development, acquisition, implementation, and support of information systems and services used in the IHS; (6) directs the activities of the IHS Information Technology Investment Review Board in assessing, implementing, and reviewing the Agency's information systems; (7) contracts for information resource and technology-related software, equipment and support services in collaboration with appropriate acquisition authorities; (8) provides project management support for information resource and technology initiatives; (9) directs the development, implementation and management of the IHS Information Technology Security program to protect the information resources of the IHS; (10) provides information technology services and support to IHS, Tribal, and Urban Indian health programs; (11) ensures accessibility to information technology services; (12) represents the IHS and enters into information technology agreements with Federal, Tribal, State and other organizations; and (13) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations, and resolution of audit findings as may be needed and appropriate.

Division of Information Technology (DIT) (GAGA)

Provides Chief Technology Officer services and advises the CIO on all aspects of information technology; (2) develops, implements, and maintains policies, procedures and standards for information resource management and technology products and services in the IHS; (3) develops and maintains information technology strategic planning documents; (4) develops and maintains the IHS enterprise architecture; (5) develops and implements information technology management initiatives in IHS: (6) ensures IHS information technology infrastructure resource consolidation and standardization efforts support IHS healthcare delivery and program administration; (7) represents the IHS to Federal, Tribal, State, and other organizations; and (8) participates in cross-cutting issues and processes that involve information technology.

Division of Information Resources Management (DIRM) (GAGB)

(1) Advises the CIO on all aspects of information resources management; (2) develops information resource policies and procedures; (3) develops the IHS information technology budget and related documents; (4) provides budget analyses and reports to the CIO; (5) develops strategies for presenting the IHS information technology budget to IHS, Tribal, and Urban Indian health programs; (6) provides technical analyses, guidance, and support for IHS capital planning and investment control activities; (7) manages the IHS portfolio management tool; (8) manages the activities of the IHS Information Technology Investment Review Board in assessing, implementing and reviewing the Agency's information systems; (9) represents the IHS to Federal, Trbal, State, and other organizations; and (10) participates in the cross-cutting issues and processes that involve information resources management.

Division of Enterprise Project Management (DEPM) (GAGC)

(1) Advises the CIO on all aspects of information technology project management; (2) develops project management policies and procedures; (3) identifies alternatives among internal and external sources and recommends the best sources to supply information resource and technology products and services to IHS; (4) develops information resource and technology project governance structures, management plans, evaluations, protocols, documentation guides, and related materials to support effective project management; (5) provides project management and related support for IHS developed and acquired information resource and technology products and services; (6) provides customer relationship management support to project stakeholders; (7) provides quality assurance and risk management support; (8) provides contract management support for information technology initiatives; (9) provides contract liaison services to appropriate acquisition authorities; (10) represents the IHS to Federal, Tribal, State, and other organizations, and (11) participates in cross-cutting issues and processes that involve information resources and technology project management.

Division of Information Security (DIS) (GAGD)

(1) Advises the CIO on all aspects of information security; (2) develops, implements and monitors the IHS Information Technology Security program to protect the information resources of the IHS; (3) develops and maintains cyber security policies and guidance for hardware, software, and telecommunications within the IHS; (4) reviews IHS security plans for sensitive systems; (5) evaluates safeguards to protect major information systems and the information technology infrastructure; (6) monitors all IHS systems development and operations for security and privacy compliance; (7) establishes and leads IHS teams to conduct reviews of Agency programs to protect IHS cyber and personnel security programs; (8) conducts vulnerability assessments of IHS information technology infrastructure; (9) coordinates activities with internal and external organizations reviewing the IHS's information resources for fraud, waste, and abuse; (10) develops,

implements, and evaluates an employee cyber security awareness and training program; (11) establishes and leads the IHS Computer Security Incident Response Capability team; (12) represents the IHS to Federal, Tribal, State, and other organizations; and (13) participates in cross-cutting issues and processes that involve information security.

Office of Public Health Support (OPHS) (GAH)

(1) Advises and supports the IHS Director on policy, budget formulation, and resource allocation regarding the operation and management of IHS, Tribal, and Urban Indian health programs; (2) provides IHS-wide leadership, guidance and support for public health program and activities including strategic planning, evaluation, Government Performance and Results Act (GPRA), research, epidemiology, statistics, and health professions; (3) provides Agency-wide leadership and consultation to IHS, Tribal, and Urban Indian health programs on IHS goals, objectives, policies, standards, and priorities; (4) advocates for the public heath needs and concerns of AI/AN and promotes quality health care; (5) manages and provides national leadership and consultation for IHS on assessments of pubic health medical services, research agendas, special pay, and public health initiatives for the Agency, (6) provides national leadership for the IHS scholarship and loan repayment programs, including physician recruitment; (7) supports and advocates for AI/AN to access State and local public health programs; and (8) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit finding as may be needed and appropriate.

Division of Epidemiology and Disease Prevention (GAHA)

(1) Prevents and controls chronic and communicable disease through epidemiology and applied public health practice; (2) builds capacity in Tribal communities through a network of Tribal Epidemiology Centers; (3) collaborates with the Centers for Disease Control and Prevention (CDC) and directs staff detailed to the IHS from the CDC; (4) describes causes, patterns, and risk factors for disease and death, and develops public health policy and interventions; (5) serves IHS and Tribal communities through disease surveillance, health data management, analysis and reporting, community surveys, emergency response, training in public health practice and epidemiology, consultation to clinicians and technical support for pubic health activities and assessment of public health system performance; (6) supports epidemiology, disease control, and prevention programs for chronic diseases, including cancer, tobacco control, cardiovascular disease, diabetes, kidney disease, environmental health, maternal health, child health, and others; and (7) supports epidemiology, disease control, and prevention programs for communicable diseases, including tuberculosis, HIV/AIDS, sexually-transmitted diseases, hepatitis, hantavirus, antibiotic-resistant infections, immunizations, bioterorism preparedness and others.

Chronic Disease Branch (CDB)

Support epidemiology, disease control, and prevention programs for chronic diseases, including cancer, tobacco control, cardiovascular diseases, diabetes, kidney disease, environmental health, maternal health, child health, and others.

Infectious Disease Branch (IDB)

Supports epidemiology, disease control, and prevention programs for communicable diseases, including tuberculosis, HIV/AIDS, sexually-transmitted diseases, hepatitis, hantavirus, antibiotic-resistant infections, immunizations, bioterrorism preparedness, and others.

Division of Program Statistics (DPS) (GAHB)

(1) Plans, develops, directs, and coordinates an analytical statistical reporting program to provide data for measuring the health status and unmet health needs of the AI/AN population; (2) develops and coordinates the collection, processing, and analysis of demographic, patient care, and clinical data for the Agency; (3) maintains, analyzes, makes accessible, and publishes results from national demographic and clinical analyses; and (4) provides statistical and analytical consultation to other divisions and agencies.

Demographics Statistics Staff (DS)

(1) Plans, develops and executes a major nation-wide statistical program for the collection, processing, analysis and dissemination of demographic characteristics of the AI/AN population located throughout the United States; (2) coordinates with the National Center for Health Statistics the analysis and reporting of vital event information for the AI/AN population; and (3) provides statistical and analytical consultation to other divisions and agencies.

Patient Care Statistics Staff (PCSS)

(1) Plans, develops and executes a major nation-wide statistical program for the collection, processing, analysis and dissemination of patient care data and special studies with emphasis on health and demographic characteristics of the AI/AN population located throughout the United States; (2) evaluates facility workload trends and participates in the development of methodologies for constructing long-range estimates of inpatient and ambulatory care workloads for use in facility construction and planning; and (3) coordinates with the IHS National Data Repositories, the analysis and reporting of program, patient care and clinical data for the Agency.

Division of Planning, Evaluation and Research (DPER) (GAHC)

(1) Develops and coordinates Agency strategic planning and performance measurement efforts (including GPRA and Program Assessment Rating Tool) with budgeting requirements in consultation with IHS program staff; (2) provides consultation and coordination on the IHS budget formulation activity for planning and data purposes; (3) conducts, facilitates, solicits, coordinates, and evaluates community-oriented practice-based research related to health problems and the delivery of care to AI/AN people and communities with a major focus on improving the health status and systems of care; (4) provides guidance and support for IHS-wide program evaluation projects; and (5) provides support for public health planning services, facilities and staffing.

Division of Health Professions Support (DHPS) (GAHD)

(1) Develops and implements IHS programs to recruit, select, assign, and retain health care professionals and coordinates these activities with the respective disciplines; (2) assesses professional staffing needs and coordinates the development of strategies and systems to satisfy these needs; (3) coordinates the planning and development of IHS strategies and systems to improve the morale and retention of all professionals; (4) coordinates Headquarters activities for physician residency and training programs; (5) coordinates the IHS National Health Service Corps (NHSC) program, including liaison and assignment of NHSC scholarship recipients to IHS; (6) develops priority sites for the loan repayment program; (7) coordinates placement of professionals

with loan repayment obligations; (8) serves as IHS coordinator for pre-medical and medical school IHS scholarship recipients; (9) retrieves, establishes, and manages information and data on the IHS work force; and (10) conducts work force data analyses, including trends and projections, identifying work force needs by major personnel systems, categories, and disciplines.

Health Professions Support Branch (HPSB)

(1) Develops the IHS program to recruit, select, assign, and retain health care professionals, in accordance with policies and guidance provided by the Division of Human Resources; (2) assesses IHS professional staffing needs; (3) provides research and analysis functions for Chief Medical Officers, Clinical Directors, and senior clinicians; (4) manages and supports health professions education programs and activities; and (5) develops and administers Indian Health Professions programs authorized by the Indian Health Care Improvement Act (IHCIA), as amended.

Loan Repayment Branch (LRB)

(1) Awards, monitors, places (in IHS, Tribal, and Urban sites), and processes waivers and defaults of participants in the Loan Repayment Program (LRP) as mandated by Section 108 of the IHCIA; (2) coordinates the LRP payment and debt management function with the Program Support Center; and (3) coordinates program administration with the IHS Area Office and Service Unit personnel, particularly recruitment and retention activities, including Clinical Directors, Chief Medical Officers, and professional recruiters.

Scholarships Branch (SB)

Develops, administers, and evaluates programs in the IHS Scholarship Program authorized under the IHCIA: Section 102 (Health Professions Recruitment Program for Indians), Section 103 (Health Professions Preparatory Scholarship Program for Indians), Section 104 (Indian Health Professions Scholarship Program), Section 105 (IHS Externs Program), Section 120 (Matching Grants to Tribes for Scholarship Programs), Section 217 (Indians Into Psychology Program), and other funded programs authorized under the IHCIA.

Office of Resource Access and Partnerships (ORAP) (GAJ)

(1) Provides Agency-wide leadership and consultation to the IHS direct operations and Tribal programs on IHS goals, objectives, policies, standards and priorities regarding the operations and management of the Business Office Service (BOS) and the Contract Health Services (CHS) and the IHS Partnership programs; (2) develops and implements objectives, priorities, standards, measures and methodologies for the BOS and CHS and Partnership program; (3) manages and provides leadership, advocacy, consultation and technical support to Headquarters, IHS Areas and local levels on the full scope of BOS, CHS and Partnership activities; (4) represents the IHS at meetings and in discussions regarding policy, legislation and other national issues; (5) provides oversight and monitors the BOS and CHS programs regarding compliance requirements, utilization reviews, revenue measures and reports; (6) formulates and analyzes BOS and CHS budgets and prepares information for program budget presentations; (7) collaborates and coordinates with IHS information technology staff and external organizations on new technologies, applications and business practices; (8) develops resource opportunities through partnerships and coordinates the BOS and CHS activities with other governmental and non-governmental programs, promoting optimum utilization of all available health resources; (9) maintains a database of all inter-agency agreements, intra-agency agreements, memoranda of agreement and memoranda of understanding with external organizations; and (10) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, and resolution of audit findings as may be needed and appropriate.

Division of Business Office Enhancement (DBOE) (GAJA)

(1) Serves as the primary focal point for BOS program operations and policy issues and represents BOS in national forums; (2) provides consultation to Headquarters and Area Offices and is liaison to Tribal organizations, HHS and Office of Management and Budget (OMB) regarding BOS issues; (3) reviews and improves the efficiency of access to resources and provides support for local capacity building through technical assistance, training, consultation and information systems support; (4) develops, disseminates, and maintains BOS policy and procedures manuals; (5) provides national leadership for Medicare, Medicaid, and private insurance reimbursement policy and procedures; (6) services as the primary liaison with the Center for Medicaid/Medicare Services for rate setting; (7) serves as the focal point regarding the impact of existing and proposed Laws, Regulations and Policies of Medicare and Medicaid managed care activities, including the review, evaluation, and monitoring of Sections 1115 and 1915(b) Medicaid waiver proposals and other State and Federal health care reform activities; (8) provides programmatic management, review and analysis of information systems for patient registration and billing and collections systems; (9) assures training on operations, various regulatory issues and negotiated managed care provider agreements; and (10) develops third-party budget materials and responds to Tribal, Congressional and HHS inquiries relating to third-party issues.

Division of Contract Care (DCC) (GAJB)

(1) Plans, develops, and coordinates the CHS program and required business practices; (2) develops, disseminates, and maintains CHS policy and procedures manuals; (3) formulates and monitors the CHS budget and distribution methodologies; (4) administers the Catastrophic Health Emergency Fund; (5) administers the CHS Quality Assurance Fund; (6) administers the CHS claims adjudication activity for the IHS Headquarters; (7) monitors the implementation of the IHS payment policy and reports the status to the Director, ORAP; (8) administers the IHS Fiscal Intermediary contract; (9) conducts data analysis and national utilization review and utilization management of CHS services rendered by private sector providers; and (10) provides consultation to Headquarters and Area Offices, and responds to inquiries from the Congress, Tribes, and other Federal agencies.

Office of Finance and Accounting (OFA) (GAK)

(1) Develops and prepares the budget submission for the Indian Health Service and Facilities appropriation to the HHS, OMB and the Presidents budget; (2) participates with HHS officials in budget briefings for the OMB and the Congress; (3) distributes, coordinates, and monitors resource allocations; (4) develops and implements budget, fiscal, and accounting procedures and conducts reviews and analyses to ensure compliance in budget activities in collaboration with Headquarters officials and the Tribes; (5) provides cost advisory and audit resolution services in accordance with applicable statutes and regulations; and (6) supports the Agency's Medicare Cost

Report efforts by providing necessary financial data to the contractor preparing the cost reports; and (7) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations, and resolution of audit findings as may be needed and appropriate.

Division of Audit (DA) (GAKA)

(1) Develops and recommends policies and procedures for Chief Financial Officer (CFO) audits; (2) develops and recommends policies and procedures for Tribes and Tribal organizations audit resolution within IHS; (3) provides advice, technical consultation, and training to IHS Headquarters, Area Offices, Tribal, and Urban Indian Health organizations for Title I, Title V, and Agency CFO audits; (4) provides audit resolution services in accordance with applicable statutes and regulations; (5) advises the Director, OFA, of proposed legislation, regulations, directives, and timelines that will affect audits within IHS, as well as how current legislation affects handling of audit-related issues; (6) manages the IHS Audit Information Management System (AIMS) and conducts analysis of data for reports and/or responses to internal and external inquiries; (7) serves as the IHS contact point to the HHS for the AIMS Report and the Accountability Report; (8) coordinates the collection of disallowed costs cited in Tribes and Tribal organizations audits; (9) coordinates the correction of non-monetary findings coded by the HHS in Tribes and Tribal organizations audits; (10) coordinates receipt of audits from all organizations funded by IHS; (11) formulates Corrective Action Plans for CFO audit deficiencies; (12) coordinates resolutions of deficiencies with IHS Headquarters senior managers and Area Directors; and (13) reports status of corrective actions to the IHS Headquarters senior managers and to the HHS.

Division of Budget Formulation (DBF) (GAKB)

(1) Interprets policies, guidelines, manual issuances, OMB circulars, and instructions from Congress, OMB, HHS, and IHS on formulation of preliminary, Departmental, and Congressional budget requests for the IHS and Indian Health Facilities appropriation requests; (2) directs the collection, review, and analysis of program and financial data from Headquarters, Area Offices, Tribes, Tribal and Urban Indian Health organizations used in determining resource requirements; (3) coordinates the preparation of the IHS preliminary, Departmental and Congressional budget justifications for the Indian Health Service and Facilities appropriations; (4) prepares witness information for hearings before the House and Senate Appropriations Committees, House Resource Committee on Interior and Insular Affairs, the Senate Committee on Indian Affairs, and other Congressional committees as requested; (5) coordinates development of responses and inserts to be used for the record by and for Congressional appropriations hearings; (6) coordinates development of briefing materials in response to Congressional concerns and hearings; and (7) develops, implements, and maintains IHS policies and procedures for Congressional budget liaison activities.

Division of Budget Execution (DBE) (GAKC)

(1) Interprets policies, guidelines, and directives from Congress, OMB, Government Accounting Office (GAO), Treasury, and the HHS on Tribal shares and execution; (2) recommends and coordinates IHS Area Budget Execution; (3) prepares apportionment requests for the Indian Health Service and Indian Health Facilities appropriations; (4) consults with the Headquarters officials on Area funding allocations; (5) monitors fund control at the appropriation level; (6) reviews IHS Headquarters memorandum of agreements for proper accounting; (7) prepares reprogramming requests; (8) advises the Director, OFA on Agency compliance with self-determination policies, administrative procedures and guidelines; (9) coordinates activities for resolution of problems with appropriate IHS Headquarters and Area staff; and (10) analyzes various operating costs and provides Program Support Center (PSC) with Area breakouts.

Division of Systems Review and Procedures (DSRP) (GAKD)

(1) Reviews, interprets and comments on policies, guidelines, and manual issuances of Congress, Treasury, GAO, the HHS and IHS on systems of fiscal managment, including the Unified Financial Management System (UFMS), and the CORE Accounting System (CORE); (2) plans, directs, and implements fiscal policies and procedures on Headquarters and field accounting; (3) Supports costs accounting activities in IHS; (4) reviews and analyzes accounting and financial management systems and trains Headquarters staff on related system interfaces; (5) supports the conversion of financial information from CORE to UFMS; (6) provides and assists Area accounting staff with accounting system transactions, correcting errors and system related emergencies; (7) serves as the Agency liaison between Agency components concerning the interface of administrative and other feeder applications with Oracle/UFMS; (8) serves as the liaison between IHS, the PSC and the HHS for reporting of prompt payment, debt management, and cash reconciliation processes; (9) coordinates, regulates, and manages the issuance of financial codes for IHS; and (10) coordinates year-end "roll-over" activities with PSC and IHS Headquarters and Area staffs.

Division of Financial Operations (DFO) (GAKE)

(1) Manages the IHS travel program, provides training, interprets travel regulations, conducts reviews and updates travel policy and procedures; (2) processes Headquarters travel orders and vouchers, including permanent change of station and international travel; (3) coordinates Area Directors' travel orders and vouchers; (4) coordinates the conference management functions for the Agency; (5) provides support and technical assistance to Headquarters operational components in the development of Headquarters operations budgets; (6) provides fund certification and maintains commitment registers for Headquarters components; (7) performs fund reconciliations and assists in coordination of discrepancies with financial officials; and (8) maintains Headquarters staffing status reports.

Office of Management Services (OMS) (GAL)

(1) Provides IHS-wide leadership, guidance and support for the management of human resources, grants, acquisition, records management, personal property and supply, and the regulations program; (2) formulates, administers, and coordinates the review and analysis of IHS-wide policies, delegations of authority, and organizations and functions development; (3) develops and oversees the implementation of policies, procedures and delegations of authority for IHS grants management activities, including grants added to self-governance compacts; (4) ensures that Agency policies and practices for the administrative functions identified above are consistent with applicable regulations, directives and guidance from higher echelons in the HHS and other Federal oversight agencies; (5) advises the IHS Director, in conjunction with the Office of the General Counsel

7C

(OGC), on the resolution of statutory and regulatory issues related to the IHS and coordinates resolution of IHS legal issues with the OGC, IHS staff, and other Federal agencies; (6) assures that IHS appeal systems meet legal standards, in conjunction with the Office of the General Counsel; (7) provides leadership and direction of activities for continuous improvement of management accountability and administrative systems for effective and efficient program support services IHS-wide; (8) ensures the accountability and integrity of grants and acquisition management, records management, personal property utilization and disposition of IHS resources; (9) assures that the IHS management services, policies, procedures, and practices support IHS Indian Self-Determination Act policies; (10) assists in the assurance of Indian access to State, local, and private health programs; (11) provides leadership and advocacy of the IHS mission and goals with the HHS, Administration, Congress, and other external authorities; and (12) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Program Integrity and Ethics Staff (PIES) (GAL1)

(1) Directs the fact-finding and resolution of allegations of impropriety such as mismanagement of resources, fraud, waste, and abuse violations of the Standards of Ethical Conduct, Hatch Act and political activity and other forms of waste; (2) advises the IHS Director and IHS management of appropriate corrective and remedial actions to correct improprieties; (3) directs and provides leadership in the formulation of plans, guidance and evaluation of the IHS Personnel Security and Drug Testing Programs; (4) administers the IHS-wide management of the Agency hotline reports of allegations; (5) serves as the Agency coordinator for the HHS Office of the Inspector General (OIG), Office of Investigations; (6) manages and directs the IHS "Ethics Program", including the implementation of all requirements, providing advice to the IHS Director and serving as the Agency liaison with all outside investigative organizations such as the Office of Special Counsel, the General Accounting Office and the OIG; and (7) develops and implements IHS directives and training for Standards of Ethical Conduct, Hatch Act and political activity, allegations and investigations of administrative fraud, waste and abuse, drug testing, and personnel security.

Grants Policy Staff (GPS) (GAL2)

(1) Initiates new and modifies existing IHS grants administration policies and procedures in accordance with HHS grants policies; (2) provides assistance to IHS staff and grantee organizations regarding policies and procedures pertinent to the administration of IHS grants to ensure stewardship of Federal funds; (3) provides guidance to and articulates grants management policy for IHS staff on the effective utilization of financial assistance mechanisms (grants and cooperative agreements); (4) provides assistance to IHS staff on program announcement requirements as issued by OMS and HHS Grants Review and Oversight; (5) develops and maintains IHS Grants Operations/Grants Policy Web site; and (6) posts all IHS funding opportunities on IHS Grants Operations/Grants Policy Web site for Grants.gov.

Management Policy and Internal Control Staff (MPICS) (GAL3)

(1) Formulates, administers, and supports IHS-wide policies, delegations of authority, and organizations and functions development; (2) provides leadership, on behalf of the IHS Director, to functional area managers at IHS Headquarters in developing, modifying, and overseeing the implementation of IHS policies and procedures; (3) provides analysis, advisory, and assistance services to IHS managers and staff for the development, clearance, and filing of IHS directives and delegations of authority; (4) serves as principal advisor and source for technical assistance for establishment or modification of organizational infrastructures, functions, and Standard Administrative Code configurations; (5) administers the IHS's Management Control Program for assuring IHS compliance with management control requirements in the Federal Managers' Financial Integrity Act; (6) coordinates the development, clearance, and transmittal of IHS responses and follow-up to reports issued by the Office of Inspector General (OIG), the General Accounting Office (GAO), and other Federal internal and external authorities; (7) provides assistance and support to special assigned task groups; (8) conducts special program or management integrity reviews as required; and (9) oversees and coordinates the annual development and submission of the Agency's Federal Activities Inventory Reform Act report to the HHS.

Division of Commissioned Personnel Support (DCPS) (GALA)

(1) Acts as the liaison between IHS and the Office of Commissioned Corps Operations, the Office of Commissioned Corps Force Management, and the Office of Commissioned Corps Officers Support HHS; (2) advises the IHS Director, supervisors, administrators, managers, officers and dependents regarding commissioned personnel benefits, policies, procedures, and regulations, as the IHS primary point of contact for commissioned personnel management; (3) develops policies, procedures, and recommendations to the Office of Commissioned Corps Operations, the Office of Commissioned Corps Force Management, and the Office of Commissioned Corps Officers Support HHS; (4) provides direct support to the IHS Director and/or the Agency representative to the Office of the Surgeon General; and (5) produces resource materials and conducts training sessions on commissioned personnel issues for officers, supervisors, and commissioned personnel specialists in IHS Area Offices.

Division of Administrative Services (DAS) (GALB)

(1) Plans, develops and directs program support and general services programs; (2) develops and disseminates policy and procedural guidelines for uniform administrative services and practices; (3) provides guidance and support in the development, planning, and implementation of administrative functions; (4) serves as liaison with the HHS and the General Services Administration (GSA) on logistics issues affecting the IHS; (5) monitors, evaluates, and reports on administrative programs and services; (6) manages a variety of special projects; (7) provides leadership and guidance for the Agency Records Management Program; (8) develops and recommends policies and procedures for the protection and disposition of IHS records and oversees the evaluation of records management activities in the IHS; (9) develops and implements a management control system for evaluation of records management functions agency-wide; (10) provides leadership for special projects and inter-and intra-agency activities; and (11) provides guidance and oversight to the IHS on the control and safeguard of classified national security information.

Office Services Branch (OSB)

(1) Administers physical security, facility management, and space

7C

management services real property and GSA lease management, telecommunication service, parking management, employee credentialing program, and employee transit subsidy program for Headquarters; (2) administers the agency forms, mail and printing program for Headquarters; (3) develops and implements policy and procedures for uniform office service; (4) provides leadership and coordination in the planning, development, operation, oversight, and evaluation of special office support projects in office relocations, and lease acquisition, and inter-and intra-agency activities; and (5) prepares reports on commercial printing and mail.

Property and Supply Management Branch (PSMB)

(1) Plans, develops, and administers the IHS policies on personal property and supply management in conformance with Federal personal property and supply management laws, regulations, policies, procedures, practices, and standards; (2) interprets regulations and provides advice on execution and coordination of personal property and supply management policies and programs; (3) administers management systems and methods for planning, utilizing, and reporting on administrative personal property and supply management programs, including the IHS personal property and supply accountability and controls systems; (4) provides guidance and serves as principal administrative authority on federal personal property and supply management laws, regulations, policies, procedures, practices, and standards, in conjunction with the Office of the General Counsel; (5) conducts surveys and studies involving evaluation and analysis of the personal property and supply management activities Agency-wide; (6) maintains liaison with the HHS and the GSA on personal property and supply management issues and programs affecting the IHS; (7) prepares reports on IHS personal property and supply; and (8) develops statements for annual budget formulation and presentation; (9) plans, develops, and administers an integrated IHS personal property and supply system; and (10) manages the Headquarters motor vehicles, personal property, special projects and inter/intra agency activities.

Division of Acquisition Policy (DAP) (GALC)

(1) Develops, recommends, and oversees the implementation of policies, procedures and delegations of authority for the acquisition management activities in the IHS, consistent with applicable regulations, directives, and guidance from higher echelons in the HHS and Federal oversight agencies; (2) advises the Director, Office of Management Services, of proposed legislation, regulations, and directives that affect contracts in the IHS; (3) provides leadership for compliance reviews of all IHS acquisition operations; (4) oversees completion of necessary corrective actions; (5) manages for the Agency, the HHS acquisition training and certification program; (6) supports and maintains the IHS Contract Information System and controls entry of data into the HHS Contract Information System; (7) serves as the IHS contact point for contract protests and the HHS contact for contract-related issues; (8) reviews and makes recommendations for approval/disapproval of contract-related documents such as: pre- and post-award documents, unauthorized commitments, procurement planning documents, justification for Other Than Full and Open Competition waivers, deviations, and determinations and findings that require action by the Agency Head of Contracting activity, or the Office of the Secretary; (9) processes unsolicited proposals for the IHS; (10) coordinates the IHS Small Business programs; and (11) oversees compliance with the Buy Indian Act.

Division of Grants Operations (DGO) (GALD)

(1) Directs grants management and operations for the IHS; (2) awards and administers grants and cooperative agreements for IHS financial assistance programs; (3) provides assistance for the resolution of audit findings for grant programs; (4) manages for the Agency, the HHS grants training and certification program; (5) assesses continuously grants operations; (6) oversees completion of necessary corrective action plans; (7) reviews and makes recommendations for improvements in grantee and potential grantee management systems; (8) serves as the IHS liaison with the HHS and the public for grants and other financial assistance programs with the IHS; (9) maintains the Catalog of Federal Domestic Assistance for IHS financial assistance programs; (10) conducts grants-related training for IHS staff, grantees, and potential grantees; (11) coordinates payment to grants, including scholarship recipients; and (12) establishes and maintains the IHS automated Grants Information System and controls data entry into the HHS automated Grants Information System.

Division of Regulatory Affairs (GALE)

(1) Manages the IHS's overall regulations program and responsibilities, including determining the need for and developing plans for changes in regulations, developing or assuring the development of needed regulations, and maintaining the various regulatory planning processes; (2) serves as IHS liaison with the Office of the Federal Register on matters relating to the submission and clearance of documents for publication in the Federal Register; (3) assures proper Agency clearance and processing of **Federal Register** documents; (4) informs management and program officials of regulatory activities of other Federal agencies; (5) manages the IHS review of non-IHS regulatory documents that impact the delivery of health services to Indians; (6) advises the IHS Director and serves as liaison with the Office of the General Counsel (OGC) on such matters as litigation, regulations, related policy issues, and administrative support issues; (7) determines the need for and obtains legal clearance of IHS directives and other issuances; (8) coordinates legal issues with the OGC, IHS, HHS components, and other Federal agencies, including the identification and formulation of legal questions and advising on the implementation of OGC opinions; (9) assures that IHS appeals processes meet legal standards; (10) advises on and participates in Indian Self-Determination and Education Assistance Act appeals and hearings; (11) provides guidance and assistance on State and Federal health reform efforts, including access and civil rights aspects and State Medicaid waiver applications; (12) advises on the administration of the contract health services (CHS) appeals system and is a participant in the IHS Director's CHS appeal decisions; (13) manages the retrieval and transmittal of information in response to requests received under the FOIA or the Privacy Act, in collaboration with the Public Affairs Staff; (14) ensures the security of sensitive and/or confidential information when responding to FOIA or Privacy Act issues; and (15) advises the IHS Director regarding requests for IHS employees to serve as expert witnesses when IHS is not a party to the suit.

Regulations and Records Access Branch (RRAB)

(1) Manages the Agency's regulation program and responsibilities; (2) serves as liaison with the Office of the Federal Register; (3) advises on the need for or changes in current regulations; (4)

develops or assures the development of IHS regulations; (5) keeps IHS officials informed on relevant regulatory activities of other agencies of the Government; (6) coordinates regulations activities with agencies within the HHS that impact on the delivery of health services to Indians; (7) maintains and updates various regulatory agendas; (8) assures that all IHS materials for publication in the **Federal Register** are properly cleared, processed, and in proper format; (9) manages the retrieval, review, and appropriate transmittal of information in response to FOIA requests, including ensuring the appropriate security of such documents; (10) manages, administers, implements and monitors the Agency's Paperwork Reduction Act (PRA) and OMB information collection/activities; (11) provides guidance and technical assistance to IHS regarding information collection requirements and procedures for obtaining OMB approvals and extensions for IHS information collections; and (12) coordinates the implementation and the application of Privacy Act requirements, including but not limited to Health Insurance Portability and Accountability Act implementation and compliance.

Policy Liaison Branch (PLB)

(1) Coordinates the resolution and development of legal advice to the IHS Director on IHS legal issues with the OGC, IHS senior staff, and other Federal agencies; (2) provides liaison with the OGC in such matters as litigation, regulations, legislation, policy review, civil rights, and administrative appeals; (3) provides advice on the development and implementation of non-personnel appeals processes to assure they meet legal standards; (4) maintains and distributes the Compendium of Legal Opinions; (5) reviews IHS directives and other issuances for needed legal clearances; (6) advises on the impact on IHS and the Indian community of State and Federal health reforms; and (7) provides policy review and advice on the need for or application of legal opinions.

Division of Human Resources (DHR) (GALG)

(1) Provides overall leadership and direction for the IHS Human Resources (HR) program; (2) evaluates, establishes and implements HR policies for Agency-wide use and provides leadership to ensure implementation; (3) provides advice, consultation, guidance and assistance to the Director, IHS, on civil service HR issues, programs and policies; (4) provides leadership and direction to the IHS Regional HR Centers; (5) assures compliance with Indian Preference statutory and policy requirements in HR practices; (6) provides HR services throughout the IHS, to include, but not limited to, strategic human capital and workforce planning, succession planning, E-government HR initiatives, HR program evaluation and oversight, management advisory services, HR leadership, classification and pay administration, staffing and placement, personnel and payroll action processing, labor-management and employee relations, benefits administration, and performance management and recognition programs; (7) provides advice, consultation, and assistance to IHS management and when requested to Tribal officials on tribal health program HR issues; (8) provides HR services, to include technical support, guidance, and assistance to IHS Headquarters staff, Regional HR Centers and other organizations and customers; (9) plans, conducts and evaluates HR programs; (10) plans and implements HR responsibilities for IHS programs covered by the headquarters appointing authority; and (11) represents the IHS in matters involving HR program services and responsibilities.

Division of Human Resources, Regional Human Resource Centers

(1) Provides overall leadership and direction for the IHS Human Resources (HR) program within the established region; (2) administers HR policies and regulations and provides leadership to ensure implementation; (3) provides advice, consultation, guidance and assistance to Area Directors, management officials, employees and other customers on civil service HR issues, programs and policies; (4) provides leadership and direction to the Human Resource staff throughout the Region; (5) assures compliance with Indian Preference statutory and policy requirements in HR practices; (6) provides HR services throughout the region, to include, but not limited to, strategic human capital and workforce planning, succession planning, E-government HR initiatives and strategic planning, HR program evaluation and oversight; strategic consultation, management advisory services, HR leadership, classification and pay administration, staffing and placement, personnel and payroll action processing, labor-management and employee relations, benefits administration and performance management; (7) provides advice, consultation, and assistance to management and when requested to Tribal officials on tribal health program HR issues; (8) plans, administers and evaluates HR programs; (9) plans and implements HR responsibilities for IHS programs covered by the region's appointing authority; and (10) represents the region in matters involving HR program responsibilities.

Western Region (GALG1)
Northern Plains (GALG2)
Southwest Region (GALG3)
Navajo Region (GALG4)
Southeast Region (GALG5)

Office of Environmental Health and Engineering (OEHE) (GAM)

(1) Advises and supports the IHS Director on policy, budget formulation, and resource allocation regarding environmental health and engineering activities of IHS and Tribal facilities programs; (2) provides Agency-wide leadership and consultation to IHS, Tribal, and Urban Indian health programs on IHS goals, objectives, policies, standards, and priorities; (3) represents the IHS within the HHS and external organizations for purposes of liaison, professional collaboration, cooperative ventures, and advocacy; (4) serves as the primary source of technical advice for the IHS Director, Headquarters, Area Offices, Tribal, and Urban Indian health programs on the full scope of health care facilities construction and operations, sanitation facilities construction and management, environmental health services, environmental engineering, clinical engineering, and realty services management; (5) develops and recommends policies, administrative procedures and guidelines for Public Law 93–638 construction activities; (6) develops objectives, priorities, standards, and methodologies to conduct and evaluate environmental health, environmental engineering, and facilities engineering and management activities; (7) coordinates the formulation of the IHS Facilities appropriation budget request and responds to all inquiries about the budget request and programs funded by the IHS Facilities appropriation; (8) maintains needs-based and workload-based methodologies for equitable resource distribution for all funds appropriated under the IHS Facilities appropriation; (9) provides leadership, consultation, and staff development to assure functional, safe, and well-maintained health care facilities, a comprehensive environmental health program, and the availability of water, sewer, and solid waste facilities for Indian homes and communities; (10) coordinates the IHS OEHE responsibilities in responding to disasters and other emergency situations, in collaboration with the

Office of Clinical and Preventive Services; and (11) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Division of Sanitation Facilities Construction (DSFC) (GAMA)

(1) Develops, implements, and manages the environmental engineering programs, including the Sanitation Facilities Construction (SFC) program, and compliance activities associated with environmental protection and historic preservation legislation; (2) provides Agency-wide management assistance and special support/consultation to address special environmental public health problems for environmental engineering/construction activities, and for compliance with environmental legislation; (3) works closely with other Federal agencies to resolve environmental issues and maximize benefits to Tribes by coordinating program efforts; (4) develops, implements, and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for SFC activities; (5) consults with Tribal groups/organizations in the development and implementation of SFC policies and initiatives, and in the identification of sanitation needs; (6) maintains a national inventory of current Tribal sanitation facilities needs, and past and present projects to address those needs; and (7) allocates financial resources Agency-wide based on need and workload using the national data inventories, in collaboration with the OFA.

Division of Facilities Operations (DFO) (GAMB)

(1) Develops, implements, and manages the programs affecting health care facilities operations, including the routine maintenance and improvement, real property asset management, realty, facilities environmental, quarters, and clinical engineering programs; (2) develops, implements, monitors and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for health care facilities operations; (3) serves as the principal resource for coordination of facilities operations and provides consultation to IHS and the Tribes on health care facilities operations; (4) maintains real property asset leasing, and quarters management systems; (5) maintains clinical engineering management systems; (6) formulates financial resources allocation methodologies Agency-wide based on need and workload data; (7) maintains Agency-wide data on Federal and Tribal facilities for program budget justification; (8) develops and evaluates technical standards and guidelines for health care facilities operations; and (9) monitors the improvement, alternation, and repair of health care facilities.

Division of Facilities Planning and Construction (DFPC) (GAMC)

(1) Develops, implements, and manages the IHS Health Care Facilities Planning and Construction program, including the facilities planning process, facilities design process, facilities acquisition, and construction project management; (2) develops, implements, monitors, and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for health care facilities planning and construction; (3) develops and maintains construction priority systems, and with the Division of Engineering Services, develops project budget documents for the health care facilities construction program; (4) services as the principal resource in providing leadership, guidance, and coordination of health care facilities engineering activities for the IHS Headquarters, Area Offices, Tribal and Urban Indian health programs; (5) evaluates justifications for major improvement and alteration projects and other large scale construction activities; (6) develops and evaluates technical standards and guidelines for health care facilities construction.

Division of Environmental Health Services (DEHS) (GAMD)

(1) Develops, implements, and manages the IHS Environmental Health Services programs, including the Injury Prevention and Institutional Environmental Health programs; (2) serves as the primary source of technical and policy advice for IHS Headquarters and Area Offices on the full scope of environmental health issues and activities; (3) maintains relationships with other Federal agencies and Tribes to maximize responses to environmental health issues and maximize benefits to Tribes by coordinating program efforts; (4) provides leadership in identifying and articulating environmental health needs of AI/AN populations and support efforts to build Tribal capacity; (5) provides personnel support services and advocates for environmental health providers; (6) maintains, analyzes, make accessible, and publishes results from national databases; (7) manages resource allocation activities in accordance with established criteria based on workload; (8) develops and evaluates standards and guidelines for environmental health programs and activities; and (9) performs functions related to environmental health programs such as injury prevention, emergency response, water quality, food sanitation, occupational health and safety, solid and hazardous waste management, environmental health issues in health care and non-health care institutions, and vector control.

Division of Engineering Services (Dallas/Seattle) (DES) (GAME)

(1) Administers all IHS new health care facilities engineering and construction projects and some repair and improvement construction projects for specified Area Offices and administers the engineering and construction of certain projects for other Federal agencies through inter-agency agreements, as negotiated; (2) carries out management activities relating to IHS-owned and utilized health care facilities, including construction, contracting, realty, and leasing services; (3) serves as the source of engineering and contracting expertise for assigned programs/projects and other technical programmatic areas affecting the planning, design, alteration, leasing, and construction of IHS health care and sanitation facilities for Indian homes and communities; (4) assists in the development of Area Office annual work plans, studies, investigations, surveys, audits, facilities planning, and technical standards development, for IHS-owned and Tribal health care facilities; and (5) designated as the IHS authority having jurisdiction for all code interpretations required to resolve conflicts that arise from interpreting and applying various codes and other related criteria in all IHS facilities and design/construction projects.

Section GA–30, Indian Health Service—Order of Succession

During my absence or disability of the IHS Director or in the event of a vacancy in that office, the following IHS Headquarters officials, in the order listed below, shall act as the IHS Director. In the event of a planned extended period of absence, the IHS Director may specify a different order of succession. The order of succession will be:

(1) Deputy Director

(2) Deputy Director for Indian Health Policy

(3) Deputy Director for Management Operations

(4) Chief Medical Officer

Section GA–40, Indian Health Service—Delegations of Authority

All delegations of authority and re-delegations of authority made to IHS officials that were in effect immediately prior to this reorganization, and that are consistent with this reorganization, shall continue in effect pending further re-delegation.

Chapter GF—IHS Area Offices

Section GF–00, Indian Health Service Area Offices—Mission

The IHS Area Offices carry out the mission of the IHS by providing a system of health care unique to the Area population.

Section GF–10, Indian Health Service Area Offices—Organization

An Area Office is a second echelon organization under the direction of an Area Director, who reports to the IHS Director.

The following are the Area Offices of the IHS:

Aberdeen Area Office (GFA); Alaska Area Office (GFB); Albuquerque Area Office (GFC); Bemidji Area Office (GFE); Billings Area Office (GFF); California Area Office (GFG); Nashville Area Office (GFH); Navajo Area Office (GFJ); Oklahoma City Area Office (GFK); Phoenix Area Office (GFL); Portland Area Office (GFM); and Tucson Area Office (GFN).

Section GF–20, Indian Health Service Area Offices—Functions

The specific functions of the IHS Area Offices vary, however, each Area Office includes functions organized to support major categories of administrative management and clinical activities. Examples include:

Administration and Management—Financial management, administrative and office services, contract/grant administration, procurement, personnel management, facilities management, management information systems, contract health services, and equal employment opportunity;

Program Planning, Analysis and Evaluation Programs—Program planning, statistical analysis, legislative initiatives, research and evaluation, health records, management information systems, and patient registration/third party collection;

Tribal Activity Programs—Provision of Pub. L. 93–638, Indian Self-Determination and Education Assistance Act, health services delivery, community health representative services, Urban Indian health, alcoholism and substance abuse, and health education;

Health Programs—Primary care, clinical activities, mental health, nursing services, health promotion, disease prevention, professional recruitment, community services, and the Joint Commission on Accreditation of Healthcare Organizations;

Environmental Health/Sanitation Facilities Programs—Environmental health and engineering/sanitation facilities construction programs; and

Information Resources Management Programs—Automated data processing (ADP), ADP planning and operations, management information systems, office automation systems, and voice/data telecommunications management.

Section GF–30, Indian Health Service Area Offices—Order of Succession

The order of succession for Area Directors at the IHS Area Offices is determined by each Area Director and continues in effect until changed.

Section GF–40, Indian Health Service Area Offices—Delegations of Authority

All delegations and re-delegations of authority made to officials in the IHS Area Offices that were in effect immediately prior to this reorganization, and that are consistent with this reorganization, shall continue in effect pending further re-delegation.

This reorganization shall be effective on October 17, 2005.

Dated: October 5, 2005.

Robert G. McSwain,

Deputy Director, Indian Health Service.

[FR Doc. 05–20584 Filed 10–14–05; 8:45 am]

BILLING CODE 4165–16–M

DEPARTMENT OF HOMELAND SECURITY

Customs and Border Protection

Quarterly IRS Interest Rates Used in Calculating Interest on Overdue Accounts and Refunds on Customs Duties

AGENCY: Customs and Border Protection, Department of Homeland Security.

ACTION: General notice.

SUMMARY: This notice advises the public of the quarterly Internal Revenue Service interest rates used to calculate interest on overdue accounts (underpayments) and refunds (overpayments) of customs duties. For the calendar quarter beginning October 1, 2005, the interest rates for overpayments will be 6 percent for corporations and 7 percent for non-corporations, and the interest rate for underpayments will be 7 percent. This notice is published for the convenience of the importing public and Customs and Border Protection personnel.

EFFECTIVE DATES: October 1, 2005.

FOR FURTHER INFORMATION CONTACT: Trong Quan, National Finance Center, Collections Section, 6026 Lakeside Boulevard, Indianapolis, Indiana 46278; telephone (317) 614–4516.

SUPPLEMENTARY INFORMATION:

Background

Pursuant to 19 U.S.C. 1505 and Treasury Decision 85–93, published in the **Federal Register** on May 29, 1985 (50 FR 21832), the interest rate paid on applicable overpayments or underpayments of customs duties must be in accordance with the Internal Revenue Code rate established under 26 U.S.C. 6621 and 6622. Section 6621 was amended (at paragraph (a)(1)(B) by the Internal Revenue Service Restructuring and Reform Act of 1998, Pub. L. 105–206, 112 Stat. 685) to provide different interest rates applicable to overpayments: one for corporations and one for non-corporations.

The interest rates are based on the Federal short-term rate and determined by the Internal Revenue Service (IRS) on behalf of the Secretary of the Treasury on a quarterly basis. The rates effective for a quarter are determined during the first-month period of the previous quarter.

In Revenue Ruling 2005–62, the IRS determined the rates of interest for the calendar quarter beginning October 1, 2005, and ending December 31, 2005. The interest rate paid to the Treasury for underpayments will be the Federal short-term rate (4%) plus three percentage points (3%) for a total of seven percent (7%). For corporate overpayments, the rate is the Federal short-term rate (4%) plus two percentage points (2%) for a total of six percent (6%). For overpayments made by non-corporations, the rate is the Federal short-term rate (4%) plus three percentage points (3%) for a total of seven percent (7%). These interest rates are subject to change for the calendar quarter beginning January 1, 2005, and ending March 31, 2005.

For the convenience of the importing public and Customs and Border Protection personnel the following list of IRS interest rates used, covering the period from before July of 1974 to date, to calculate interest on overdue accounts and refunds of customs duties, is published in summary format.

7C

Dated: April 28, 2005.

Phyllis Eddy,

Acting Deputy Director, Indian Health Service.

[FR Doc. 05–9013 Filed 5–5–05; 8:45 am]

BILLING CODE 4165–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Organization, Functions, and Delegations of Authority

Part G—Indian Health Service

Part G, of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (HHS), as amended at 52 FR 47053–47067, December 11, 1987, as amended at 60 FR 56606, November 9, 1995, and most recently amended at 61 FR 67048, December 19, 1996, is hereby amended to reflect a reorganization of the Indian Health Service (IHS) Headquarters (HQ). The goal of the reorganization is to demonstrate increased leadership and advocacy, while improving the Agency's responsibilities for oversight and accountability. We have considered the President's Management Agenda, the Secretary's Workforce Restructuring Plan and recommendations from the Indian Health Design Team and the IHS Restructuring Initiatives Workgroup. Delete the functional statements for the IHS Headquarters in their entirety and replace with the following:

Chapter GA

Office of the Director

Section GA–10, Indian Health Service—Organization

The IHS is an Operating Division within the Department of Health and Human Services (HHS) and is under the leadership and direction of a Director who is directly responsible to the Secretary of Health and Human Services. The IHS Headquarters consists of the following major components:

Office of the Director (GA)
Office of Tribal Self-Governance (GAA)
Office of Tribal Programs (GAB)
Office of Urban Indian Health Programs (GAC)
Policy Formulation and Communications Group (GAE)
Office of Clinical and Preventive Services (GAF)
Office of Information Technology (GAG)
Office of Public Health Support (GAH)
Office of Resource Access and Partnerships (GAJ)
Office of Finance and Accounting (GAK)
Office of Management Services (GAL)
Office of Environmental Health and Engineering (GAM)

Section GA–20, Indian Health Service—Functions

Office of the Director (OD) (GA)

Provides overall direction and leadership for the IHS: (1) Establishes goals and objectives for the IHS consistent with the mission of the IHS; (2) provides for the full participation of Indian Tribes in the programs and services provided by the Federal Government; (3) develops health care policy; (4) ensures the delivery of quality comprehensive health services; (5) advocates for the health needs and concerns of American Indians/Alaska Natives (AI/AN); (6) promotes the IHS programs at the local, State, national, and international levels; (7) develops and demonstrates alternative methods and techniques of health services management and delivery with maximum participation by Indian Tribes and Indian organizations; (8) supports the development of individual and Tribal capacities to participate in Indian health programs through means and modalities that they deem appropriate to their needs and circumstances; (9) ensures the responsibilities of the United States are not waived, modified, or diminished, in any way with respect to Indian Tribes and individual Indians, by any grant, contract, compact, or funding agreement awarded by the IHS under the Indian Self-Determination and Education Assistance Act, Public Law (Pub. L.) 93–638, as amended; (10) affords Indian people an opportunity to enter a career in the IHS by applying Indian preference; and (11) ensures full application of the principles of Equal Employment Opportunity laws and the Civil Rights Act in managing the human resources of the IHS.

Office of Tribal Self-Governance (OTSG) (GAA)

(1) Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS, under Title V of the Indian Self-Determination and Education Assistance Act, Pub. L. 93–638, as amended; (2) develops and recommends policies, administrative procedures, and guidelines for IHS Tribal self-governance activities, with maximum input from IHS staff and workgroups, Tribes and Tribal organizations, and the Tribal Self-Governance Advisory Committee; (3) advises the IHS Director on Agency compliance with self-governance policies, administrative procedures and guidelines and coordinates activities for resolution of problems with appropriate IHS and HHS staff; (4) provides resource and technical assistance to Tribes and Tribal organizations for the implementation of the Tribal Self-Governance Program (TSGP); (5) participates in the reviewing of proposals from Tribes for self-governance planning and negotiation grants and recommends approvals to the IHS Director; (6) determines eligibility for Tribes and Tribal organizations desiring to participate in the TSGP; (7) oversees the negotiation of self-governance compacts and annual funding agreements with participating Tribal governments; (8) identifies the amount of Area Office and Headquarters managed funds necessary to implement the annual funding agreements and prepares annual budgets for available Tribal shares in conjunction with IHS Area and Headquarters components; (9) coordinates semi-annual reconciliation of funding agreements with IHS Headquarters components, Area Offices, and participating Tribes; (10) serves as the principal IHS office for developing, releasing, and presenting information on behalf of the IHS Director related to the IHS Tribal self-governance activities to Tribes, Tribal organizations, HHS officials, IHS officials, and officials from other Federal agencies, State and local governmental agencies, and other agencies and organizations; (11) arranges national self-governance meetings to promote the participation by all AI/AN Tribes in IHS self-governance activities and program direction; (12) participates in meetings for Self-Governance Tribal delegations visiting IHS Headquarters; and (13) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Office of Tribal Programs (OTP) (GAB)

(1) Assures that Indian Tribes and Tribal organizations are informed regarding pertinent health policy and program management issues; (2) assures that consultation and participation by Indian Tribes and organizations occurs during the development of IHS policy and decision making; (3) provides overall Agency leadership concerning functions and responsibilities associated with self-determination contracting (Title I of the Indian Self-Determination Act); (4) advises the IHS Director and senior management on activities and issues related to self-determination

7C

contracting; (5) monitors Agency compliance with self-determination policies, administrative procedures, and guidelines; (6) administers a national grant program designed to assist Tribes and Tribal organizations in beginning and/or expanding self-determination activities; (7) provides Agency leadership in the development of policy; (8) discharges operational responsibilities, with respect to the contract support cost (CSC) program administered by the IHS; (9) provides advice to the IHS Director and senior management on Tribal issues and concerns by acting as liaison with Tribal leaders, national Tribal organizations, inter-Tribal consortiums and Area health boards; (10) provides leadership in the management process of receiving visiting delegations of Tribal leaders and representatives to IHS Headquarters and provides staff assistance to the Office of the Director with respect to Tribal meetings at locations outside of Headquarters; (11) provides overall Agency leadership with respect to policy development and issues concerning the Federal recognition of new Tribes; (12) supports Tribes in managing health programs; (13) coordinates available support from other public and private agencies and organizations; (14) maintains a central database on relevant information to contact Tribal leaders, health programs, etc.; and (15) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Office of Urban Indian Health Programs (OUIHP) (GAC)

(1) Advises the IHS Director on the activities and issues related to the IHS" implementation of Title V, "Indian Health Care Improvement Act", as amended; (2) develops and recommends policies, administrative procedures, and guidelines for IHS services and activities for Urban Indian health programs and organizations; (3) assures that Urban Indian health programs and organizations are informed of pertinent health policies; (4) ensures that consultation with Urban Indian health programs and organizations occurs during the development of IHS policy; (5) supports Urban Indian health programs and organizations in managing health programs; (6) coordinates support available from other public and private agencies and organizations; (7) advises the IHS Director on Agency compliance with Urban Indian health program policies, administrative procedures, and guidelines; (8) maintains relevant information on Urban Indian health programs and organizations; (9) coordinates meetings and other communications with Urban Indian health program representatives; and (10) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Policy Formulation and Communications Group (PFCG) (GAE)

(1) Coordinates the review and analysis of policy-related issues; (2) provides recommendations for resolving policy conflicts; (3) evaluates policy options and forecasts their costs, benefits, and long-term results; (4) ensures consistency between and within public agency statements, external correspondence, legislative and regulatory positions and internal policy development; (5) disseminates information to IHS consumers, stakeholders, and the general public regarding the activities of the IHS and the health status of AI/AN people and communities; and (6) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Public Affairs Staff (PAS) (GAE1)

(1) Serves as the principal advisor for strategic planning on communications, media relations, and public affairs policy formulation and implementation; (2) ensures IHS policy is consistent with directives from the Assistant Secretary for Public Affairs; (3) provides leadership and advocacy to establish and implement policy for internal and external dissemination of Agency information intended for public release or employee and stakeholder information; (4) serves as the central office for technical guidance and assistance to IHS staff for the development of internal and external communications; (5) coordinates public affairs activities with other public and private sector organizations; (6) coordinates the clearance of IHS public relations activities, campaigns, and communications materials; (7) represents the IHS in discussions regarding policy and public affairs initiatives/implementation; (8) provides technical assistance and advice relative to the effect public affairs initiatives/implementation would have on the IHS; (9) collaborates with the Division of Regulatory Affairs, Records Access and Policy Liaison for review and response to media requests received under the Freedom of Information Act (FOIA) or the Privacy Act, and ensures the security of IHS documents used in such responses that contain sensitive and/or confidential information; and (10) serves as the IHS liaison office for press and public affairs with HHS, IHS Area Offices, media and other external organizations and representatives.

Equal Employment Opportunity and Civil Rights Staff (EEO) (GAE2)

(1) Administers the IHS equal employment opportunity, civil rights, and affirmative action programs, in accordance with applicable laws, regulations, and HHS policies; (2) plans and oversees the implementation of IHS affirmative employment and special emphasis programs; (3) reviews data on IHS employee personnel actions and advises IHS managers of possible discriminatory trends; (4) ensures immediate implementation of required actions on complaints of alleged sexual harassment or discrimination; (5) decides on accepting, for investigation, or dismissing discrimination complaints and evaluates accepted complaints for procedural sufficiency and investigates, adjudicates, and resolves such complaints; and (6) develops EEO education and training programs for IHS managers, supervisors, counselors, and employees.

Executive Secretariat Staff (ESS) (GAE3)

(1) Serves as the Agency's liaison with the Office of the Secretary's Executive Secretariat on IHS program, policy, and special matters; (2) reviews correspondence received by the IHS Director and assigns reply or follow-up action to appropriate IHS Headquarters program offices and IHS Area Offices; (3) ensures the quality (responsiveness, clarity, and substance) of IHS-generated correspondence prepared for the IHS Director's signature by coordinating the review of integrity and policy issues, and performing standard edits and revisions; (4) reviews and coordinates clearance of decision documents for the IHS Director's approval to ensure successful operations and policy-making within the Agency; (5) assists IHS officials as they prepare documents for the HHS Secretary's review, decision, and/or signature; (6) performs special writing assignments for the IHS Director; (7) manages the flow of executive correspondence and related information to Tribes, Tribal organizations, heads of Federal

7C

departments and agencies, Congressional Staff offices, and members of Congress; (8) maintains official records for the IHS Director's correspondence and conducts topic research of files, as needed; (9) maintains an automated document tracking and reporting system (ATS) to assist in managing the timely processing of internal and external executive correspondence; (10) conducts training to promote conformance by IHS Headquarters and Area staff to the IHS Executive Correspondence Guidelines and the ATS system; and (11) tracks reports required by Congress.

Congressional and Legislative Affairs Staff (CLAS) (GAE4)

(1) Serves as the principal advisor to the IHS Director on all legislative and Congressional relations matters; (2) advises the IHS Director and other IHS officials on the need for changes in legislation and manages the development of IHS legislative initiatives; (3) serves as the IHS liaison office for Congressional and legislative affairs with Congressional offices, the HHS, the Office of Management and Budget (OMB), the White House, and other Federal agencies; (4) tracks all major legislative proposals in the Congress that would impact Indian health; (5) ensures that the IHS Director and appropriate IHS and HHS officials are briefed on the potential impact of proposed legislation; (6) represents the IHS in discussions regarding policy and legislative initiatives/implementation; (7) provides technical assistance and advice relative to the effect that initiatives/implementation would have on the IHS; (8) establishes collaborations with Headquarters Offices on programmatic and financial issues related to budget formulation; (9) conducts legislative analysis; (10) provides support and serves as liaison to the IHS Director relative to IHS appropriations efforts; (11) directs the development of IHS briefing materials for Congressional hearings, testimony, and bill reports; (12) analyzes legislation for necessary action within the IHS; (13) develops appropriate Legislative Implementation Plans; and (14) coordinates with IHS offices as appropriate to provide leadership, advocacy, and technical support to respond to requests from the public, including Tribal governments, Tribal organizations, and Indian community organizations regarding IHS legislative issues.

Management Policy and Internal Control Staff (MPICS) (GAE5)

(1) Formulates, administers, and supports IHS-wide policies, delegations of authority, and organizations and functions development; (2) provides leadership, on behalf of the IHS Director, to functional area managers at IHS Headquarters in developing, modifying, and overseeing the implementation of IHS policies and procedures; (3) provides analysis, advisory, and assistance services to IHS managers and staff for the development, clearance, and filing of IHS directives and delegations of authority; (4) serves as principal advisor and source for technical assistance for establishment or modification of organizational infrastructures, functions, and Standard Administrative Code configurations; (5) administers the IHS Management Control Program for assuring IHS' compliance with management control requirements in the Federal Managers' Financial Integrity Act; (6) coordinates the development, clearance, and transmittal of IHS responses and follow-up to reports issued by the Office of Inspector General (OIG), the General Accounting Office (GAO), and other Federal internal and external authorities; (7) provides assistance and support to special assigned task groups; (8) conducts special program or management integrity reviews as required; and (9) oversees and coordinates the annual development and submission of the Agency's Federal Activities Inventory Reform Act report to the HHS.

Policy Support Staff (PSS) (GAE6)

(1) Organizes, facilitates, and supports stakeholder task teams to advise the IHS Director on major policy issues; (2) represents the IHS Director in meetings with IHS employees and high-level management officials within the IHS, the HHS, or other Federal agencies, Tribes, and other organizations; (3) provides staff support to the IHS Director, including preparation of presentations and briefings; (4) provides staff support to senior managers, councils and groups; (5) completes special assignments for the IHS Director that may require coordination with other IHS offices or other Federal agencies, Tribes, or Tribal organizations; (6) serves as the IHS liaison for inter-governmental and private sector initiatives that impact health care services and management of the IHS; and (7) participates on inter-governmental task forces.

Office of Clinical and Preventive Services (OCPS) (GAF)

(1) Serves as the primary source of national advocacy, policy development, budget development and allocation for clinical, preventive, and public health programs for the IHS, Area Offices, and Service Units; (2) provides leadership in articulating the clinical, preventive, and public health needs of AI/AN, including consultation and technical support to clinical and public health programs; (3) develops, manages, and administers program functions that include, but are not limited to, alcohol and substance abuse, behavioral health, chronic diseases such as diabetes, asthma, dental services, medical services, domestic violence, pharmacy and pharmaceutical acquisition, community health representatives, emergency medical services, health records, disabilities, Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), maternal health, child health, clinical nursing, professional credentialing, public health nursing, women's health, nutrition and dietetics, and elder care; (4) investigates service delivery and community prevention evidence-based and best practice models for dissemination to community service locations; (5) expands the availability of resources available for AI/AN health by working with public and private entities as well as Federal agencies within and outside the HHS; (6) coordinates development of staffing requirements for new or replacement health care facilities and approves Congressional budget requests for staffing, in collaboration with the Office of Environmental Health and Engineering; (7) provides program oversight and direction for the facilities planning and construction process; (8) develops and coordinates various Health Initiative and Nursing grant programs; (9) provides the national focus for recruitment and retention of health professionals and coordinates with the scholarship and loan repayment programs; (10) works with the Contract Health Services (CHS) program on CHS denial appeals to the IHS Director and in determining CHS medical priorities; (11) manages the clinical (medical, nursing, pharmacy, dental) features of medical tort claims against the IHS; (12) works with the Office of Management Services in managing the clinical aspects of the IHS workman's compensation claims; (13) oversees IHS efforts in a variety of quality assurance and improvement activities, including patient safety; (14) monitors approximately one-half of the IHS' Government Performance and

7C

Results Act (GPRA) indicators, overseeing indicator development, data collection, and reporting results; and (15) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, border health initiatives, Tribal delegation meetings, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Emergency Preparedness and Emergency Medical Services Staff (EPEMSS)

(1) Provides overall direction and leadership for the IHS in regard to establishing IHS goals and objectives consistent with those of the Department of Homeland Security and the HHS, addressing the mission critical elements of emergency preparedness; (2) provides leadership for the development of emergency preparedness plans, policies, and services, including the continuity of operations plans, deployment, public health infrastructure, and emergency medical services; (3) coordinates IHS activities and resources with the activities and available resources of other government and non-government programs for essential services related to homeland security and emergency preparedness; (4) advocates for the emergency preparedness needs and concerns of AI/AN and promotes these program activities at the local, State, national, and international levels; and (5) advocates and coordinates support for Tribal emergency medical services programs, including training and equipment.

Division of Behavioral Health (DBH) (GAFA)

(1) Applies identified profession and program standards, monitors and evaluates community and Area-wide services provided through grants or contracts with AI/AN Tribes, villages, organizations, and direct IHS operations for mental health, social services, and alcohol/substance abuse; (2) coordinates AI/AN community behavioral health programs including alcohol/substance abuse prevention and treatment, mental health, and social work with program directors, division staff, Area staff, and other agencies and institutions; (3) coordinates contracts and grants for behavioral health services and monitors services provided; (4) makes program and policy changes using data analysis, recommendations from operational levels, research results, and coordinates resource allocation from program policies; (5) provides behavioral health program consultation to AI/AN groups and IHS staff; (6) provides leadership in the identification of behavioral change interventions and supports implementation at the community level; (7) coordinates with Federal, State, professional, private, and community organizations on alternate health care resources; (8) works with other Federal agencies and departments to provide additional Federal resources for AI/AN behavioral health programs; (9) provides financial resources and programmatic oversight for complying with the Americans With Disabilities Act through programs such as the Indian Children's Program, and for elders through partnerships with the Administration on Aging and the National Indian Council on Aging; (10) measures and evaluates the quality of behavioral health care services; and (11) prepares information on behavioral health for budgetary hearings and provides program evaluation results to the IHS Director, the Congress, and the Administration.

Division of Clinical and Community Services (DCCS) (GAFB)

(1) Manages, develops, and coordinates a comprehensive clinical, preventive and public health approach to clinical and community programs focusing on maternal and child health, Indian children services including Head Start and Early Head Start Health Programs, medicine, nutrition, HIV/AIDS, pharmacy, laboratory, health records, health education, health promotion, and disease prevention; (2) develops objectives, priorities, and methodologies for the conduct and evaluation of clinical, preventive, and public health for community health-based programs; (3) provides, develops, and implements IHS guidelines, standards, policies, and procedures on clinical, preventive, and public health for community based programs and initiatives; (4) monitors, evaluates, and provides consultation to clinical and community programs; (5) plans jointly with other programs and divisions of the IHS and other agencies on research and coordination of services; (6) coordinates professional staff recruitment and training needs, and scholarship recipient assignments and development to meet Area Office, Service Unit, and Tribal health professional human resource needs; (7) coordinates and monitors contracts and grants with IHS programs and other entities, in collaboration with the Division of Acquisitions Policy and the Division of Grants Operations; (8) develops and disseminates information and materials to IHS facilities and to Tribes and Urban Indian health programs; (9) is responsible for resource management, program data collection, administrative system integrity and accountability by developing program budget materials and responding to Congressional and Departmental inquiries; and (10) manages the Veterans Affairs Pharmaceutical Prime Vendor Contract and IHS National Core Formulary.

Division of Nursing Services (DNS) (GAFC)

(1) Plans, develops, coordinates, evaluates, manages and advocates for the Nursing Services, Women's Health, and Community Health Representative Programs; (2) identifies and establishes standards for these programs; (3) provides leadership, professional guidance, and staff development; (4) plans, develops, coordinates, manages, and evaluates nursing education; (5) coordinates professional staff, including nursing recruitment, scholarship recipients, assignment and development to meet Area Office, Service Unit, and Tribal needs in accordance with IHS policies and procedures; (6) provides guidance in planning, developing, and maintaining management information systems; and (7) prepares budgetary data, analysis and program evaluations and prepares information for program and budget presentations, as well as Congressional hearings.

Division of Oral Health (DOH) (GAFD)

(1) Plans, develops, coordinates, and evaluates dental health programs; (2) establishes staffing, procedural, facility, and dental contract standards; (3) coordinates professional recruitment, assignment, and staff development; (4) represents dental staff and Area Dental Programs in personnel matters, including the monitoring of personnel orders for both appointments and transfers, establishing promotion priority lists, processing special pay and retention bonus contracts, and serving as the HQ representative on adverse action cases; (5) improves effectiveness and efficiency of dental programs; (6) develops resource opportunities and monitors utilization of resources for dental health programs; (7) formulates, allocates and analyzes dental program budget and prepares information for program and budget presentations as well as Congressional inquiries; (8) advocates for oral health needs of the AI/AN population; (9) coordinates health promotion and disease prevention activities for the dental program; (10) monitors oral health status and treatment needs of the AI/AN population; (11) provides clinical and technical support to field staff by way

of oral health surveys, provision of clinical trials, consultation on treatment cases, publication of quarterly newsletters and serving as liaison with public and private institutions, as well as major universities to evaluate new and existing strategies for addressing oral health problems in AI/AN; (12) serves as the IHS liaison for oral health issues with other Federal agencies; (13) serves as main source of information transfer to field staff via mediums including, but not limited to, teleconference hookups, electronics (email/listservs), conventional mail and meeting attendance; and (14) maintains and distributes information from the IHS centralized dental database, including workload, program resource directories and exploring the applicability of new health informatics technologies and systems.

Division of Diabetes Treatment and Prevention (DDTP) (GAFE)

(1) Plans, manages, develops, coordinates, and evaluates a comprehensive clinical and community program focusing on type 2 diabetes in AI/AN communities; (2) plans, manages, develops, coordinates, and evaluates the Congressionally-mandated Special Diabetes Program for Indians, a large grant program focused on the prevention and treatment of diabetes; (3) coordinates and monitors contracts and grants with IHS, Tribal, Urban Indian health programs and other entities; (4) develops objectives, priorities and methodologies for the conduct of clinical and community diabetes programs; (5) monitors, evaluates, and provides consultation to clinical and community diabetes grant programs and other new initiatives; (6) provides leadership, professional guidance, and staff development to Area Diabetes Consultants, Model Diabetes Programs and Diabetes Field Coordinators; (7) coordinates diabetes training needs for Area Offices, Service Units, and Tribes; (8) develops and implements IHS standards of care, clinical guidelines, policies, and procedures for diabetes and diabetes-related conditions; (9) coordinates model diabetes program sites; (10) develops and disseminates diabetes-related information and materials to IHS, Tribes and Urban Indian health programs; and (11) is responsible for preparing budgetary data, analysis and program evaluations for budget presentations and Congressional hearings.

Office of Information Technology (OIT) (GAG)

(1) Provides Chief Information Officer (CIO) services and advises the IHS Director on all aspects of information resource management and technology ensuring Agency compliance with related Federal laws, regulations and policies; (2) directs the development, implementation, and maintenance of policies, procedures, standards, and architecture for information resource management, technology activities, and services in the IHS; (3) directs strategic planning and budgeting processes for information resources and technology; (4) leads IHS efforts in the development and implementation of information resource and technology management initiatives in IHS; (5) directs the design, development, acquisition, implementation, and support of information systems and services used in the IHS; (6) directs the activities of the IHS Information Technology Investment Review Board in assessing, implementing, and reviewing the Agency's information systems; (7) contracts for information resource and technology-related software, equipment and support services in collaboration with appropriate acquisition authorities; (8) provides project management support for information resource and technology initiatives; (9) directs the development, implementation and management of the IHS Information Technology Security program to protect the information resources of the IHS; (10) provides information technology services and support to IHS, Tribal, and Urban Indian health programs; (11) ensures accessibility to information technology services; (12) represents the IHS and enters into information technology agreements with Federal, Tribal, State and other organizations; and (13) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations, and resolution of audit findings as may be needed and appropriate.

Division of Information Technology (DIT) (GAGA)

(1) Provides Chief Technology Officer services and advises the CIO on all aspects of information technology; (2) develops, implements, and maintains policies, procedures and standards for information resource management and technology products and services in the IHS; (3) develops and maintains information technology strategic planning documents; (4) develops and maintains the IHS enterprise architecture; (5) develops and implements information technology management initiatives in IHS; (6) ensures IHS information technology infrastructure resource consolidation and standardization efforts support IHS healthcare delivery and program administration; (7) represents the IHS to Federal, Tribal, State, and other organizations; and (8) participates in cross-cutting issues and processes that involve information technology.

Division of Information Resources Management (DIRM) (GAGB)

(1) Advises the CIO on all aspects of information resources management; (2) develops information resource policies and procedures; (3) develops the IHS information technology budget and related documents; (4) provides budget analyses and reports to the CIO; (5) develops strategies for presenting the IHS information technology budget to IHS, Tribal, and Urban Indian health programs; (6) provides technical analyses, guidance, and support for IHS capital planning and investment control activities; (7) manages the IHS portfolio management tool; (8) manages the activities of the IHS Information Technology Investment Review Board in assessing, implementing and reviewing the Agency's information systems; (9) represents the IHS to Federal, Tribal, State, and other organizations; and (10) participates in the cross-cutting issues and processes that involve information resources management.

Division of Enterprise Project Management (DEPM) (GAGC)

(1) Advises the CIO on all aspects of information technology project management; (2) develops project management policies and procedures; (3) identifies alternatives among internal and external sources and recommends the best sources to supply information resource and technology products and services to IHS; (4) develops information resource and technology project governance structures, management plans, evaluations, protocols, documentation guides, and related materials to support effective project management; (5) provides project management and related support for IHS developed and acquired information resource and technology products and services; (6) provides customer relationship management support to project stakeholders; (7) provides quality assurance and risk management support; (8) provides contract management support for information technology initiatives; (9) provides contract liaison services to appropriate acquisition authorities; (10) represents the IHS to Federal, Tribal, State, and other organizations; and (11) participates in cross-cutting issues and processes that involve information

resources and technology project management.

Division of Information Security (DIS) (GAGD)

(1) Advises the CIO on all aspects of information security; (2) develops, implements and monitors the IHS Information Technology Security program to protect the information resources of the IHS; (3) develops and maintains cyber security policies and guidance for hardware, software, and telecommunications within the IHS; (4) reviews IHS security plans for sensitive systems; (5) evaluates safeguards to protect major information systems and the information technology infrastructure; (6) monitors all IHS systems development and operations for security and privacy compliance; (7) establishes and leads IHS teams to conduct reviews of Agency programs to protect IHS' cyber and personnel security programs; (8) conducts vulnerability assessments of IHS' information technology infrastructure; (9) coordinates activities with internal and external organizations reviewing the IHS' information resources for fraud, waste, and abuse; (10) develops, implements, and evaluates an employee cyber security awareness and training program; (11) establishes and leads the IHS Computer Security Incident Response Capability team; (12) represents the IHS to Federal, Tribal, State, and other organizations; and (13) participates in cross-cutting issues and processes that involve information security.

Office of Public Health Support (OPHS) (GAH)

(1) Advises and supports the IHS Director on policy, budget formulation, and resource allocation regarding the operation and management of IHS, Tribal, and Urban Indian health programs; (2) provides IHS-wide leadership, guidance and support for public health program and activities including strategic planning, evaluation, Government Performance and Results Act (GPRA), research, epidemiology, statistics, and health professions; (3) provides Agency-wide leadership and consultation to IHS, Tribal, and Urban Indian health programs on IHS goals, objectives, policies, standards, and priorities; (4) advocates for the public health needs and concerns of AI/AN and promotes quality health care; (5) manages and provides national leadership and consultation for IHS on assessments of public health medical services, research agendas, special pay, and public health initiatives for the Agency; (6) provides national leadership for the IHS scholarship and loan repayment programs, including physician recruitment; (7) supports and advocates for AI/AN to access State and local public health programs; and (8) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Division of Epidemiology (GAHA)

(1) Prevents and controls chronic and communicable disease through epidemiology and applied public health practice; (2) builds capacity in Tribal communities through a network of Tribal Epidemiology Centers; (3) collaborates with the Centers for Disease Control and Prevention (CDC) staff detailed to the Division of Epidemiology from the CDC; (4) describes causes, patterns, and risk factors for disease and death, and develops public health policy; (5) serves IHS and Tribal communities through disease surveillance, health data management, analysis and reporting, community surveys, emergency response, training in public health practice and epidemiology, consultation to clinicians and technical support for public health activities and assessment of public health system performance; (6) supports epidemiology, disease control, and prevention programs for chronic diseases, including cancer, tobacco control, cardiovascular disease, diabetes, kidney disease, environmental health, maternal health, child health, and others; and (7) supports epidemiology, disease control, and prevention programs for communicable diseases, including tuberculosis, HIV/AIDS, sexually-transmitted diseases, hepatitis, hantavirus, antibiotic-resistant infections, immunizations, bioterrorism preparedness and others.

Chronic Disease Branch (CDB)

Supports epidemiology, disease control, and prevention programs for chronic diseases, including cancer, tobacco control, cardiovascular disease, diabetes, kidney disease, environmental health, maternal health, child health, and others.

Infectious Disease Branch (IDB)

Supports epidemiology, disease control, and prevention programs for communicable diseases, including tuberculosis, HIV/AIDS, sexually-transmitted diseases, hepatitis, hantavirus, antibiotic-resistant infections, immunizations, bioterrorism preparedness, and others.

Division of Program Statistics (DPS) (GAHB)

(1) Plans, develops, directs, and coordinates an analytical statistical reporting program to provide data for measuring the health status and unmet health needs of the AI/AN population; (2) develops and coordinates the collection, processing, and analysis of demographic, patient care, and clinical data for the Agency; (3) maintains, analyzes, makes accessible, and publishes results from national demographic and clinical analyses; and (4) provides statistical and analytical consultation to other divisions and agencies.

Demographics Staff (DS)

(1) Plans, develops and executes a major nation-wide statistical program for the collection, processing, analysis and dissemination of demographic characteristics of the AI/AN population located throughout the United States; (2) coordinates with the National Center for Health Statistics the analysis and reporting of vital event information for the AI/AN population; and (3) provides statistical and analytical consultation to other divisions and agencies.

Patient Care Statistics Staff (PCSS)

(1) Plans, develops and executes a major nation-wide statistical program for the collection, processing, analysis and dissemination of demographic data and special studies with emphasis on health and demographic characteristics of the AI/AN population located throughout the United States; (2) evaluates facility workload trends and participates in the development of methodologies for constructing long-range estimates of inpatient and ambulatory care workloads for use in facility construction and planning; and (3) coordinates with the IHS National Data Repositories, the analysis and reporting of program, patient care and clinical data for the Agency.

Division of Planning, Evaluation and Research (DPER) (GAHC)

(1) Develops and coordinates Agency strategic planning and performance measurement efforts (including GPRA and Program Assessment Rating Tool) with budgeting requirements in consultation with IHS program staff; (2) provides consultation and coordination on the IHS budget formulation activity for planning and data purposes; (3) conducts, facilitates, solicits, coordinates, and evaluates community-oriented practice-based research related to health problems and the delivery of care to AI/AN people and communities with a major focus on improving the

7C

health status and systems of care; and (4) provides guidance and support for IHS-wide program evaluation projects.

Division of Health Professions Support (DHPS) (GAHD)

(1) Develops and implements IHS programs to recruit, select, assign, and retain health care professionals and coordinates these activities with the respective disciplines; (2) assesses professional staffing needs and coordinates the development of strategies and systems to satisfy these needs; (3) coordinates the planning and development of IHS strategies and systems to improve the morale and retention of all professionals; (4) coordinates Headquarters activities for physician residency and training programs; (5) coordinates the IHS National Health Service Corps (NHSC) program, including liaison and assignment of NHSC scholarship recipients to IHS; (6) develops priority sites for the loan repayment program; (7) coordinates placement of professionals with loan repayment obligations; (8) serves as IHS coordinator for pre-medical and medical school IHS scholarship recipients; (9) retrieves, establishes, and manages information and data on the IHS work force; and (10) conducts work force data analyses, including trends and projections, identifying work force needs by major personnel systems, categories, and disciplines.

Health Professions Support Branch (HPSB)

(1) Develops the IHS program to recruit, select, assign, and retain health care professionals, in accordance with policies and guidance provided by the Division of Human Resources; (2) assesses IHS professional staffing needs; (3) provides research and analysis functions for Chief Medical Officers, Clinical Directors, and senior clinicians; (4) manages and supports health professions education programs and activities; and (5) develops and administers Indian Health Professions programs authorized by the Indian Health Care Improvement Act (IHCIA), as amended.

Loan Repayment Branch (LRB)

(1) Awards, monitors, places (in IHS, Tribal, and Urban sites), and processes waivers and defaults of participants in the Loan Repayment Program (LRP) as mandated by Section 108 of the IHCIA; (2) coordinates the LRP payment and debt management function with the Program Support Center; and (3) coordinates program administration with the IHS Area Office and Service Unit personnel, particularly placement activities, including Clinical Directors, Chief Medical Officers, and professional recruiters.

Scholarships Branch (SB)

Develops, administers, and evaluates programs in the IHS Scholarship Program authorized under the IHCIA: Section 102 (Health Professions Recruitment Program for Indians), Section 103 (Health Professions Preparatory Scholarship Program for Indians), Section 104 (Indian Health Professions Scholarship Program), Section 105 (IHS Externs Program), Section 120 (Matching Grants to Tribes for Scholarship Programs), Section 217 (Indians Into Psychology Program), and other funded programs authorized under the IHCIA.

Office of Resource Access and Partnerships (ORAP) (GAJ)

(1) Provides Agency-wide leadership and consultation to the IHS direct operations and Tribal programs on IHS goals, objectives, policies, standards and priorities regarding the operations and management of the Business Office Services (BOS) and the Contract Health Services (CHS) programs; (2) develops and implements objectives, priorities, standards, measures and methodologies for the BOS and CHS programs; (3) manages and provides leadership, advocacy, consultation and technical support to Headquarters, IHS Areas and local levels on the full scope of BOS and CHS activities; (4) represents the IHS at meetings and in discussions regarding policy, legislation and other national issues; (5) provides oversight and monitors the BOS and CHS programs regarding compliance requirements, utilization reviews, revenue measures and reports; (6) formulates and analyzes BOS and CHS budgets and prepares information for program budget presentations; (7) collaborates and coordinates with IHS information technology staff and external organizations on new technologies, applications and business practices; (8) develops resource opportunities and coordinates the BOS and CHS activities with other governmental and non-governmental programs, promoting optimum utilization of all available health resources; (9) maintains a database of all inter-agency agreements, intra-agency agreements, memoranda of agreement and memoranda of understanding with external organizations; and (10) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, and resolution of audit findings as may be needed and appropriate.

Division of Business Office Enhancement (DBOE) (GAJA)

(1) Serves as the primary focal point for BOS program operations and policy issues and represents BOS in national forums; (2) provides consultation to Headquarters and Area Offices and is liaison to Tribal organizations, HHS and Office of Management and Budget (OMB) regarding BOS issues; (3) reviews and improves the efficiency of access to resources and provides support for local capacity building through technical assistance, training, consultation and information systems support; (4) develops, disseminates, and maintains BOS policy and procedures manuals; (5) provides national leadership for Medicare, Medicaid, and private insurance reimbursement policy and procedures; (6) serves as the primary liaison with the Center for Medicaid/Medicare Services for rate setting; (7) serves as the focal point regarding Medicare and Medicaid managed care activities, including the review, evaluation, and monitoring of Sections 1115 and 1915(b) Medicaid waiver proposals and other State and Federal health care reform activities; (8) provides programmatic management, review and analysis of information systems for patient registration and billing and collections systems; (9) assures training on operations, various regulatory issues and negotiated managed care provider agreements; and (10) develops third-party budget materials and responds to Tribal, Congressional and HHS inquiries relating to third-party issues.

Division of Contract Care (DCC) (GAJB)

(1) Plans, develops, and coordinates the CHS program and required business practices; (2) develops, disseminates, and maintains CHS policy and procedures manuals; (3) formulates and monitors the CHS budget and distribution methodologies; (4) administers the Catastrophic Health Emergency Fund; (5) administers the CHS Quality Assurance Fund; (6) administers the CHS claims adjudication activity for the IHS Headquarters; (7) monitors the implementation of the IHS payment policy and reports the status to the Director, ORAP; (8) administers the IHS Fiscal Intermediary contract; (9) conducts data analysis and national utilization review and utilization management of CHS services rendered by private sector providers; and (10) provides consultation to Headquarters and Area Offices, and responds to

7C

inquiries from the Congress, Tribes, and other Federal agencies.

Office of Finance and Accounting (OFA) (GAK)

(1) Develops and prepares the budget submission for the Indian Health Service and Facilities appropriation to the HHS, OMB and the Presidents budget; (2) participates with HHS officials in budget briefings for the OMB and the Congress; (3) distributes, coordinates, and monitors resource allocations; (4) develops and implements budget, fiscal, and accounting procedures and conducts reviews and analyses to ensure compliance in budget activities in collaboration with Headquarters officials and the Tribes; (5) provides cost advisory and audit resolution services in accordance with applicable statutes and regulations; and (6) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Division of Audit (DA) (GAKA)

(1) Develops and recommends policies and procedures for Chief Financial Officer (CFO) audits; (2) develops and recommends policies and procedures for Tribes and Tribal organizations audit resolution within IHS; (3) provides advice, technical consultation, and training to IHS Headquarters, Area Offices, Tribal, and Urban Indian Health organizations for Title I, Title V, and Agency CFO audits; (4) provides audit resolution services in accordance with applicable statutes and regulations; (5) advises the Director, OFA, of proposed legislation, regulations, directives, and timelines that will affect audits within IHS, as well as how current legislation affects handling of audit-related issues; (6) manages the IHS Audit Information Management System (AIMS) and conducts analysis of data for reports and/or responses to internal and external inquiries; (7) serves as the IHS contact point to the HHS for the AIMS Report and the Accountability Report; (8) coordinates the collection of disallowed costs cited in Tribes and Tribal organizations audits; (9) coordinates the correction of non-monetary findings coded by the HHS in Tribes and Tribal organizations audits; (10) coordinates receipt of audits from all organizations funded by IHS; (11) formulates Corrective Action Plans for CFO audit deficiencies; (12) coordinates resolutions of deficiencies with IHS Headquarters senior managers and Area Directors; and (13) reports status of corrective actions to the IHS Headquarters senior managers and to the HHS.

Division of Budget Formulation (DBF) (GAKB)

(1) Interprets policies, guidelines, manual issuances, OMB circulars, and instructions from Congress, OMB, HHS, and IHS on formulation of preliminary, Departmental, and Congressional budget requests for the IHS and Indian Health Facilities appropriation requests; (2) directs the collection, review, and analysis of program and financial data from Headquarters, Area Offices, Tribes, Tribal and Urban Indian Health organizations used in determining resource requirements; (3) coordinates the preparation of the IHS preliminary, Departmental and Congressional budget justifications for the Indian Health Service and Facilities appropriations; (4) prepares witness information for hearings before the House and Senate Appropriations Committees, House Resource Committee on Interior and Insular Affairs, the Senate Committee on Indian Affairs, and other Congressional committees as requested; (5) coordinates development of responses and inserts to be used for the record by and for Congressional appropriations hearings; (6) coordinates development of briefing materials in response to Congressional concerns and hearings; and (7) develops, implements, and maintains IHS policies and procedures for Congressional budget liaison activities.

Division of Budget Execution (DBE) (GAKC)

(1) Interprets policies, guidelines, and directives from Congress, OMB, Government Accounting Office (GAO), Treasury, and the HHS on Tribal shares and execution; (2) recommends and coordinates IHS Area Budget Execution; (3) prepares apportionment requests for the Indian Health Service and Indian Health Facilities appropriations; (4) consults with the Headquarters officials on Area funding allocations; (5) maintains fund control; (6) establishes and maintains IHS Headquarters memorandum-accounts-of-obligations; (7) prepares reprogramming requests; (8) coordinates and maintains relevant information on IHS Headquarters and Area Tribal shares; (9) consults with Headquarters and Area components on Tribal share allocations; (10) advises the Director, OFA on Agency compliance with self-determination policies, administrative procedures and guidelines; (11) coordinates activities for resolution of problems with appropriate IHS Headquarters and Area staff; (12) participates in the review and reconciliation of Tribal funding agreements and certifies IHS Headquarters funding of proposals from Tribal governments in conjunction with the Office of Tribal Self-Governance and the Office of Tribal Programs; (13) manages the financial review of Tribal agreements to identify sources of funds necessary to implement the Tribal funding agreements; and (14) participates in meetings with Tribal delegations as requested.

Division of Systems Review and Procedures (DSRP) (GAKD)

(1) Reviews, interprets and comments on policies, guidelines, and manual issuances of Congress, Treasury, GAO, the HHS and IHS on systems of fiscal management, including the Unified Financial Management System (UFMS), Common Accounting Numbers/Budget and Accounting Classification Structure Crosswalk and the CORE Accounting System (CORE); (2) plans, directs, and implements fiscal policies and procedures on Headquarters and field accounting; (3) coordinates the cost accounting system for IHS; (4) reviews and analyzes accounting and financial management systems and related system interfaces; (5) supports the conversion of financial information from CORE to UFMS; (6) provides and assists Area accounting staff with accounting system transactions, correcting errors and system related emergencies; (7) serves as the Agency liaison between Agency components concerning the interface of administrative and other feeder applications with Oracle/UFMS; (8) serves as the liaison between IHS, the Program Support Center (PSC) and the HHS for reporting of prompt payment, debt management, and cash reconciliation processes; (9) coordinates, regulates, and manages the issuance of financial codes for IHS; and (10) coordinates year-end "roll-over" activities with PSC and IHS Headquarters and Area staffs.

Division of Financial Operations (DFO) (GAKE)

(1) Manages the IHS travel program, provides training, interprets travel regulations, conducts reviews and updates travel policy and procedures; (2) processes Headquarters travel orders and vouchers, including permanent change of station and international travel; (3) coordinates Area Directors' travel orders and vouchers; (4) coordinates the conference management functions for the Agency; (5) processes all Memoranda of Understanding (or Agreement) to verify accounting data

and ensure proper payment/collection; (6) prepares reports and analyzes third-party collection data for management; (7) analyzes various operating costs and provides PSC with Area breakouts; (8) monitors PSC disbursements to assure proper accounting; (9) participates in the development of Medicare cost reports with Headquarters, Area Offices, Service Units and contractors; (10) provides contractor with data from various data systems; (11) provides support and technical assistance to Headquarters operational components in the development of Headquarters operations budgets; (12) provides fund certification and maintains commitment registers for Headquarters components; (13) performs fund reconciliations and assists in coordination of discrepancies with financial officials; (14) maintains Headquarters staffing status reports; and (15) serves as coordinator and conducts training for the Headquarters Administrative Resource and Management System.

Office of Management Services (OMS) (GAL)

(1) Provides IHS-wide leadership, guidance and support for the management of human resources, grants, acquisition, records management, personal property and supply, and the regulations program; (2) develops and oversees the implementation of policies, procedures and delegations of authority for IHS grants management activities, including grants added to self-governance compacts; (3) ensures that Agency policies and practices for the administrative functions identified above are consistent with applicable regulations, directives and guidance from higher echelons in the HHS and other Federal oversight agencies; (4) advises the IHS Director, in conjunction with the Office of the General Counsel (OGC), on the resolution of statutory and regulatory issues related to the IHS and coordinates resolution of IHS legal issues with the OGC, IHS staff, and other Federal agencies; (5) assures that IHS appeal systems meet legal standards, in conjunction with the Office of the General Counsel; (6) provides leadership and direction of activities for continuous improvement of management accountability and administrative systems for effective and efficient program support services IHS-wide; (7) ensures the accountability and integrity of grants and acquisition management, records management, personal property utilization and disposition of IHS resources; (8) assures that the IHS management services, policies, procedures, and practices support IHS Indian Self-Determination Act policies; (9) assists in the assurance of Indian access to State, local, and private health programs; (10) provides leadership and advocacy of the IHS mission and goals with the HHS, Administration, Congress, and other external authorities; and (11) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Program Integrity and Ethics Staff (PIES) (GAL1)

(1) Directs the fact-finding and resolution of allegations of impropriety such as mismanagement of resources, fraud, waste, and abuse violations of the Standards of Ethical Conduct, Hatch Act and political activity and other forms of waste; (2) advises the IHS Director and IHS management of appropriate corrective and remedial actions to correct improprieties; (3) directs and provides leadership in the formulation of plans, guidance and evaluation of the IHS Personnel Security and Drug Testing Programs; (4) administers the IHS-wide management of the Agency hotline reports of allegations; (5) serves as the Agency coordinator for the HHS Office of the Inspector General (OIG), Office of Investigations; (6) manages and directs the IHS "Ethics Program", including the implementation of all requirements, providing advice to the IHS Director and serving as the Agency liaison with all outside investigative organizations such as the Office of Special Counsel, the General Accounting Office and the OIG; and (7) develops and implements IHS directives and training for Standards of Ethical Conduct, Hatch Act and political activity, allegations and investigations of administrative fraud, waste and abuse, drug testing, and personnel security.

Division of Commissioned Personnel Support (DCPS) (GALA)

(1) Acts as the liaison between IHS and the Program Support Center, Division of Commissioned Personnel, HHS; (2) advises the IHS Director, supervisors, administrators, managers, officers and dependents regarding commissioned personnel benefits, policies, procedures, regulations, as the IHS primary point of contact for commissioned personnel management; (3) develops policies, procedures, and recommendations to the Division of Commissioned Personnel, HHS; (4) provides direct support to the IHS Director and/or the Agency representative to the Office of the Surgeon General; and (5) produces resource materials and conducts training sessions on commissioned personnel issues for officers, supervisors, and commissioned personnel specialists in IHS Area Offices.

Division of Administrative Services (DAS) (GALB)

(1) Plans, develops and directs program support and general services programs; (2) develops and disseminates policy and procedural guidelines for uniform administrative services and practices; (3) provides guidance and support in the development, planning, and implementation of administrative functions; (4) serves as liaison with the HHS and the General Services Administration (GSA) on logistics issues affecting the IHS; (5) monitors, evaluates, and reports on administrative programs and services; (6) provides advice and technical assistance on design, layout, inventories, and print order tracking for IHS publications; and (7) manages a variety of special projects.

Office Services Branch (OSB)

(1) Administers physical security, supply, and space management services for Headquarters; (2) develops and disseminates policy and procedural guidelines for uniform office service programs; (3) provides leadership and coordination in the planning, development, operation, and evaluation of special office support programs in small purchase acquisitions, facilities management, office relocations, lease acquisition, GSA supplies, equipment, furniture, telecommunications, transportation, mail management, forms management, photocopying, and printing; (4) manages the Headquarters facilities program, physical security, motor vehicles, personal property, special projects and inter-agency activities; (5) develops and recommends policies and procedures for the protection and disposition of IHS records and oversees the evaluation of records management activities in the IHS; (6) provides leadership for special projects and inter-agency activities; (7) develops and recommends policies and procedures for the protection and disposition of IHS records; (8) oversees the evaluation of records management activities in the IHS; (9) provides leadership and guidance for the Agency Records Management Program; and (10) develops and implements a management control system for evaluation of records management functions Agency-wide.

7C

Property and Supply Management Branch (PSMB)

(1) Plans, develops, and administers the IHS policies on personal property management in conformance with Federal personal property management laws, regulations, policies, procedures, practices, and standards; (2) interprets regulations and provides advice on execution and coordination of personal property management policies and programs; (3) administers management systems and methods for planning, utilizing, and reporting on administrative personal property management programs, including the IHS personal property accountability and controls systems; (4) provides guidance and serves as principal administrative authority on Federal personal property management laws, regulations, policies, procedures, practices, and standards, in conjunction with the Office of the General Counsel; (5) conducts surveys and studies involving evaluation and analysis of the personal property management activities Agency-wide; (6) maintains liaison with the HHS and the GSA on personal property management issues and programs affecting the IHS; (7) prepares reports on IHS personal property; and (8) develops statements for annual budget formulation and presentation.

Division of Acquisitions Policy (DAP) (GALC)

(1) Develops, recommends, and oversees the implementation of policies, procedures and delegations of authority for the acquisition management activities in the IHS, consistent with applicable regulations, directives, and guidance from higher echelons in the HHS and Federal oversight agencies; (2) advises the Director, Office of Management Services, of proposed legislation, regulations, and directives that affect contracts in the IHS; (3) provides leadership for compliance reviews of all IHS procurement operations; (4) oversees completion of necessary corrective actions; (5) manages for the Agency, the HHS acquisition training and certification program and the project officer training program; (6) supports and maintains the IHS Contract Information System and controls entry of data into the HHS Contract Information System; (7) serves as the IHS contact point for contract protests and the HHS contact for contract-related issues; (8) reviews and makes recommendations for approval/disapproval of contract-related documents such as: Pre- and post-award documents, unauthorized commitments, procurement planning documents, Justification for Other Than Full and Open Competition documents, waivers, deviations, and determinations and findings that require action by the Agency Principal Official Responsible for Acquisition, the Agency Head of Contracting, or the Office of the Secretary; (9) processes unsolicited proposals for the IHS; (10) coordinates the IHS Small, Disadvantaged, and Women-Owned Business programs; (11) oversees compliance with the Buy Indian Act; and (12) provides advice to Agency officials negotiating inter- and intra-agency agreements, in accordance with the IHS agreements program.

Division of Grants Operations (DGO) (GALD)

(1) Directs grants management and operations for the IHS; (2) awards and administers grants and cooperative agreements for IHS financial assistance programs; (3) provides leadership for the resolution of audit findings for grant programs; (4) manages for the Agency, the HHS grants training and certification program; (5) continuously assesses grants operations; (6) oversees completion of necessary corrective action plans; (7) reviews and makes recommendations for improvements in grantee and potential grantee management systems; (8) serves as the IHS liaison with the HHS and the public for grants and other financial assistance programs within the IHS; (9) maintains the Catalog of Federal Domestic Assistance for IHS financial assistance programs; (10) conducts grants-related training for IHS staff, grantees, and potential grantees; (11) coordinates payment to grantees, including scholarship recipients; and (12) establishes and maintains the IHS automated Grants Information System and controls data entry into the HHS automated Grants Information System.

Division of Regulatory Affairs, Records Access and Policy Liaison (GALE)

(1) Manages the IHS' overall regulations program and responsibilities, including determining the need for and developing plans for changes in regulations, developing or assuring the development of needed regulations, and maintaining the various regulatory planning processes; (2) serves as IHS liaison with the Office of the Federal Register on matters relating to the submission and clearance of documents for publication in the **Federal Register**; (3) assures proper Agency clearance and processing of **Federal Register** documents; (4) informs management and program officials of regulatory activities of other Federal agencies; (5) manages the IHS review of non-IHS regulatory documents that impact the delivery of health services to Indians; (6) advises the IHS Director and serves as liaison with the Office of the General Counsel (OGC) on such matters as litigation, regulations, related policy issues, and administrative support issues; (7) determines the need for and obtains legal clearance of IHS directives and other issuances; (8) coordinates legal issues with the OGC, IHS, HHS components, and other Federal agencies, including the identification and formulation of legal questions and advising on the implementation of OGC opinions; (9) assures that IHS' appeals processes meet legal standards; (10) advises on and participates in Indian Self-Determination and Education Assistance Act appeals and hearings; (11) provides guidance and assistance on State and Federal health reform efforts, including access and civil rights aspects and State Medicaid waiver applications; (12) advises on the administration of the contract health services (CHS) appeals system and is a participant in the IHS Director's CHS appeal decisions; (13) manages the retrieval and transmittal of information in response to requests received under the FOIA or the Privacy Act, in collaboration with the Public Affairs Staff; (14) ensures the security of sensitive and/or confidential information when responding to FOIA or Privacy Act issues; and (15) advises the IHS Director regarding requests for IHS employees to serve as expert witnesses when IHS is not a party to the suit.

Regulations and Records Access Branch (RRAB)

(1) Manages the Agency's regulation program and responsibilities; (2) serves as liaison with the Office of the Federal Register; (3) advises on the need for or changes in current regulations; (4) develops or assures the development of IHS regulations; (5) keeps IHS officials informed on relevant regulatory activities of other agencies of the Government; (6) coordinates regulations activities with agencies within the HHS that impact on the delivery of health services to Indians; (7) maintains and updates various regulatory agendas; (8) assures that all IHS materials for publication in the **Federal Register** are properly cleared, processed, and in proper format; (9) manages the retrieval, review, and appropriate transmittal of information in response to FOIA requests, including ensuring the appropriate security of such documents; (10) manages, administers, implements and monitors the Agency's Paperwork

Reduction Act (PRA) and OMB information collection/activities; (11) provides guidance and technical assistance to IHS regarding information collection requirements and procedures for obtaining OMB approvals and extensions for IHS information collections; and (12) coordinates the implementation and the application of Privacy Act requirements, including but not limited to Health Insurance Portability and Accountability Act implementation and compliance.

Policy Liaison Branch (PLB)

(1) Coordinates the resolution and development of legal advice to the IHS Director on IHS legal issues with the OGC, IHS senior staff, and other Federal agencies; (2) provides liaison with the OGC in such matters as litigation, regulations, legislation, policy review, civil rights, and administrative appeals; (3) provides advice on the development and implementation of non-personnel appeals processes to assure they meet legal standards; (4) maintains and distributes the Compendium of Legal Opinions; (5) reviews IHS directives and other issuances for needed legal clearances; (6) advises on the impact on IHS and the Indian community of State and Federal health reforms; and (7) provides policy review and advice on the need for or application of legal opinions.

Division of Human Resources (DHR) (GALG)

(1) Advises the IHS Director on personnel management issues, programs and policies for civil service and commissioned corps personnel programs; (2) assures implementation of the Indian preference policy in all personnel practices; (3) develops personnel management policies, programs, and reports in accordance with applicable laws, regulations, and policies; (4) provides personnel management and services throughout IHS, to include, but not limited to, manpower planning and utilization, staffing, recruitment, compensation, classification, human resource development, pay administration, labor, and employee relations; (5) provides advice, consultation, and assistance to IHS management and Tribal officials on Tribal health program personnel policy issues; (6) provides technical support, guidance, and assistance on all personnel programs to IHS Headquarters operations and other organizations as necessary; and (7) represents IHS in all personnel management matters.

Human Resources Advisory Branch (HRAB)

(1) Plans, conducts, and evaluates personnel functional programs; (2) develops IHS personnel policies, programs, and reports; (3) provides personnel program and policy advice and assistance throughout IHS; (4) provides advice and assistance to IHS management and Tribal officials on Tribal health program personnel policies; and (5) develops and implements Indian preference policies and procedures.

Human Resources Operations Branch (HROB)

(1) Plans and implements personnel servicing responsibilities for IHS programs covered by the Headquarters appointing authority, including staffing, recruitment, classification, pay administration, and employee relations; (2) provides staff support for the establishment and recruitment of Senior Executive Service positions, including performance management, compensation and award nominations; (3) processes personnel actions and appoints all civil service employees; and (4) provides advice and training on timekeeping and pay administration.

Office of Environmental Health and Engineering (OEHE) (GAM)

(1) Advises and supports the IHS Director on policy, budget formulation, and resource allocation regarding environmental health and engineering activities of IHS and Tribal facilities programs; (2) provides Agency-wide leadership and consultation to IHS, Tribal, and Urban Indian health programs on IHS goals, objectives, policies, standards, and priorities; (3) represents the IHS within the HHS and external organizations for purposes of liaison, professional collaboration, cooperative ventures, and advocacy; (4) serves as the primary source of technical advice for the IHS Director, Headquarters, Area Offices, Tribal, and Urban Indian health programs on the full scope of health care facilities construction and operations, sanitation facilities construction and management, environmental health services, environmental engineering, clinical engineering, and realty services management; (5) develops and recommends policies, administrative procedures and guidelines for Pub. L. 93–638 construction activities; (6) develops objectives, priorities, standards, and methodologies to conduct and evaluate environmental health, environmental engineering, and facilities engineering and management activities; (7) coordinates the formulation of the IHS Facilities appropriation budget request and responds to all inquiries about the budget request and programs funded by the IHS Facilities appropriation; (8) maintains needs-based and workload-based methodologies for equitable resource distribution for all funds appropriated under the IHS Facilities appropriation; (9) provides leadership, consultation, and staff development to assure functional, safe, and well-maintained health care facilities, a comprehensive environmental health program, and the availability of water, sewer, and solid waste facilities for Indian homes and communities; (10) coordinates the IHS OEHE responsibilities in responding to disasters and other emergency situations, in collaboration with the Office of Clinical and Preventive Services; and (11) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Division of Sanitation Facilities Construction (DSFC) (GAMA)

(1) Develops, implements, and manages the environmental engineering programs, including the Sanitation Facilities Construction (SFC) program, and compliance activities associated with environmental protection and historic preservation legislation; (2) provides Agency-wide management assistance and special support/consultation to address special environmental public health problems for environmental engineering/construction activities, and for compliance with environmental legislation; (3) works closely with other Federal agencies to resolve environmental issues and maximize benefits to Tribes by coordinating program efforts; (4) develops, implements, and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for SFC activities; (5) consults with Tribal groups/organizations in the development and implementation of SFC policies and initiatives, and in the identification of sanitation needs; (6) maintains a national inventory of current Tribal sanitation facilities needs, and past and present projects to address those needs; and (7) allocates financial resources Agency-wide based on need and workload using the national data inventories, in collaboration with the OFA.

Division of Facilities Operations (DFO) (GAMB)

(1) Develops, implements, and manages the programs affecting health care facilities operations, including the routine maintenance and improvement, real property asset management, quarters, and clinical engineering programs; (2) develops, implements, monitors and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for health care facilities operations; (3) serves as the principal resource for coordination of facilities operations and provides consultation to IHS and the Tribes on health care facilities operations; (4) maintains real property asset and quarters management systems; (5) maintains clinical engineering management systems; (6) formulates financial resources allocation methodologies Agency-wide based on need and workload data; (7) maintains Agency-wide data on Federal and Tribal facilities for program budget justification; (8) develops and evaluates technical standards and guidelines for health care facilities operations; and (9) monitors construction activities and the improvement, alteration, and repair of health care facilities.

Division of Facilities Planning and Construction (DFPC) (GAMC)

(1) Develops, implements, and manages the IHS Health Care Facilities Planning and Construction program, including the facilities planning process, facilities design process, facilities acquisition, and construction project management; (2) develops, implements, monitors, and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for health care facilities planning and construction; (3) develops and maintains construction priority systems, and with the Division of Engineering Services, develops project budget documents for the health care facilities construction program; (4) serves as the principal resource in providing leadership, guidance, and coordination of health care facilities engineering activities for the IHS Headquarters, Area Offices, Tribal and Urban Indian health programs; (5) evaluates justifications for major improvement and alteration projects and other large scale construction activities; and (6) develops and evaluates technical standards and guidelines for health care facilities construction.

Division of Environmental Health Services (DEHS) (GAMD)

(1) Develops, implements, and manages the IHS Environmental Health Services programs, including the Injury Prevention and Institutional Environmental Health programs; (2) serves as the primary source of technical and policy advice for IHS Headquarters and Area Offices on the full scope of environmental health issues and activities; (3) maintains relationships with other Federal agencies and Tribes to maximize responses to environmental health issues and maximize benefits to Tribes by coordinating program efforts; (4) provides leadership in identifying and articulating environmental health needs of AI/AN populations and support efforts to build Tribal capacity; (5) provides personnel support services and advocates for environmental health providers; (6) maintains, analyzes, makes accessible, and publishes results from national databases; (7) manages resource allocation activities in accordance with established criteria based on workload; (8) develops and evaluates standards and guidelines for environmental health programs and activities; and (9) performs functions related to environmental health programs such as injury prevention, emergency response, water quality, food sanitation, occupational health and safety, solid and hazardous waste management, environmental health issues in health care and non-health care institutions, and vector control.

Division of Engineering Services (Dallas/Seattle) (DES) (GAME)

(1) Administers health care facilities engineering and construction projects for specified Area Offices and administers the engineering and construction of certain projects for other Federal agencies through inter-agency agreements; (2) carries out management activities relating to IHS-owned and utilized health care facilities, including construction, contracting, realty, and leasing services; (3) serves as the source of engineering and contracting expertise for assigned programs/projects and other technical programmatic areas affecting the planning, design, alteration, leasing, and construction of IHS health care and sanitation facilities for Indian homes and communities; and (4) assists in the development of Area Office annual work plans, studies, investigations, surveys, audits, facilities planning, and technical standards development, for IHS-owned and Tribal health care facilities.

Section GA–30, Indian Health Service—Order of Succession

During my absence or disability of the IHS Director or in the event of a vacancy in that office, the following IHS Headquarters officials, in the order listed below, shall act as the IHS Director. In the event of a planned extended period of absence, the IHS Director may specify a different order of succession. The order of succession will be:

(1) Deputy Director.
(2) Deputy Director for Indian Health Policy.
(3) Deputy Director for Management Operations.
(4) Chief Medical Officer.

Section GA–40, Indian Health Service—Delegations of Authority

All delegations of authority and re-delegations of authority made to IHS officials that were in effect immediately prior to this reorganization, and that are consistent with this reorganization, shall continue in effect pending further re-delegation.

Chapter GF

IHS Area Offices

Section GF–00, Indian Health Service Area Offices—Mission

The IHS Area Offices carry out the mission of the IHS by providing a system of health care unique to the Area population.

Section GF–10, Indian Health Service Area Offices—Organization

An Area Office is a bureau-level organization under the direction of an Area Director, who reports to the IHS Director.

The following are the Area Offices of the IHS:

- Aberdeen Area Office (GFA)
- Alaska Area Office (GFB)
- Albuquerque Area Office (GFC)
- Bemidji Area Office (GFE)
- Billings Area Office (GFF)
- California Area Office (GFG)
- Nashville Area Office (GFH)
- Navajo Area Office (GFJ)
- Oklahoma City Area Office (GFK)
- Phoenix Area Office (GFL)
- Portland Area Office (GFM)
- Tucson Area Office (GFN).

Section GF–20, Indian Health Service Area Offices—Functions

The specific functions of the IHS Area Offices vary, however, each Area Office includes functions organized to support major categories of administrative management and clinical activities. Examples include:

Administration and Management—Financial management, administrative

7C

and office services, contract/grant administration, procurement, personnel management, facilities management, management information systems, contract health services, and equal employment opportunity;

Program Planning, Analysis and Evaluation Programs—Program planning, statistical analysis, legislative initiatives, research and evaluation, health records, management information systems, and patient registration/third party collection;

Tribal Activity Programs—Provision of Pub. L. 93–638, Indian Self-Determination and Education Assistance Act, health services delivery, community health representative services, Urban Indian health, alcoholism and substance abuse, and health education;

Health Programs—Primary care, clinical activities, mental health, nursing services, health promotion, disease prevention, professional recruitment, community services, and the Joint Commission on Accreditation of Healthcare Organizations;

Environmental Health/Sanitation Facilities Programs—Environmental health and engineering/sanitation facilities construction programs; and

Information Resources Management Programs—Automated data processing (ADP), ADP planning and operations, management information systems, office automation systems, and voice/data telecommunications management.

Section GF–30, Indian Health Service Area Offices—Order of Succession

The order of succession for Area Directors at the IHS Area Offices are determined by each Area Director and continue in effect until changed.

Section GF–40, Indian Health Service Area Offices—Delegations of Authority

All delegations and re-delegations of authority made to officials in the IHS Area Offices that were in effect immediately prior to this reorganization, and that are consistent with this reorganization, shall continue in effect pending further re-delegation.

This reorganization shall be effective on August 23, 2004.

Dated: April 28, 2005.

Phyllis Eddy,

Acting Deputy Director, Indian Health Service.

[FR Doc. 05–9012 Filed 5–5–05; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health, National Library of Medicine

Notice of Meeting

Pursuant to section 10(a) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the fifth meeting of the Commission on Systemic Interoperability.

The meeting will be open to the public, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The mission of the Commission on Systemic Interoperability is to submit a report to the Secretary of Health and Human Services and to Congress on a comprehensive strategy for the adoption and implementation of health care information technology standards that includes a timeline and prioritization for such adoption and implementation. In developing that strategy, the Commission will consider: (1) The costs and benefits of the standards, both financial impact and quality improvement; (2) the current demand on industry resources to implement the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and other electronic standards, including HIPAA standards; and (3) the most cost-effective and efficient means for industry to implement the standards.

Name of Committee: Commission on Systemic Interoperability.

Date: May 18, 2005.

Time: 8 a.m. to 4 p.m.

Agenda: Healthcare Information Technology Standards.

Place: Hubert H. Humphrey Building, Room 800, 200 Independence Avenue, Washington, DC 20201.

Contact Person: Ms. Dana Haza, Director, Commission on Systemic Interoperability, National Library of Medicine, National Institutes of Health, Building 38, Room 2N21, Bethesda, MD 20894, 301–594–7520.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The comments should include the name, address, telephone number and, when applicable, the business or professional affiliation of the interested person.

Dated: April 28, 2005.

Anna Snouffer,

Deputy Director, Office of Federal Advisory Committee Policy.

[FR Doc. 05–9047 Filed 5–5–05; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Dental-Biology and Material Sciences.

Date: May 11, 2005.

Time: 11 a.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Tamizchelvi Thyagarajan, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4016K, MSC 7814, Bethesda, MD 20892, (301) 451–1327, *tthyagar@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, PA–04–002: ICOHRTA.

Date: May 27, 2005.

Time: 9 a.m. to 12 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Dan D. Gerendasy, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5132, MSC 7843, Bethesda, MD 20892, (301) 594–6830, *gerendad@csr.nih.gov.*

Name of Committee: Genes, Genomes, and Genetics Integrated Review Group, Molecular Genetics B Study Section.

Date: June 2–3, 2005.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: The Admiral Fell Inn, 888 South Broadway, Historic Fell's Point, Baltimore, MD 21231.

Contact Person: Richard A. Currie, PhD, Scientific Review Administrator, Center for

of the grant, the terms and conditions of the award, the effective date of the award, and the budget/project period.

2. Administrative Requirements

Grants are administered in accordance with the following documents:

- This Program Announcement.
- 45 CFR part 74, "Uniform Administrative Requirements for Awards to Institutions of Higher Education, Hospitals, Other Non-Profit Organizations, and Commercial Organizations."
- Grants Policy Guidance: HHS Grants Policy Statement, January 2007.
- "Non-Profit Organizations" (Title 2 part 230).
- *Audit Requirements:* OMB Circular A–133, "Audits of States, Local Governments, and Non-Profit Organizations."

3. *Indirect Costs:* This section applies to indirect costs in accordance with HHS Grants Policy Statement, Part 11–27. The IHS requires applicants to have a current indirect cost rate agreement in place prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate means the rate covering the applicable activities and the award budget period. If the current rate is not on file with the awarding office, the award shall include funds for reimbursement of indirect costs. However, the indirect costs portion will remain restricted until the current rate is provided to the DGO.

If an urban Indian organization has questions regarding the indirect costs policy, please contact the DGO at (301) 443–5204.

4. Reporting

A. *Progress Report.* Program progress reports are required semi-annually. These reports will include a brief comparison of actual accomplishments to the goals established for the period, reasons for slippage (if applicable), and other pertinent information as required. A final report must be submitted within 90 days of expiration of the budget/project period.

B. *Financial Status Report.* Semi-annual financial status reports must be submitted within 30 days of the end of the half year. Final financial status reports are due within 90 days of expiration of the budget period. Standard Form 269 (long form) will be used for financial reporting.

Failure to submit required reports within the time allowed may result in suspension or termination of an active agreement, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) The imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This applies whether the delinquency is attributable to the failure of the organization or the individual responsible for preparation of the reports.

Telecommunication for the hearing impaired is available at: TTY 301–443–6394.

VII. Agency Contacts

For program-related and general information regarding this announcement: Danielle Steward, Health Systems Specialist, Office of Urban Indian Health Programs, 801 Thompson Avenue, Room 200, Rockville, MD 20852, (301) 443–4680 or *danielle.steward@ihs.gov.*

For specific grant-related and business management information: Denise Clark, Senior Grants Management Specialist, 801 Thompson Avenue, TMP 360, Rockville, MD 20852, 301–443–5204 or *denise.clark@ihs.gov.*

Dated: July 8, 2008.

Robert G. McSwain,

Director, Indian Health Service.

[FR Doc. E8–16051 Filed 7–16–08; 8:45 am]

BILLING CODE 4165–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Organization, Functions, and Delegations of Authority, Part G, Indian Health Service, Proposed Functional Statement

Office of Information Technology (OIT) (GAG)

(1) Provides Chief Information Officer (CIO) services and advises the Director, Indian Health Service (IHS), on all aspects of information resource management and technology; (2) ensures Agency compliance with related Federal laws, regulations, and policies; (3) directs the development, implementation, and maintenance of policies, procedures, standards, and architecture for information resource management, technology activities, and services in the IHS; (4) directs strategic planning and budgeting processes for information resources and technology; (5) leads IHS efforts in developing and implementing information resource and technology management initiatives in IHS; (6) directs the design, development, acquisition, implementation, and support of robust information systems and services used in the IHS; (7) directs the activities of the IHS Information Technology Investment Review Board (ITIRB) in assessing, implementing, and reviewing the Agency's information systems; (8) contracts for information resource and technology-related software, equipment, and support services in collaboration with appropriate acquisition authorities; (9) provides project management support for information resource and technology initiatives; (10) directs the development, implementation, and management of the IHS Information Technology Security program to protect the information resources of the IHS; (11) provides information technology (IT) services and support to IHS, Tribal, and Urban Indian Health Programs (UIHP), including the Resource and Patient Management System (RPMS), Electronic Health Record (EHR), and the National Patient Information Reporting System (NPIRS); (12) ensures accessibility to IT services; (13) represents the IHS and enters into IT agreements with Federal, Tribal, State and other organizations; and (14) participates in cross-cutting issues and processes including, but not limited to, emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations, and resolution of audit findings as may be needed and appropriate.

Division of Information Technology (GAGA)

(1) Provides Chief Technology Officer IT services and advises the CIO on all aspects of IT; (2) develops clinical and business practice healthcare applications such as the RPMS and the EHR; (3) develops healthcare statistical applications for NPIRS; (4) obtains system and business requirements from stakeholders for system design; (5) provides quality assurance and risk management for software development; (6) develops, implements, and maintains policies, procedures, and standards for system development and technology products and services in the IHS; (7) develops and maintains IT strategic planning documents; (8) develops and maintains the IHS enterprise architecture; (9) develops and implements IT management initiatives in IHS; (10) ensures IHS IT infrastructure resource consolidation and standardization efforts support IHS healthcare delivery and program

7C

administration; (11) represents the IHS to Federal, Tribal, State, and other organizations; and (12) participates in cross-cutting issues and processes that involve IT.

Division of Program Management and Budget (GAGB)

(1) Advises the CIO on all business aspects of information resources and project management; (2) develops information resource policies and procedures; (3) develops the IHS IT budget and related documents; (4) provides budget analyses and reports to the CIO; (5) develops strategies for presenting the IHS IT budget to IHS, Tribal, and UIHP; (6) provides technical analyses, guidance, and support for IHS capital planning and investment control activities; (7) manages the IHS portfolio management tool; (8) manages the activities of the IHS ITIRB in assessing, implementing and reviewing the Agency's information systems; (9) develops project management policies and procedures; (10) identifies alternatives among internal and external sources and recommends the best sources to supply information resource and technology products and services to IHS; (11) develops information resource and technology project governance structures to support effective project management; (12) provides project management and related support for IHS developed and acquired information resources and technology products and services; (13) provides contract management support for IT initiatives; (14) provides contract liaison services to appropriate acquisition authorities; (15) participates in cross-cutting issues and processes that involve IT; and (16) represents the IHS to Federal, Tribal, State, and other organizations.

Division of Information Technology Operations (GAGC)

(1) Advises the CIO on all aspects of implementing and deploying computer systems including RPMS; (2) installs and maintains enterprise computer systems and associated hardware and operating systems; (3) installs and maintains enterprise application software; (4) furnishes IRS-wide video conferencing solutions and services; (5) delivers desktop and office automation support; (6) provides 24 x 7 helpdesk support for RPMS and office applications; (7) maintains LISTserv capabilities; (8) provides customer relationship management support for IT systems; (9) performs Web monitoring and filtering services; (10) designs and implements Web sites in compliance with Section 508 Accessibility regulations; (11) operates and maintains data centers; (12) installs and supports e-mail, file, and print services; (13) provides Domain Name Services; (14) designs, implements, and maintains IHS's backbone network infrastructure; (15) monitors network infrastructure for anomalies; (16) provides project management support for systems design and deployment to ensure customer satisfaction; (17) represents the IRS to Federal, Tribal, State, and other organizations; and (18) participates in cross-cutting issues and processes that involve information resources and technology project management.

Division of Information Security (GAGD)

(1) Advises the CIO on all aspects of information security; (2) develops, implements, and monitors the IHS Information Security program to ensure adequate protection of information; (3) develops and maintains information security policies, procedures, and guidelines to safeguard information and IT systems; (4) develops and reviews IHS IT security plans; (5) assesses the risk and magnitude of harm that could result from unauthorized access, use, disclosure, disruption, modification, or destruction of information and information systems that support the operations and assets of IHS; (6) ensures that security and privacy have been incorporated in information system lifecycle plans; (7) conducts vulnerability assessment of IHS's IT infrastructure; (8) coordinates activities with internal and external organizations reviewing the IHS's information resources for fraud, waste, and abuse; (9) develops and implements employee information security awareness training programs; (10) manages the IHS Information Security Incident Response Team; (11) represents the IHS to Federal, Tribal, State, and other organizations regarding information security; and (12) participates in cross-cutting issues and processes that involve information security.

This reorganization shall be effective July 17, 2008.

Dated: July 8, 2008.

Robert G. McSwain,

Director, Indian Health Service

[FR Doc. E8–16353 Filed 7–16–08; 8:45 am]

BILLING CODE 4160–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the Center for Scientific Review Special Emphasis Panel, July 29, 2008, 7 a.m. to July 29, 2008, 7 p.m., National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD, 20892, which was published in the **Federal Register** on June 9, 2008, 73 FR 32589–32590.

The meeting title has been changed to "EPR Shared Instrumentation Study Section.

The meeting is closed to the public.

Dated: July 3, 2008.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E8–15821 Filed 7–16–08; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Special Topics in Neural Drug Discovery.

Date: July 18, 2008.

Time: 1 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Mary Custer, PhD, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4148, MSC 7850, Bethesda, MD 20892–7850, (301) 435–1164, *custerm@csr.nih.gov.*

7C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Notice of Meeting

In accordance with section 10(d) of the Federal Advisory Committee Act (5 U.S.C., Appendix 2), announcement is made of a Health Care Policy and Research Special Emphasis Panel (SEP) meeting.

A Special Emphasis Panel is a group of experts in fields related to health care research who are invited by the Agency for Healthcare Research and Quality (AHRQ), and agree to be available, to conduct on an as needed basis, scientific reviews of applications for AHRQ support. Individual members of the Panel do not attend regularly-scheduled meetings and do not serve for fixed terms or a long period of time. Rather, they are asked to participate in particular review meetings which require their type of expertise.

Substantial segments of the upcoming SEP meeting listed below will be closed to the public in accordance with the Federal Advisory Committee Act, section 10(d) of 5 U.S.C., Appendix 2 and 5 U.S.C. 552b(c)(6). Grant applications for the Accelerating Implementation of Evidence-Based Findings through AHRQ networks (R18) applications are to be reviewed and discussed at this meeting. These discussions are likely to reveal personal information concerning individuals associated with the applications. This information is exempt from mandatory disclosure under the above-cited statutes.

SEP Meeting on: Accelerating Implementation of Evidence-Based Findings through AHRQ networks (R18).

Date: July 23, 2010 (Open on July 23 from 12 p.m. to 12:15 p.m. and closed for the remainder of the meeting).

Place: Doubletree Bethesda Hotel & Executive Meeting Center, 8120 Wisconsin Avenue, Conference Room TBD, Bethesda, Maryland 20852.

Contact Person: Anyone wishing to obtain a roster of members, agenda or minutes of the non—confidential portions of this meeting should contact Mrs. Bonnie Campbell, Committee Management Officer, Office of Extramural Research, Education and Priority Populations, AHRQ, 540 Gaither Road, Room 2038, Rockville, Maryland 20850, Telephone (301) 427–1554.

Agenda items for this meeting are subject to change as priorities dictate.

Dated: June 23, 2010.

Carolyn M. Clancy,

Director.

[FR Doc. 2010–15792 Filed 6–30–10; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment; Notice of Meeting

Pursuant to Public Law 92–463, notice is hereby given that the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council will meet July 14, 2010, 1–3 p.m. via teleconference.

The meeting will include discussion and evaluation of grant applications reviewed by Initial Review Groups. Therefore, the meeting will be closed to the public as determined by the Administrator, SAMHSA, in accordance with Title 5 U.S.C. 552b(c)(6) and 5 U.S.C. App. 2, Section 10(d).

Substantive program information, a summary of the meeting and a roster of Council members may be obtained as soon as possible after the meeting, either by accessing the SAMHSA Committee Web site at *https://nac.samhsa.gov/CSATcouncil/index.aspx,* or by contacting the CSAT National Advisory Council Designated Federal Official, Ms. Cynthia Graham (*see* contact information below).

Committee Name: SAMHSA's Center for Substance Abuse Treatment National Advisory Council

Date/Time/Type: July 14, 2010, 1–3 p.m.: Closed.

Place: SAMHSA Building, 1 Choke Cherry Road, Rock Creek Room, Rockville, Maryland 20857.

Contact: Cynthia Graham, M.S., Designated Federal Official, SAMHSA CSAT National Advisory Council, 1 Choke Cherry Road, Room 5–1035, Rockville, Maryland 20857, Telephone: (240) 276–1692, *Fax:* (240) 276–1690, *E-mail: cynthia.graham@samhsa.hhs.gov.*

Toian Vaughn,

Committee Management Officer, Substance Abuse and Mental Health, Services Administration.

[FR Doc. 2010–15940 Filed 6–30–10; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Organization, Functions, and Delegations of Authority; Part G; Indian Health Service; Proposed Functional Statement

Program Integrity and Ethics Staff (PIES) (GAL1)

(1) Directs the fact-finding and resolution of allegations of impropriety such as mismanagement of resources, fraud, waste, and abuse, violations of the Standards of Ethical Conduct, Hatch Act and political activity and other forms of waste; (2) advises the IHS Director and IHS management of appropriate corrective and remedial actions to correct improprieties; (3) directs and provides leadership in the formulation of plans, guidance, and evaluation of the IHS Personnel Security and Drug Testing Programs; (4) administers the IHS-wide management of the Agency hotline reports of allegations; (5) manages and directs the IHS "Ethics Program," including the implementation of all requirements, providing advice to the IHS Director and serving as the Agency liaison with all outside investigative organizations such as the Office of Special Counsel, the Government Accountability Office (GAO) and HHS Office of Inspector General (OIG); (6) develops and implements IHS directives and training for Standards of Ethical Conduct, the Hatch Act and political activity, allegations and investigations of administrative fraud, waste and abuse, drug testing, and personnel security; and (7) serves as the IHS liaison with the OIG and GAO, and coordinates the development, clearance, and transmittal of IHS responses and follow-up to matters and reports issued by the OIG, the GAO, and other Federal internal and external authorities.

Management Policy and Internal Control Staff (MPICS) (GAL3)

(1) Formulates, administers, and supports IHS-wide policies, delegations of authority, and organizations and functions development; (2) provides leadership, on behalf of the IHS Director, to functional area managers at IHS Headquarters in developing, modifying, and overseeing the implementation of IHS policies and procedures; (3) provides analysis, advisory, and assistance services to IHS managers and staff for the development, clearance, and filing of IHS directives and delegations of authority; (4) serves as principal advisor and source for

7C

technical assistance for establishment or modification of organizational infrastructures, functions, and Standard Administrative Code configurations; (5) administers the IHS's Management Control Program for assuring IHS compliance with management control requirements in the Federal Managers' Financial Integrity Act; (6) provides assistance and support to special assigned task groups; (7) conducts special program or management integrity reviews as required; and (8) oversees and coordinates the annual development and submission of the Agency's Federal Activities Inventory Reform Act report to the HHS.

Division of Grants Management (DGM) (GALD)

(1) Directs grants management and operations for the IHS; (2) initiates new and modifies existing IHS grants administration policies and procedures in accordance with HHS grants policies; (3) provides assistance to IHS staff and grantee organizations regarding policies and procedures pertinent to the administration of IHS grants to ensure stewardship of Federal funds; (4) provides guidance to and articulates grants management policy for IHS staff on the effective utilization of financial assistance mechanisms (grants and cooperative agreements); (5) advises and provides technical support to IHS staff on program announcement requirements as issued by OMS and HHS Grants Review and Oversight; (6) develops and maintains IHS Grants Operations/Grants Policy website; (7) posts all IHS funding opportunities on IHS Grants Operations/Grants Policy website for Grants.gov; (8) administers grants and cooperative agreements for all IHS grant recipients; (9) awards and administers grants and cooperative agreements for IHS financial assistance programs; (10) provides assistance for the resolution of audit findings for grant programs; (11) manages for the IHS, the HHS grants training and certification program; (12) performs internal controls assessments on all facets of the IHS grant programs and issues and oversees the completion of necessary corrective action plans; (13) reviews and makes recommendations for improvements in grantee and potential grantee management systems; (14) serves as the IHS liaison with the HHS and the public for grants and other financial assistance matters within the IHS; (15) maintains the Catalog of Federal Domestic Assistance for IHS financial assistance programs; (16) conducts grants-related training for IHS staff, grantees, and potential grantees; (17) coordinates payment to grantees, including scholarship recipients; and (18) establishes and maintains the IHS automated Grants Information System and controls data entry into the HHS automated Grants Information System.

Section GA–30, Indian Health Service—Order of Succession

During my absence or disability of the IHS Director or in the event of a vacancy in that office, the following IHS Headquarters officials, in the order listed below, shall act as the IHS Director. In the event of a planned extended period of absence, the IHS Director may specify a different order of succession. The order of succession will be:

(1) Deputy Director
(2) Deputy Director for Management Operations
(3) Chief Medical Officer
(4) Deputy Director for Field Operations

Section GA–40, Indian Health Service—Delegations of Authority

All delegations of authority and re-delegations of authority made to IHS officials that were in effect immediately prior to this reorganization, and that are consistent with this reorganization, shall continue in effect pending further re-delegation.

This reorganization shall be effective June 2, 2010.

Dated: June 2, 2010.

Yvette Roubideaux,

Director, Indian Health Service.

[FR Doc. 2010–15973 Filed 6–30–10; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Mental Health; Notice of Request for Information

Notice is hereby given of a Request for Information (RFI): Updating the Interagency Autism Coordinating Committee Strategic Plan for Autism Spectrum Disorder (ASD) Research, NOT–MH–10–025, issued by the National Institute of Mental Health on behalf of the Interagency Autism Coordinating Committee (IACC).

The purpose of this RFI is to request input from ASD stakeholders to inform the next update of the Strategic Plan in 2011. Please see the official RFI notice at *http://grants.nih.gov/grants/guide/notice-files/NOT-MH-10-025.html* for more information and instructions for responding by the deadline of July 30, 2010. All responses must be submitted electronically via the Web-based form found at *http://www.acclaroresearch.com/oarc/2010rfi/.*

Contact Person: Attention: RFI on Updating the Strategic Plan for ASD Research, Office of the Autism Research Coordination, National Institute of Mental Health, NIH, 6001 Executive Boulevard, Room 8185, Bethesda, MD 20892–9669, or e-mail *IACCRFI@mail.nih.gov.*

Information about the IACC is available on the Web site: *http://iacc.hhs.gov.*

Dated: June 25, 2010.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2010–16035 Filed 6–30–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2010–0009]

Agency Information Collection Activities: Submission for OMB Review; Comment Request, OMB No. 1660–NEW; Environmental and Historic Preservation Environmental Screening Form

AGENCY: Federal Emergency Management Agency, DHS.

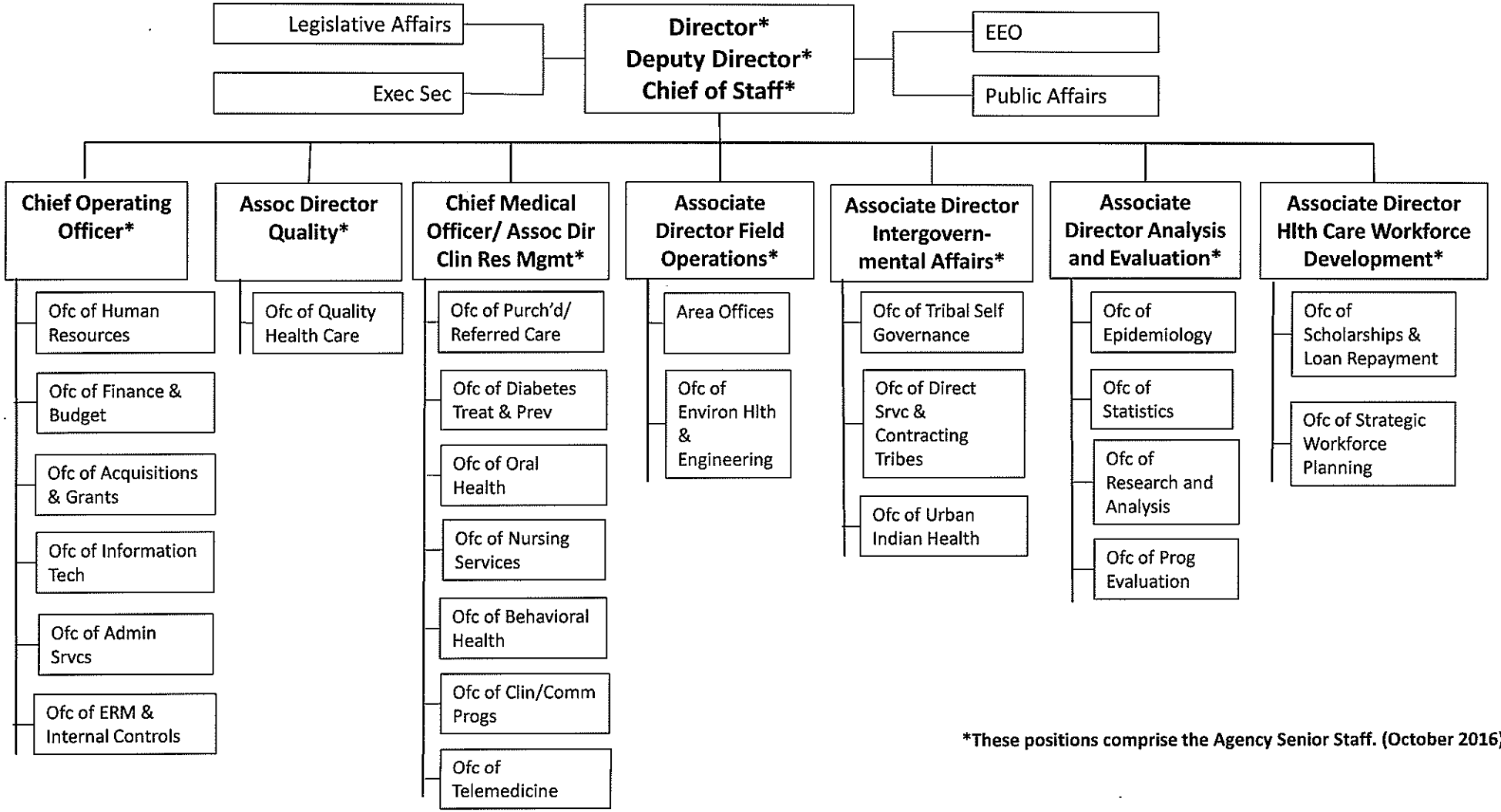
ACTION: Notice; 30-day notice and request for comments; new information collection; OMB No. 1660–NEW; FEMA Form 024–0–1, Environmental and Historic Preservation Environmental Screening Form.

SUMMARY: The Federal Emergency Management Agency (FEMA) has submitted the information collection abstracted below to the Office of Management and Budget for review and clearance in accordance with the requirements of the Paperwork Reduction Act of 1995. The submission describes the nature of the information collection, the categories of respondents, the estimated burden (*i.e.*, the time, effort and resources used by respondents to respond) and cost, and the actual data collection instruments FEMA will use.

DATES: Comments must be submitted on or before August 2, 2010.

ADDRESSES: Submit written comments on the proposed information collection to the Office of Information and Regulatory Affairs, Office of Management and Budget. Comments should be addressed to the Desk Officer

INDIAN HEALTH SERVICE HEADQUARTERS



*These positions comprise the Agency Senior Staff. (October 2016)

Enclosure – DRAFT Functional Statements – IHS Headquarters Realignment (October 2015)

Part G—Indian Health Service

Part G, of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (HHS), as amended at 52 FR 47053–67, December 11, 1987, as amended at 60 FR 56606, November 9, 1995, as amended at 61 FR 67048, December 19, 1996, as amended at 69 FR 41825 July 12, 2004, as amended at 70 FR 24087 May 6, 2005, and most recently as amended at _____ is hereby amended to reflect a reorganization of the Indian Health Service (IHS) Headquarters (HQ). The goal of the reorganization is to ensure clear lines of authority to senior leadership and improve the Agency's responsibilities for oversight and accountability. Delete the functional statements for the IHS Headquarters in their entirety and replace with the following:

Chapter GA – Office of the Director

Section GA-10, Indian Health Service—Organization

The IHS is an Operating Division within the Department of Health and Human Services (HHS) and is under the leadership and direction of a Director who is directly responsible to the Secretary of Health and Human Services. The IHS Headquarters consists of the following major components:

Office of the Director (GA), Chief Operating Officer (Gxx), Associate Director Quality (Gxx), Chief Medical Officer (Gxx), Associate Director Field Operations (Gxx), Associate Director Intergovernmental Affairs (Gxx), and Associate Director Analysis and Evaluation (Gxx).

Section GA-20, Indian Health Service—Functions

Office of the Director (OD) (GA)

Provides overall direction and leadership for the IHS: (1) Establishes goals and objectives for the IHS consistent with the mission of the IHS and ensures Agency performance is managed through goals/objectives, achievements, and/or improved outcomes; (2) provides for the full participation of Indian Tribes in the programs and services provided by the Federal Government; (3) develops health care policy; (4) ensures the delivery of quality comprehensive health services; (5) advocates for the health needs and concerns of American Indians/Alaska Natives (AI/AN); (6) promotes the IHS programs at the local, State, national, and international levels; (7) develops and demonstrates alternative methods and techniques of health services management and delivery with maximum participation by Indian Tribes and Indian organizations; (8) supports the development of individual and Tribal capacities to participate in Indian health programs through means and modalities that they deem appropriate to their needs and circumstances; (9) the IHS will carry out the responsibilities of the United States to Indian Tribes and individual Indians; (10) affords Indian people an opportunity to enter a career in the IHS by applying Indian preference; and (11) ensures full application of the principles of Equal Employment Opportunity laws and the Civil Rights Act in managing the human resources of the IHS.

Legislative Affairs (LA) (GAxx)

(1) Serves as the principal advisor to the IHS Director on all legislative and congressional relations matters; (2) advises the IHS Director and other IHS officials on the need for changes in legislation and

manages the development of IHS legislative initiatives; (3) serves as the IHS liaison office for congressional and legislative affairs with Congressional offices, the HHS, the Office of Management and Budget (OMB), the White House, and other Federal agencies; (4) tracks all major legislative proposals in the Congress that would impact Indian health; (5) ensures that the IHS Director and appropriate IHS and HHS officials are briefed on the potential impact of proposed legislation; (6) develops legislative strategy for key policy and legislative initiatives; (7) provides technical assistance and advice relative to the effect that initiatives/implementation would have on the IHS; (9) provides support and collaborates with OFA relative to IHS appropriations efforts; (10) directs the development of IHS briefing materials for congressional hearings, testimony, and bill reports; (11) analyzes legislation for necessary action within the IHS; (12) develops appropriate legislative implementation plans; and (13) coordinates with IHS Headquarters and Area offices as appropriate to provide leadership, advocacy, and technical support to respond to requests from the public, including Tribal governments, Tribal organizations, and Indian community organizations regarding IHS legislative issues.

Executive Secretariat (ES) (GAxx)

(1) Manages the processing of executive correspondence and related information to the IHS Director from Tribes and Tribal governments, Tribal and Urban Indian organizations, Federal departments and agencies, Congress and congressional staff offices, attorneys, patients, schools, universities, employees, grantees, contractors, and the general public; (2) reviews and monitors correspondence received by the IHS Director and assigns reply or follow-up action to appropriate IHS Headquarters program offices and IHS Area Offices; (3) ensures the quality (responsiveness, clarity, and substance) of IHS-generated correspondence prepared for the IHS Director's signature by coordinating the review of integrity and policy issues, and performing standard edits and revisions; (4) reviews and coordinates clearance of decision documents for the IHS Director's approval to ensure successful operations and policy-making within the Agency; (5) assists IHS officials as they prepare documents for the HHS Secretary's review, decision, and/or signature; (6) serves as the Agency's liaison with the HHS Office of the Secretary's Executive Secretariat on IHS program, policy, and special maters; (7) performs special writing assignments for the IHS Director; (8) maintains official records of the IHS Director's correspondence and conducts topic research of files, as needed; (9) oversees an electronic document handling system to assist in managing the timely processing of internal and external executive correspondence; (10) conducts training to promote conformance by IHS Headquarters and Area staff to the IHS Executive Correspondence Guidelines; (11) tracks reports required by Congress; (12) formulates, administers, and supports IHS-wide policies, delegations of authority, and organizations and functions development; (13) provides leadership, on behalf of the IHS Director, to functional area managers at IHS Headquarters in developing, modifying, and overseeing the implementation of IHS policies and procedures; (14) provides analysis, advisory, and assistance services to IHS managers and staff for the development, clearance, and filing of IHS directives and delegations of authority; (15) serves as principal advisor and source for technical assistance for establishment or modification of organizational infrastructures, functions, and Standard Administrative Code configurations; (16) manages the IHS' overall regulations program and responsibilities, including determining the need for and developing plans for changes in regulations, developing or assuring the development of needed regulations, and maintaining the various regulatory planning processes; (17) serves as IHS liaison with the Office of the Federal Register on matters relating to the submission and clearance of documents for publication in the Federal Register; (18) assures proper Agency clearance and processing of Federal Register documents; and (19) manages the IHS

review of non-IHS regulatory documents that impact the delivery of health services to Indians including but not limited to access and civil rights aspects and State Medicaid waiver applications by coordinating with the OGC Public Health Division.

Equal Employment Opportunity (EEO) (GAxx)

(1) Administers the IHS equal employment opportunity, civil rights, and affirmative action and alternative Dispute Resolution programs, in accordance with applicable laws, regulations, and HHS policies; (2) plans and oversees the implementation of IHS affirmative employment and special emphasis programs; (3) reviews data and advises IHS managers of possible discriminatory trends; (4) ensures immediate implementation of required actions on complaints of alleged sexual harassment or discrimination; (5) decides on accepting, for investigation, or dismissing discrimination complaints and evaluates accepted complaints for procedural sufficiency and investigates and resolves complaints; (6) evaluates accepted formal complaints of discrimination for procedural sufficiency and adjudicates and resolves complaints; and (7) develops/administers equal employment opportunity education and training programs for IHS managers, supervisors, counselors, and employees.

Public Affairs (PA) (GAxx)

Serves as the principal advisor for strategic planning on communications, media relations, and public affairs policy formulation and implementation; (2) ensures IHS policy is consistent with directives from the Assistant Secretary for Public Affairs; (3) provides leadership and advocacy to establish and implement policy for internal and external dissemination of Agency information intended for public release or employee and stakeholder information; (4) serves as the central office for technical guidance and assistance to IHS staff for the development of public affairs and media communication; (5) coordinates public affairs activities with other public and private sector organizations; (6) coordinates the clearance of IHS public relations activities, campaigns, and communications materials; (7) represents the IHS in discussions regarding policy and public affairs initiatives/implementation; (8) provides technical assistance and advice relative to the effect public affairs initiatives/ implementation would have on the IHS; (9) collaborates with the Division of Regulatory Affairs, for review and response to media requests received under the Freedom of Information Act (FOIA) or the Privacy Act, and ensures the security of IHS documents used in such responses that contain sensitive and/or confidential information; and (10) serves as the IHS liaison office for press and public affairs with HHS, IHS Area Offices, media and other external organizations and representatives.

Chief Operating Officer (COO) (Gxx)

The Chief Operating Officer (COO): (1) oversees and supervises the human resources, finance and budget, acquisitions and grants, information technology, and administrative services functions; (2) oversees development and implementation of administrative policies and procedures; (3) ensures Agency compliance with applicable laws, regulations, policies, and procedures governing the COO functions; (4)

Office of Human Resources (OHR) (Gxxx)

(1) Advises the Director, IHS, on HR goals, objectives, policies, and priorities of the Agency and the HR profession; (2) provides leadership, direction, and oversight of Agency-wide HR activities that support the IHS organization and programs; (3) develops and maintains strategic and operational HR plans to ensure a current and future work force for management, program delivery, and administrative support systems; (4) furthers the Agency's Indian Preference by ensuring compliance with Indian Preference statutory and policy requirements; (5) develops, promulgates, and administers Agency HR guidelines, and instructions in accordance with Office of Personnel Management (OPM), HHS, Public Health Service policies and the Indian Health Care Improvement Act (IHCIA), as amended; (6) ensures consistency in recruitment, training, and development applications, approaches, and outcomes by administering an Agency-wide HR system of functional responsibility, authority, and accountability; (7) issues standards to monitor and evaluate all IHS training and development activities and ensures that expenditures for recruitment, training, and development support the Agency's mission and goals; (8) provides Agency-wide policy guidance, consultation, and technical assistance on all IHS HR management, recruitment, and retention activities; (9) manages Agency work force information and conducts analyses, including trends analysis and forecasting necessary for Agency HR planning, management, and evaluation; (10) administers an Agency-wide information clearinghouse on HR recruitment, training, and development that serves all IHS organizations and Tribal health programs; (11) oversees the programs authorized under IHCIA Section 1612, administering the Agency-wide scholarship, loan repayment, professional recruitment and retention, training, and development systems; (12) administers human resources management operations and services for HQ organizational units; (13) ensures a safe, healthy, and productive work environment for IHS personnel to carry out their assigned duties and responsibilities, and that HR factors are part of the Agency's decision making processes; (14) establishes and maintains liaison and coordination with a variety of public and private organizations to provide the IHS with up-to-date HR recruitment, management, training, retention and development technologies; (15) ensures that organization and program changes involve assessments of appropriate HR requirements, including work design, knowledge, skills, abilities, and work load; (16) prepares reports and studies reflecting IHS HR activities in response to the Congress, other Federal agencies, and Tribal Governments; and (17) provides leadership and direction to the IHS Regional HR Offices; (18) manages recruitment and performance management activities for Senior Executive Service positions; and (19) participates in cross-cutting issues and processes, including but not limited to, emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Division of Personnel Security and Ethics (DPSE) (Gxxxx)

(1) Advises the IHS Director and IHS management and supervisors of appropriate corrective and remedial actions to address or correct improprieties by Agency employees; (2) directs and provides leadership in the formulation of plans, guidance and evaluation of the IHS Personnel Security and Drug Testing Programs; (3) manages and directs the IHS "Ethics Program", including the implementation of all ethics requirements, providing advice to the Agency on actions necessary to ensure compliance with ethics laws and policies, reviewing and approving public financial disclosure statements, supervising and auditing the confidential financial reports filed by regular and special government employees, reviewing and clearing all requests for approval of outside activity and requests to accept travel expenses from non-Federal sources, and training Agency employees on ethics statutes and regulations; (4) servesas the Agency liaison

with all outside investigative organizations related to personnel matters, such as the Office of Special Counsel, the Government Accountability Office (GAO) and the Office of Inspector General (OIG); and (5) administers and coordinates the IHS personnel security program including, administering and coordinating all background checks and adjudicates findings, coordinating with OPM on tracking background checks for all Agency personnel, and provides guidance for determining position sensitivity in accordance with OPM requirements for position sensitivity and public trust.

Division of Commissioned Personnel Support (DCPS) (Gxxxx)

(1) Acts as the liaison between IHS and the Office of the Surgeon General (OSG), Division of Commissioned Corps Personnel and Readiness (DCCPR), and Division of Systems Integration; (2) advises the IHS Director, Senior Staff, HQ Office Directors, Area Directors, supervisors, administrators, managers, officers and dependents regarding commissioned personnel benefits, policies, procedures, and regulations, as the IHS primary point of contact for commissioned personnel management; (3) develops Agency policies, procedures, and recommendations to Agency senior leadership regarding commissioned personnel management and provides recommendations to DCCPR regarding Commissioned Corps policy; (4) provides direct support to the IHS Director and/or the Agency representative to the Surgeon General's Policy Advisory Council; (5) evaluates learning needs, produces resource materials and conducts training sessions on commissioned personnel issues for officers, supervisors, and commissioned personnel specialists in IHS Area Offices; (6) manages the Agency honor and service awards program for commissioned personnel; (7) facilitates and monitors the progress of Agency commissioned personnel adverse actions to assure accurate and timely completion; (8) prepares reports reflecting IHS Commissioned Corps activities in response to requests from Agency leadership, Congress, other Federal agencies, and Tribal Governments; (9) reviews and processes all commissioned personnel actions for the Agency; (10) develops and manages all Agency commissioned personnel direct access positions; (11) provides oversight and coordination of Temporary, Permanent, and Exception Proficiency Promotion processes; (12) acts as a subject matter expert and advises Agency travel officials on commissioned personnel travel and Joint Travel Regulations; (13) coordinates with DCCPR on all Agency deployment processes, obtains Agency approvals for officer deployments, and communicates with Agency leadership and officer supervisors on the status of deployment requests and operations; (14) facilitates and monitors all medical and compensation processes (including special pays) for accuracy, timeliness, and completion; and (15) advises Agency supervisors on the performance, discipline, and conduct of commissioned personnel.

Division of Human Resources Operations and Systems (DHROS) (Gxxxx)

(1) Provides overall leadership and direction for the IHS Headquarters HR program; (2) administers HR policies and regulations and develops Headquarters HR procedures as appropriate; (3) provides advice, consultation, guidance and assistance to IHS Headquarters Leadership on civil service HR issues, programs and policies; (4) provides leadership and direction to the IHS Regional HR Centers on HR systems; (5) manages the overall IHS personnel and pay action functions for civil service employees; (6) advises IHS leadership on HR systems solutions for IHS business needs; (7) provides project management for enterprise HR systems

and functional aspects of IHS public and internal web sites; (8) collaborates with business process owners to perform requirements analysis, selection, testing, implementation, deployment, and support and recommend future enhancements for HR systems and reporting solutions; (9) analyzes HR metrics/benchmarks, business practices, processes, and programs to enable the organization to make better decisions concerning our human capital resources; (10) provides HR advice regarding core operational functions and services (in the areas of strategic recruitment, staffing, delegated examining, position classification, payroll, timekeeping, performance management, awards, and Federal benefit programs), strategic human capital and workforce planning, succession planning, e-government HR initiatives and strategic planning for IHS HQ Offices; (11) provides advice, consultation, guidance and assistance to HQ Office Directors, management officials, employees and other customers on HR operational services, programs, and policies; (12) interfaces with staff of the other OHR Divisions and Branches to provide for a full range of HR operational services to the HQ; and (13) complies with Indian Preference statutory and policy requirements in HR practices.

Division of Workforce Relations and Policy (DWRP) (Gxxxx)

(1) Develops, administers and evaluates OHR policies for Agency-wide use and provides leadership to ensure implementation; (2) provides advice, consultation, guidance and assistance to IHS Leadership on OHR issues, programs and policies; (3) provides advisory and consulting services to IHS Leadership and Areas on policy and programs designed to recruit, compensate, and retain a highly qualified, motivated, and diverse workforce; (4) provides support and assistance to IHS leadership with planning and preparing IHS workforce programs; (5) responsible for the management of OHR delegations of authority; (6) develops and provides guidance and oversight for policy for Title 5 employment mechanisms, and coordinates HR programs and policies with HHS; (7) manages the IHS Labor-Management Relations program to include representing the IHS in matters involving labor organizations; (8) manages the IHS Employee Relations program, developing ER-related policies and guidance, providing training, and representing the IHS before third parties; and (9) responds to a variety of OHR issues and cases that arise from the IHS HQ and Areas that are precedent-setting, controversial, and/or require sensitive handling.

Regional Human Resources Offices (RHRO) (Gxxxx)

Western Region (Gxxxxx); Northern Plains Region (Gxxxxx); Southwest Region (Gxxxxx); Navajo Region (Gxxxxx); Southeast Region (Gxxxxx)

(1) Provides overall leadership and direction for the IHS HR program within the established Region; (2) administers HR policies and regulations and provides leadership to ensure implementation; (3) provides advice, consultation, guidance and assistance to Area Directors, management officials, employees and other customers on civil service HR issues, programs and policies; (4) provides leadership and direction to the HR staff throughout the Region; (5) assures compliance with Indian Preference statutory and policy requirements in HR practices; (6) provides HR services throughout the Region, to include, but not limited to, strategic human capital and workforce planning, succession planning, E-government HR initiatives and strategic planning, HR program evaluation and oversight; strategic consultation, management advisory services, HR leadership, classification and pay administration, staffing and placement, personnel

and payroll action processing, labor-management and employee relations, benefits administration and performance management; (7) provides advice, consultation, and assistance to management and when requested to Tribal officials on Tribal health program HR issues; (8) plans, administers and evaluates HR programs; (9) plans and implements HR responsibilities for IHS programs covered by the Region's appointing authority; and (10) represents the Region in matters involving HR program responsibilities.

Division of Recruitment and Outreach (DRO) (Gxxxx)

(1) Develops and implements goals, objectives, and priorities to support IHS programs to recruit and retain health care professionals and coordinates these activities with the respective disciplines and/or national council; (2) assesses professional staffing needs and coordinates the development of recruitment and retention strategies through national marketing, social media, and professional sourcing outlets; (3) provides research and analysis functions related to recruitment and retention of health professionals; (4) generates and tracks applicant leads through various marketing sources in collaboration with IHS Regional offices, Areas, and recruiters; (5) assesses recruitment strategies and provides workforce planning data and reports on key metrics for data driven decision making and cost savings; (6) conducts workforce data analyses, including trends and projections, identifying workforce needs by personnel systems, categories, and disciplines; (7) conducts national/global recruitments for health professional positions; (8) provides advice, consultation, and guidance regarding national recruitments and outreach strategies; (9) manages, advises, develops, and administers student Pathways program recruitments IHS-wide; and (10) develops the IHS program to recruit and retain health care professionals, in accordance with policies and guidance provided by the DWRP.

Office of Finance and Budget (OFB) (Gxxxx)

(1) Develops and prepares the budget submission for for all IHS appropriations/accounts to HHS, OMB and the Congress (Presidents Budget); (2) participates with HHS officials in budget briefings for the OMB and the Congress; (3) distributes, coordinates, and monitors resource allocations; (4) develops and implements budget, fiscal, and accounting procedures and conducts reviews and analyses to ensure compliance in budget activities in collaboration with Headquarters officials and the Tribes; (5) provides cost advisory and audit resolution services in accordance with applicable statutes and regulations; (6) supports the Agency's Medicare Cost Report efforts by providing necessary financial data to the contractor preparing the cost reports; and (7) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations, and resolution of audit findings as may be needed and appropriate.

Division of Audit (DA) (Gxxxx)

(1) Develops and recommends policies and procedures for Chief Financial Officer (CFO) audits; (2) develops and recommends policies and procedures for Tribes and Tribal organizations audit resolution within IHS; (3) provides advice, technical consultation, and training to IHS Headquarters, Area Offices, Tribal, and Urban Indian Health organizations for Title I, Title V, and Agency CFO audits; (4) provides audit resolution services in accordance with applicable statutes and regulations; (5) advises the Director, OFB, of proposed legislation, regulations, directives, and timelines that will affect audits within IHS, as well as how current legislation affects

handling of audit-related issues; (6) manages the IHS Division of Audit Resolution Management Information System (DARMIS) and the OIG Stewardship Reports and conducts analysis of data for reports and/or responses to internal and external inquiries; (7) serves as the IHS contact point to the HHS for the DARMIS, OIG Stewardship Reports, and the HHS Agency Financial Report; (8) coordinates the collection of disallowed costs cited in Tribes' and Tribal organizations audits; (9) coordinates the correction of all findings coded by the HHS in Tribes' and Tribal organizations' audits; (10) coordinates receipt of audits from all organizations funded by IHS; (11) coordinates corrective action plans for CFO audit deficiencies and provides status updates to the IHS Headquarters' senior managers and to the HHS; (12) coordinates resolution of deficiencies with IHS Headquarters' senior managers and Area Directors; (13) administers the Agency's internal control program in compliance with the Federal Managers' Financial Integrity Act, OMB Circular No. A-123, and other applicable requirements; and (14) coordinates and performs Contract Support Costs litigation claim analyses.

Division of Budget Formulation (DBF) (Gxxxxx)

(1) Interprets policies, guidelines, manual issuances, OMB circulars, and instructions from Congress, OMB, HHS, and IHS on formulation of preliminary, Departmental, and Congressional budget requests for all IHS appropriations/accounts; (2) directs the collection, review, and analysis of program and financial data from Headquarters, Area Offices, Tribes, Tribal and Urban Indian Health organizations used in determining resource requirements; (3) coordinates the Agency's Tribal budget consultation process ; (4) coordinates the preparation of the IHS preliminary, Departmental and Congressional budget justifications for all IHS appropriations/accounts; (5) prepares witness information for hearings before the House and Senate Appropriations Committees, House Resource Committee on Interior and Insular Affairs, the Senate Committee on Indian Affairs, and other Congressional committees as requested; (6) coordinates development of responses and inserts to be used for the record by and for Congressional appropriations hearings; (7) coordinates development of briefing materials in response to Congressional concerns and hearings; and (8) develops, implements, and maintains IHS policies and procedures for Congressional budget liaison activities.

Division of Budget Execution (DBE) (Gxxxx)

(1) Interprets policies, guidelines, and directives from Congress, OMB, Government Accounting Office (GAO), Treasury, and the HHS on Tribal shares and execution; (2) recommends and coordinates IHS-wide Area Budget Execution; (3) prepares apportionment requests for all IHS appropriations/accounts; (4) consults with Headquarters officials on and issues Area funding allocations; (5) monitors fund control at the appropriation level; (6) reviews IHS Headquarters memorandum of agreements for proper accounting; (7) provides fund certifications; (8) prepares reprogramming requests; (9) advises the Director, OFB on Agency compliance with self-determination policies, administrative procedures, and guidelines; (10) coordinates activities for resolution of budget execution issues with appropriate IHS Headquarters and Area staff; (11) analyzes various operating costs and provides Program Support Center (PSC) with Area breakouts; (12) manages and processes Intra-Governmental Payment and Collection transactions; and (13) prepares and responds to Budget Data Requests from HHS and OMB.

Division of Financial Systems (DFS) (Gxxxxx)

(1) Provides detailed data and analysis required to support IHS cost accounting activities; (2) coordinates with the Federal Enterprise Systems Management (FESM) within the HHS Office of Finance and to support the Unified Financial Management System (UFMS) change and release management process; (3) designs and develops training materials for the UFMS, HHS Consolidated Acquisition Solution (HCAS), and Financial Business Intelligence System (FBIS), and schedules and executes training for relevant users; (4) provides technical support to analyze reconciliation programs, reports, and extracts, and collaborate and develop solutions to ensure accurate information is available for Agency reconciliation activities; (5) provides direct support, expertise, and coordination to ensure successful implementation of new software, upgrades to existing software, and technical and functional application changes within UFMS, HCAS, FBIS, and interfacing applications; (6) supports end users of UFMS, HCAS, and FBIS to resolve technical and functional issues encountered through use of the applications; and (7) plans, directs, and coordinates the month-end and year-end closing and opening of UFMS.

Division of Financial Operations (DFO) (Gxxxx)

(1) Manages the IHS travel program, provides training, interprets travel regulations, conducts reviews and updates travel policy and procedures; (2) processes Headquarters travel orders and vouchers, including permanent change of station; (3) reviews and manages Agency-wide requests for travel allowances that require special approvals, such as international travel; (4) coordinates the conference management functions related to travel for the Agency; (5) provides support and technical assistance to Headquarters operational components in the development and maintenance of Headquarters operations budgets; (6)) recommends Headquarters funding allocations; (7) performs fund certification for Headquarters ; (8) monitors the status of Headquarters funds and assists with reconciliations and resolution of discrepancies; and (9) reviews and processes Headquarters vendor payments.

Division of Financial Policy and Reporting (DFRP) (Gxxxx)

(1) Reviews, interprets, and comments on policies, guidelines, and manual issuances of Congress, Treasury, the Government Accountability Office (GAO), the HHS, and the IHS on systems of fiscal management, including the Unified Financial Management System (UFMS); (2) develops Agency-wide policies, procedures, and standards for financial management areas such as cash management, debt management, and payment and disbursement activities and functions; (3) prepares quarterly and annual financial statements, monitors budgetary and proprietary accounts, and performs reconciliations to meet statutory and regulatory requirements; (4) assures the adequacy of IHS internal controls related to financial management; (5) specializes in the analysis and reporting of accounting data, preparation and distribution of financial reports, audited financial statements, financial statement notes, and supplemental information.

Division of Third Party Reimbursements (DTPR) (Gxxxx)

(1) Serves as the primary focal point for Agency-wide business office program operations and policy issues; (2) provides consultation to Headquarters and Area Offices and is liaison to Tribal organizations, HHS and Office of Management and Budget (OMB) regarding business office issues; (3) reviews and implements strategies to improve the efficiency of access to resources

and provides support for local capacity building through technical assistance, training, consultation and information systems support; (4) develops, disseminates, and maintains business office policy and procedures manuals; (5) provides national leadership for Medicare, Medicaid, and private insurance reimbursement policy and procedures; (6) serves as the primary liaison with the Center for Medicare & Medicaid Services for rate setting; (7) serves as the focal point regarding the impact of existing and proposed laws, regulations and policies of Medicare and Medicaid managed care activities, including the review, evaluation, and monitoring of Sections 1115 and 1915(b) Medicaid waiver proposals and other State and Federal health care reform activities; (8) provides programmatic management, review and analysis of information systems for patient registration and billing and collections systems; (9) assures training on operations, various regulatory issues and negotiated managed care provider agreements; and (10) develops third-party budget materials and responds to Tribal, Congressional and HHS inquiries relating to third-party issues.

Office of Grants and Acquisitions (OGA) (Gxxx)

(1) Develops, recommends, and oversees the implementation of policies, procedures and delegations of authority for the acquisitions and grants management activities in the IHS, consistent with applicable regulations, directives, and guidance from higher echelons in the HHS and Federal oversight agencies; (2) fulfills the Agency Head of Contracting Activity responsibilities; (3) fulfills the Agency Grants Management Officer responsibilities; (4) manages the acquisitions and grants training programs; (5) manages the acquisitions and grants systems; and (6) coordinates the processing of Inter- and Intra-agency Agreements as well as Memoranda of Understanding.

Division of Acquisitions Management (Gxxxxx)

(1) develops, recommends, and oversees the implementation of policies, procedures and delegations of authority for the acquisitions management activities in the IHS, consistent with applicable regulations, directives, and guidance from higher echelons in the HHS and Federal oversight agencies; (2) advises the Chief Operating Officer and other senior staff of proposed legislation, regulations, and directives that affect contracting in the IHS; (3) provides leadership for compliance reviews of all IHS acquisition operations; (4) oversees completion of necessary corrective actions; (5) manages for the Agency, the HHS acquisition training and certification program; (6) supports and maintains the IHS Contract Information System and controls entry of data into the HHS Contract Information System; (7) serves as the IHS contact point for contract protests and the HHS contact for contract-related issues; (8) reviews and makes recommendations for approval/disapproval of contract-related documents such as: pre- and post-award documents, unauthorized commitments, procurement planning documents, Justification for Other Than Full and Open Competition waivers, deviations, and determinations and findings that require action by the Agency Head of the Contracting Activity, or the Office of the Secretary; (9) processes unsolicited proposals for the IHS; (10) coordinates the IHS Small Business programs; (11) oversees compliance with the Buy Indian Act; and (12) manages the processing of Inter- and Intra-agency agreements as well as Memoranda of Understanding.

Division of Grants Management (Gxxxxx)

(1) Directs grants management and operations for the IHS; (2) awards and administers grants and cooperative agreements for IHS financial assistance programs; (3) provides assistance for the resolution of audit findings for grant programs; (4) manages for the Agency, the HHS grants training and certification program; (5) continuously assesses grants operations; (6) oversees completion of necessary corrective action plans; (7) reviews and makes recommendations for improvements in grantee and potential grantee management systems; (8) serves as the IHS liaison with the HHS and the public for grants and other financial assistance programs within the IHS; (9) maintains the Catalog of Federal Domestic Assistance for IHS financial assistance programs; (10) conducts grants-related training for IHS staff, grantees, and potential grantees; (11) coordinates payment to grantees, including scholarship recipients; and (12) establishes and maintains the IHS automated Grants Information System and controls data entry into the HHS automated Grants Information System.

Office of Information Technology (OIT) (Gxxx)

(1) Provides Chief Information Officer (CIO) services and advises the Director, Indian Health Service (IHS), on all aspects of information resource management and health information technology (HIT) in compliance with related Federal laws, regulations, and policies; (2) directs the development, implementation, and maintenance of policies, procedures, standards, and architecture for information resource management, technology activities, and services in the IHS; (3) directs strategic planning and budgeting processes for information resources and technology; (4) leads IHS efforts in developing and implementing information resource and HIT management initiatives in IHS; (5) provides executive leadership and direction for health informatics throughout IHS; (6) directs the design, development, acquisition, implementation, operations, maintenance, and support of robust information systems and services used in the IHS; (7) directs the activities of the IHS Information Technology Investment Review Board (ITIRB) in assessing, implementing, and reviewing the Agency's information systems; (8) contracts for information resource and technology-related software, equipment, and support services in collaboration with appropriate acquisition authorities; (9) provides project management support for information resource and technology initiatives; (10) directs the development, implementation, and management of the IHS IT Security program to protect the information resources of the IHS; (11) provides IT services and support to IHS, Tribal, and Urban Indian Health Programs (UIHP), including the Resource and Patient Management System (RPMS), Electronic Health Record (EHR), and the National Patient Information Reporting System (NPIRS); (12) oversees the IHS Section 508 program; (13) represents the IHS through development and procurement management of IT/HIT agreements with Federal, Tribal, Urban, State and other organizations; and (14) develops, implements, and maintains policies for Health Information Management (HIM) and provides HIM program direction across the IHS; (15) provides liaison services with and develops strategies for presenting the IHS IT budget and services to the IHS, Tribal, and UIHP; (16) advises the Office of Human Resources and Area IT programs on IT workforce issues, recruitment and training, (17) oversees the development and maintenance of the IHS enterprise architecture; and (18) participates in cross-cutting issues and processes including, but not limited to, emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations, and resolution of audit findings as may be needed and appropriate.

Division of Health Information Technology (DIT) (Gxxxx)

(1) Provides Chief Technology Officer IT services and advises the CIO on all aspects of HIT; (2) develops clinical and business practice healthcare applications such as the RPMS and the EHR; (3) develops, implements, and supports health data interoperability applications and services; (4) develops, implements, and supports patient engagement and patient access applications and services; (5) develops healthcare statistical and quality reporting applications for NPIRS; (6) obtains system and business requirements from stakeholders for system design; (7) focuses on improving the HIT systems user experience to improve the usability and adoption of HIT; (8) provides quality assurance and risk management for software development; (9) supports enterprise wide implementations and enterprise wide support of HIT systems including deployment, configuration, and administration of IHS EHR systems; (10) ensures IHS IT infrastructure resource consolidation and standardization efforts support IHS healthcare delivery and program administration; (11) participates in cross-cutting issues and processes that involve HIT; (12) supports IHS program offices in ensuring compliance with Federal certification and accreditation requirements for HIT; and (13) represents the IHS to Federal, Tribal, Urban, State, and other organizations.

Division of Healthcare Information and Informatics (DHI) (Gxxxx)

(1) Provides Chief Health Informatics services and advises the CIO on all aspects of health informatics; (2) shapes the future of IHS clinical information systems through deliberate application of health informatics and HIT to deliver solutions that transform health care delivery; (3) provides leadership, direction, facilitation, and coordination for clinical informatics activities throughout IHS and coordinates Clinical Application Coordinator (CAC) activities across the enterprise; (4) facilitates and coordinates inter-agency agreements, federated trust agreements, contracts, and third-party clinical informatics services (i.e., ePrescribing, health information exchange, release of information, etc.) in support of the Agency's health informatics and HIT requirements; (5) provides leadership, strategic direction, and support for the IHS' efforts at modernization HIT; (6) supports the programmatic requirements for clinical information systems, with emphasis on the development and deployment of HIT solutions; (7) ensures alignment of Agency health informatics requirements and policies with Federal privacy and security laws, regulations, and policies; (8) provides education and mentoring to Federal, Tribal, and Urban stakeholders to accelerate the use of data for clinical operations, performance improvement, and decision making; (9) supports Agency quality initiatives, including developing measures to track clinical and other outcomes aligned to evidence-based practice; (10) leads IHS efforts to improve the adoption and meaningful use of HIT; (11) provides subject matter expertise and oversight of International Classification of Diseases (ICD) Coding System and other medical nomenclature implementation; and (12) represents the IHS to Federal, Tribal, Urban, State, and other organizations.

Division of Project Management and Budget (DPMB) (Gxxxx)

(1) Advises the CIO on all business aspects of information resources and project management; (2) develops and maintains the IHS enterprise architecture; (3) develops the IHS IT budget and related documents; (4) provides budget analyses and reports to the CIO; (5) provides technical analyses, guidance, and support for IHS capital planning and investment control activities; (6) manages the IHS portfolio management tool; (7) manages the activities of the IHS ITIRB in

assessing, implementing and reviewing the Agency's information systems; (8) identifies alternatives among internal and external sources and recommends the best sources to supply information resource and technology products and services to IHS; (9) develops information resource and technology project governance structures, policies, and procedures to support effective project management; (10) provides project management and related support for IHS developed and acquired information resources and technology products and services; (11) provides centralized IT acquisition guidance for all IT/HIT procurement actions; (12) provides contract management support for IT initiatives; (13) provides contract liaison services to appropriate acquisition authorities; (14) provides enterprise software licensing support for IHS; (15) serves as IHS' Section 508 program for compliance assurance, policy-setting on accessibility requirements, and the use of accessibility tools; (16) participates in cross-cutting issues and processes that involve IT; (17) responsible for the procurement management of IT/HIT agreements; and (18) represents the IHS to Federal, Tribal, State, and other organizations.

Division of Information Technology Operations (DITO) (Gxxxxx)

(1) Advises the IHS CIO on all matters related to IHS IT infrastructure support services including data center services, network operations, telecommunications services, messaging services, web services, and the IT national service desk (including HQ user support) services; (2) provides data center support services by hosting HIT, enterprise and administrative applications utilized by health care facilities throughout the IHS; (3) provides network operations support services that provides for network connectivity for Federal, Tribal, and Urban healthcare facilities; (4) provides enterprise-wide messaging services; (5) provides web services by developing and sustaining the IHS internet web presence including web based applications used for engagement and interaction; (6) provides enterprise wide service desk services by providing 24 x 7 IT-related support services; (7) participate in cross-cutting technology improvements and process that involve information resources and enterprise technology project management services; and (8) represents the IHS to Federal, Tribal, State, and other organizations.

Division of Information Security (DIS) (Gxxxxx)

(1) Provides the Chief Information Security Officer (CISO) cybersecurity services and advises the CIO on all aspects of IT and HIT information security; (2) provides agency-wide leadership in maintaining and improving the availability, confidentiality and integrity of data maintained in the Agency's information systems; (3) develops and maintains enterprise-wide information security governance, policies, procedures, and guidelines to safeguard information and IT systems; (4) develops and oversees a risk management framework process for the Agency; (5) maintains and serves as the Agency's official repository for Plans of Action and Milestones (POA&M) to address weaknesses disclosed by Federal Information Security Management Act (FISMA) reviews, audits, security authorizations and Federal Managers Financial Management Integrity Act (FMFIA) annual certifications related to IT security matters; (6) provides system security engineering support to system owners and developers, and maintains cybersecurity process coordination within the Agency's System Development Life Cycle (SDLC); (7) assembles and validates security authorization packages and makes recommendations to the CIO and the IHS Authorizing Official; (8) coordinates activities with internal and external organizations reviewing IT information resources for fraud, waste, and abuse; (9) defines cybersecurity

curricula and provides specialized security training for the Agency's technical staff and general security awareness/orientation training required of all Agency employees; (10) manages and coordinates agency-wide IT security incident identification, reporting and response activities, and serves as the cybersecurity liaison with the Office of General Counsel, US Computer Emergency Response Team (US-CERT), the Federal Bureau of Investigation, Office of Inspector General and other external law enforcement agencies concerning IT security incident reporting and follow-up activities; (11) develops and oversees an enterprise-wide disaster recovery and contingency planning framework for IT systems; (12) monitors acquisition and budget execution for operational cybersecurity programs and projects to ensure fiscally responsible usage of funds; (13) participates in cross-cutting issues and processes that involve IT; and (14) represents the IHS to Federal, Tribal, Urban, State, and other organizations.

Office of Administrative Services (OAS) (Gxxxx)

(1) Administers physical security, facility management, space management services, parking management, including the employee transit subsidy program, the IHS mail and commercial printing programs, and HSPD-12 badge issuance for Headquarters; (2) coordinates with OIT to provide telecommunication services to Headquarters; (3) serves as liaison with the HHS and the GSA on logistics issues affecting the IHS; (4) provides guidance and oversight to the IHS on the control and safeguard of classified national security information; (5) plans, develops and administers the IHS-wide Homeland Security Presidential Directive 12 (HSPD-12) program to include providing leadership on the Physical Access Control Systems, and the Physical Security Program; (6) provides special transportation and security; (7) provides leadership and guidance for the IHS Forms Management Program; (8) provides leadership and coordination in the planning, development, operation, oversight, and evaluation of special office support projects for office relocations, and inter-and intra-agency activities; (9) plans, develops, and administers the IHS policies on supply management in conformance with Federal supply management laws, regulations, policies, procedures, practices, and standards; (10) interprets regulations, policies, procedures, practices and standards, and provides advice on execution and coordination of supply management policies and programs; (11) administers management systems and methods for planning, utilizing, and reporting on administrative supply management programs, including the IHS supply accountability and controls systems; (16) conducts surveys and studies involving evaluation and analysis of the supply management activities IHS-wide; (17) maintains liaison with the HHS and the GSA on supply management issues and programs affecting the IHS; ; (20) plans, develops, and administers the IHS personal property management program in conformance with Federal personal property management laws, regulations, policies, procedures, practices, and standards; (21) interprets regulations and provides advice on execution and coordination of personal property management policies and programs; (22) administers management systems and methods for planning, utilizing, and reporting on personal property programs, including the precious metals recovery program and IHS personal property accountability and control systems; (23) provides guidance and serves as principal administrative authority on Federal personal property management laws, regulations, policies, procedures, practices, and standards, in conjunction with the OGC; (24) conducts surveys and studies involving evaluation and analysis of the personal property management activities IHS-wide; (25) maintains liaison with the HHS and the General Services Administration (GSA) on personal property management issues and programs affecting the IHS; (26) plans, develops and administers the IHS Fleet Management Program; (27) prepares reports on IHS personal property activities; and (28) administers

the local Headquaraters personal property management program to include receiving, tagging, storage and disposal in addition to conducting the annual inventory for all HQ locations.

Office of Enterprise Risk Management and Internal Controls (OERMIC) (Gxx)

(1) Coordinates with key Headquarters Offices to ensure cross cutting agency strategic planning, enterprise risk management (ERM), and management of internal control across IHS; (2) ensures IHS' portfolio of enterprise risks are appropriately and effectively managed by identifying accountable individual risk owners; (3) provides the Agency Chief Risk Officer to advise on risk management and provide expertise, advice, and assistance to the Director, IHS, Office Directors, Area Directors and other key staff at both Headquarters and Area levels on ERM matters; (4) develops goals and objectives for the ERM program, integrates them with broader IHS-wide strategic goals/objectives, and tracks progress toward achieving them; (5) evaluates and monitors systems of internal control across IHS and uses the assessments of the internal control program as an integral part of ERM to effectively manage risks across IHS.

Associate Director Quality (ADQ) (Gxx)

The Associate Director Quality (ADQ): (1) provides operational and management information and expertise necessary for the formulation of quality policies, goals and objectives, and operational strategies, and in program and resource allocation decisions which impact the quality approach for the organization. (2) Works to identify issues, deficiencies, and requirements to be used as a basis for planning new programs, the expansion, contraction, or elimination of ongoing programs, and for determining program effectiveness through evaluation, which includes the utilization of data analytics and reporting. (3) Proactively evaluates current state, existing compliance, quality, risk, reliability, and safety information in an actionable value-driven manner to better facilitate sound decision making, to better focus priorities, and to develop forward-looking policies. (4) Advises the IHS Director on strategies that will position the IHS as a leader in the provisioning of safe and high quality care delivery in the backdrop of reform and the context of the healthcare community. (5) Leverages best industry practices to accelerate needed organizational change. (6) Acts on behalf of the IHS Director on expert panels, and in negotiations to reconcile conflicting policies and assures utilization of all possible resources, including those gained through collaborative efforts with other HHS Operating Divisions. (7) Interacts with or represents HHS Agency and Department officials as well as high level representatives of other Federal Agencies, including the National Indian Health Board, the Office of Management and Budget (OMB), the Congress, States, Tribal and inter-Tribal Governments, and other individuals and groups active and influential in shaping opinions, policies and actions in Indian health. (8) Manages mission, organization programs and compliance requirements of health care delivery systems, and directs health care programs at a national level. (9) Oversees, directs, and guides healthcare management areas to influence and provide input on healthcare policy and plans, workforce management, strategic planning, risk management and budget for the IHS health care delivery system. (10) Advises the IHS Director on intersecting clinical and business processes, medical quality assurance, quality improvement methods, and application of improvement science. (11) Derives evidence-based decisions that lead to quality results by applying critical thinking, performance measurement system and communication methods, calculating risks, and understanding customer expectations and demands. (12) Integrates information sources for organizational performance improvement through data analysis

from quantitative and qualitative sources and research studies, display and interpretation of data dashboards, and Health Information Technology and Health Information Exchange resources, including data networks, database management, and operating systems and interfaces.

Office of Quality Health Care (OQHC) (Gxxx)

(1) Implements and routinely updates the IHS Quality Framework, integrating feedback and inputs from various levels of the organization and Tribal/Urban Indian Health Programs partners; (2) oversees accreditation readiness activities and compliance with accreditation requirements for all IHS Direct Service facilities, to include periodic mock surveys and formal accreditation surveys; (3) conducts training and informational activities that promote skills development in quality improvement, quality assurance, and performance improvement; (4) routinely assesses and reports on patient satisfaction and experience using standardized survey instruments and processes, and facilitates improvement activities based on survey results; (5) coordinates and organizes participation of IHS facilities and staff in interagency quality improvement activities; (6) monitors quality improvement and assurance metrics for healthcare delivery processes and outcomes, and advises other IHS Offices on quality improvement methods to improve support and outcomes of IHS administrative functions and processes; (7) assess, address, and continuously improve systems and processes to reduce and improve patient wait times in all related healthcare settings; (8) consult on and provide guidance for standardization of healthcare delivery policies and protocols; (9) oversee patient safety management and reporting systems and processes, sentinel event investigations/root cause analyses, and clinical risk management; (10) oversee and manage credentialing of licensed independent practitioners via standardized methods and a uniform system; and (11) institutionalize patient-centered care processes, engagement of patients as partners in care, and patient activation through self-management support and involvement in delivery service improvements.

Division of National Credentialing (DNC) (Gxxxx)

(1) Manages credentialing standards and policy; (2) acquires and maintains centralized credentialing software system; (3) ensures unification of credentialing officers/prime source verification officers; (4) ensures standardized training and support resources for credentialing officers.

Division of Facility Standards and Compliance (DFSC) (Gxxxx)

(1) Manages and coordinates mock surveys; (2) ensures accreditation services coordination; (3) provides accreditation resource management; (4) provides survey corrective action plan development assistance and coordination; (5) manages accreditation and certification survey reports; (6) ensures multidisciplinary integration of survey readiness support activities; (7) ensures unification of Area Quality Managers and Service Unit QAPI Officers.

Division of Healthcare Facility Management (DHFM) (Gxxxx)

(1) Coordinates training and support resources for healthcare facility management staff; (2) standardizes position descriptions and competencies for management staff; (3) standardizes management tools and resources; (4) provides Just Culture model education, training and application; (5) provides leadership development and skill-building; (6) facilitates change management to support quality assurance and quality improvement.

Division of Clinical Risk Management (DCRM) (Gxxxx)

(1) Employs strategies that reduce the possibility of a specific loss; (2) systematically gathers and utilizes data; (3) implements proactive and reactive components to prevent losses and mitigates impact of losses; (4) implements strategies to reduce the risk of harm to patients, liability exposure of healthcare providers, and financial loss to the IHS; (5) performs incident identification and reporting; (6) identifies and addresses potential tort claims, sequestering medical records, and investigation of medical adverse events; (7) reviews patient grievances concerning quality of care; (8) performs sentinel event/root cause analysis review and documentation; (9) analyzes methods for dismissal of patients from care; (10) reviews outside requests for medical records; (11) responds to inquiries from governmental agencies, media, and advocacy groups; (12) ensures compliance with regulatory, accreditation, and contractual agreements; (13) examining issue related to determination of "standards of care"; (14) represents IHS when claims are presented for review by the Malpractice Claims Review Panel chartered by the Department of Health and Human Services; (15) maintains case files and a malpractice claims database; (16) provides case summaries, peer review, outcome information, and feedback of risk management recommendations; (17) disseminates information about the review process; (18) responds to outside organizations requesting tort claim-involvement histories on former employees; (19) assists providers with Malpractice Claims Review Panel; (20) submits payment reports to the National Practitioner Data Bank.

Division of Quality Improvement (DQI) (Gxxxx)

(1) Trains healthcare staff and support team members in the Model for Improvement to rapidly test small scale changes at the local level for improvement in clinical processes to improve patient outcomes, experience of care, and resource utilization; (2) leads change management for practice transformation to embrace new models of care delivery and to enhance efficiency of the care delivery process; (3) improves patient and staff satisfaction with healthcare service delivery; (4) establishes and monitors metrics to evaluate improvement efforts and outcomes and ensures all staff members understand the metrics for success; (5) builds capability in all staff to support improvement and ensure that patients, families, providers and care team members are involved in quality improvement activities; (6) optimizes use of health information technology and data to continuously improve performance, quality and service (Resource and Patient Management System and iCare); (7) implements and enhances patient empanelment to facilitate care management and population health; (8) develops continuous and team-based healing relationships in which roles are well defined and tasks are distributed among multidisciplinary care team members to reflect the skills, abilities and credentials of the individual team members; (9) fosters patient-centered interactions through expanded patient roles in decision making, health-related behaviors and self-management; (10) reduces barriers to accessing care through more efficient service delivery processes, alternative care delivery methods, expanded access to the care team, and appointment scheduling flexibility; (11) boosts care coordination through community resource linkages, integrating specialty care referral and coordination processes, assisting with referral-related processes, and assuring completion of all elements of care; (12) reduces all types of hospital acquired conditions through technological innovation, attention to detail, and implementation of high reliability science; (13) reduces

avoidable hospital readmissions through enhanced transition-of-care planning and coordination, communication with primary care, and management of community-based resource delivery.

Chief Medical Officer (CMO) (Gxx)

The Chief Medical Officer (CMO) (1) :serves as the primary source of national advocacy, policy development, budget development and allocation for clinical, preventive, and public health programs for the IHS, Area Offices, and Service Units; (2) provides leadership in articulating the clinical, preventive, and public health needs of AI/AN, including consultation and technical support to clinical and public health programs; (3) develops, manages, and administers program functions that include, but are not limited to, alcohol and substance abuse, behavioral health, chronic diseases such as diabetes, asthma, dental services, medical services, Health Promotion/Disease Prevention, domestic violence, pharmacy and pharmaceutical acquisition, community health representatives, emergency medical services, health records, disabilities, Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome, maternal health, child health, clinical nursing, public health nursing, women's health, nutrition and dietetics, and elder care; (4) investigates service delivery and community prevention evidence-based and best practice models for dissemination to community service locations; (5) expands the availability of resources available for AI/AN health by working with public and private entities as well as Federal agencies within and outside the HHS; (6) coordinates development of staffing requirements for new or replacement health care facilities and approves Congressional budget requests for staffing, in collaboration with the Office of Environmental Health and Engineering; (7) provides program oversight and direction for the facilities planning and construction process; (8) develops and coordinates various Health Initiative and Nursing grant programs; (9) provides the national focus for recruitment and retention of health professionals and coordinates with the scholarship and loan repayment programs; (10) works with the Contract Health Services (CHS) program on CHS denial appeals to the IHS Director and in determining CHS medical priorities; (11) manages the clinical (medical, nursing, pharmacy, dental) features of medical tort claims against the IHS; (12) works with the Office of Management Services in managing the clinical aspects of the IHS workman's compensation claims; (13) oversees IHS efforts in a variety of quality assurance and improvement activities, including patient safety; (14) monitors approximately one-half of the IHS's Government Performance and Results Act (GPRA) indicators, overseeing indicator development, data collection, and reporting results; and (15) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, border health initiatives, Tribal delegation meetings, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Office of Purchased and Referred Care (OPRC) (Gxxx)

(1) Plans, develops, and coordinates the PRC program and required business practices; (2) develops, disseminates, and maintains PRC policy and procedures manuals; (3) establishes eligibility criteria for Federal PRC benefits and determining PRC eligibility under such criteria; (4) formulates and monitors the PRC budget and distribution methodologies; (5) administers the Catastrophic Health Emergency Fund; (6) administers the PRC Quality Assurance Fund; (7) administers the PRC claims adjudication activity for the IHS Headquarters; (8) monitors the implementation of the IHS payment policy and reports the status to the Chief Medical Officer; (9) administers the IHS Fiscal Intermediary contract; (10) conducts data analysis and national utilization review and utilization management of PRC services rendered by private

sector providers; and (11) provides consultation to Headquarters and Area Offices, and responds to inquiries from the Congress, Tribes, and other Federal agencies.

Office of Diabetes Treatment and Prevention (ODTP) (Gxxxx)

(1) Plans, manages, coordinates, and evaluates a comprehensive clinical and community program focusing on type 2 diabetes in AI/AN communities; (2) plans, manages, develops, coordinates, and evaluates the Congressionally-mandated Special Diabetes Program for Indians, a large grant program focused on the prevention and treatment of diabetes; (3) coordinates and monitors contracts and grants with IHS, Tribal, Urban Indian health programs and other entities; (4) develops objectives, priorities and methodologies for the conduct of clinical and community diabetes programs; (5) monitors, evaluates, and provides consultation to clinical and community diabetes grant programs and other new initiatives; (6) provides leadership, professional guidance, and staff development to Area Diabetes Consultants, Model Diabetes Programs and IHS, Tribal, Urban diabetes program providers; (7) coordinates diabetes training needs for Area Offices, Service Units, and Tribes; (8) develops and implements IHS standards of care, clinical guidelines, policies, and procedures for diabetes and diabetes-related conditions; (9) coordinates model diabetes program sites; (10) develops and disseminates diabetes-related information and materials to IHS, Tribes and Urban Indian health programs; (11) is responsible for preparing budgetary data, analysis and program evaluations for budget presentations and Congressional hearings; and (12) coordinates a chronic disease strategic plan initiative for the IHS.

Office of Oral Health (OOH) (Gxxxx)

(1) Plans, develops, coordinates, and evaluates dental health programs; (2) establishes staffing, procedural, facility, and dental contract standards; (3) coordinates professional recruitment, assignment, and staff development; (4) represents dental staff and Area Dental Programs in personnel matters, including the monitoring of personnel orders for both appointments and transfers, establishing promotion priority lists, processing special pay and retention bonus contracts, and serving as the HQ representative on adverse action cases; (5) improves effectiveness and efficiency of dental programs; (6) develops resource opportunities and monitors utilization of resources for dental health programs; (7) formulates, allocates and analyzes dental program budget and prepares information for program and budget presentations as well as Congressional inquiries; (8) advocates for oral health needs of the AI/AN population; (9) coordinates health promotion and disease prevention activities for the dental program; (10) monitors oral health status and treatment needs of the AI/AN population; (11) provides clinical and technical support to field staff by way of oral health surveys, provision of clinical trials, consultation on treatment cases, publication of quarterly newsletters and serving as liaison with public and private institutions, as well as major universities to evaluate new and existing strategies for addressing oral health problems in AI/AN; (12) serves as the IHS liaison for oral health issues with other Federal agencies; (13) serves as main source of information transfer to field staff via mediums including, but not limited to, teleconference hookups, electronics (email/listservs), conventional mail and meeting attendance; and (14) maintains and distributes information from the IHS centralized dental database, including workload, program resource directories and exploring the applicability of new health informatics technologies and systems.

Office of Nursing Services (ONS) (Gxxxx)

(1) Plans, develops, coordinates, evaluates, manages and advocates for Clinical and public health Nursing Services, including acute care, ambulatory care, and public health nursing services, Women's Health, and Community Health Representative Programs (CHR); (2) identifies and establishes standards for these programs; (3) provides leadership, professional guidance, and staff development; (4) plans, develops, coordinates, manages, and evaluates nursing CHR education to better meet the needs of nursing and CHRs in Indian Health programs; (5) coordinates professional staff, including nursing recruitment, scholarship recipients, assignment and development to meet Area Office, Service Unit, and Tribal needs in accordance with IHS policies and procedures; (6) provides guidance in planning, developing, and maintaining management information systems that will benefit documentation and data collection by and for nurses and community health workers; and (7) prepares budgetary data, analysis and program evaluations and prepares information for program and budget presentations, as well as Congressional hearings.

Office of Behavioral Health (OBH) (Gxxxx)

(1) Applies identified profession and program standards, monitors and evaluates community and Area-wide services provided through grants or contracts with AI/AN Tribes, villages, organizations, and direct IHS operations for mental health, social services, and alcohol/substance abuse; (2) coordinates AI/AN community behavioral health programs including alcohol/substance abuse prevention and treatment, mental health, and social work with program directors, division staff, Area staff, and other agencies and institutions; (3) coordinates contracts and grants for behavioral health services and monitors services provided; (4) makes program and policy changes using data analysis, recommendations from operational levels, research results, and coordinates resource allocation from program policies; (5) provides behavioral health program consultation to AI/AN groups and IHS staff; (6) provides leadership in the identification of behavioral change interventions and supports implementation at the community level; (7) coordinates with Federal, State, professional, private, and community organizations on alternate health care resources; (8) works with other Federal agencies and departments to provide additional Federal resources for AI/AN behavioral health programs; (9) provides financial resources and programmatic oversight for complying with the Americans With Disabilities Act through programs such as the Indian Children's Program, and for elders through partnerships with the Administration on Aging and the National Indian Council on Aging; (10) measures and evaluates the quality of behavioral health care services; (11) manages the Tele-Behavioral Health Program; and (11) prepares information on behavioral health for budgetary hearings and provides program evaluation results to the IHS Director, the Congress, and the Administration.

Office of Clinical and Community Programs (OCCP) (Gxxxx)

(1) Manages, develops, and coordinates a comprehensive clinical, preventive and public health approach to clinical and community program focusing on maternal and child health, Indian children services including preventive health support services for medicine, nutrition, HIV/ AIDS, pharmacy, health records, health education, health promotion, and disease prevention; (2) develops objectives, priorities, and methodologies for the conduct and evaluation of clinical, preventive, and public health for community health-based programs; (3) provides, develops, and implements IHS guidelines, standards, policies, and procedures on clinical, preventive, and public health for community based programs and initiatives; (4) monitors, evaluates, and provides consultation to clinical and community programs; (5) plans jointly with other programs and divisions of the IHS and other agencies on research and

coordination of services; (6) coordinates professional staff recruitment and training needs, and scholarship recipient assignments and development to meet Area Office, Service Unit, and Tribal health professional human resource needs; (7) coordinates and monitors contracts and grants with IHS programs and other entities, in collaboration with the Division of Acquisitions Policy and the Division of Grants Operations; (8) develops and disseminates information and materials to IHS facilities and to Tribes and Urban Indian health programs; (9) develops program budget materials for resource management, program data collection, administrative system integrity and accountability and responds to Congressional and Departmental inquiries; and (10) manages the Veterans Affairs Pharmaceutical Prime Vendor Contract and IHS National Core Formulary.

Office of Telemedicine (OT) (Gxxx)

(1)

Associate Director Field Operations (ADFO) (Gxx)

The Associate Director Field Operations (ADFO): (1) oversees and supervises the IHS Area Offices; (2) oversees and supervises the Headquarters Office of Environmental Health and Engineering; (3) advises the Director and other senior staff on key activities, concerns, and needs that arise in the Areas and OEHE; (3) provides leadership and serves as liaison to the Area Directors to address issues, coordinate responses, manage deployment of Area staff to assist national or local efforts, and monitor Area and service unit procurements and budgets; and (4) provides expert advice and recommendations from the field perspective for initiatives, program needs, process improvements, etc. as requested.

Area Offices (AO) (Gxx)

Each Area Office: (1) plans, develops, directs program support to ensure the provision of preventive, curative and rehabilitative health services; (2) manages the transfer of programs, services, functions, and activities and related funding to Tribes through Title I Self Determination contracts; (3) builds partnerships with the Tribes within its region; and (4) assures Area Office and service unit compliance with all applicable laws, regulations, policies, etc. in carrying out operational duties.

Office of Environmental Health and Engineering (OEHE) (Gxx)

(1) Advises and supports the IHS Director on policy, budget formulation, and resource allocation regarding environmental health and engineering activities of IHS and Tribal facilities programs; (2) provides Agency-wide leadership and consultation to IHS, Tribal, and Urban Indian health programs on IHS goals, objectives, policies, standards, and priorities; (3) represents the IHS within the HHS and external organizations for purposes of liaison, professional collaboration, cooperative ventures, and advocacy; (4) serves as the primary source of technical advice for the IHS Director, Headquarters, Area Offices, Tribal, and Urban Indian health programs on the full scope of health care facilities acquisition construction and operations, sanitation facilities acquisition construction and management, environmental health services, environmental engineering, clinical engineering, and realty services management; (5) develops and recommends policies, administrative procedures and guidelines for Public Law 93–638 construction activities; (6) develops objectives, priorities, standards, and methodologies to conduct and evaluate environmental health, environmental engineering, and facilities

engineering and management activities; (7) coordinates the formulation of the IHS Facilities appropriation budget request and responds to all inquiries about the budget request and programs funded by the IHS Facilities appropriation; (8) maintains needs-based and workload-based methodologies for equitable resource distribution for all funds appropriated under the IHS Facilities appropriation; (9) provides leadership, consultation, and staff development to assure functional, safe, and well-maintained health care facilities, a comprehensive environmental health program, and the availability of water, sewer, and solid waste facilities for Indian homes and communities; (10) coordinates the IHS OEHE responsibilities in responding to disasters and other emergency situations, in collaboration with the Office of Clinical and Preventive Services; (11) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate; and (12) provides leadership, coordination and representation for the IHS Sustainability Program.

Division of Sanitation Facilities Construction (DSFC) (Gxxxx)

(1) Develops, implements, and manages the environmental engineering programs, including the Sanitation Facilities Construction (SFC) program, and compliance activities associated with environmental protection and historic preservation legislation; (2) provides Agency-wide management assistance and special support/ consultation to address special environmental public health problems for environmental engineering/ construction activities, and for compliance with environmental legislation; (3) works closely with other Federal agencies to resolve environmental issues and maximize benefits to Tribes by coordinating program efforts; (4) develops, implements, and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for SFC activities; (5) consults with Tribal groups/organizations in the development and implementation of SFC policies and initiatives, and in the identification of sanitation needs; (6) maintains a national inventory of current Tribal sanitation facilities needs, and past and present projects to address those needs; and (7) allocates financial resources Agency-wide based on need and workload using the national data inventories, in collaboration with the OFA.

Division of Facilities Operations (DFO) (Gxxxx)

(1) Develops, implements, and manages the programs affecting health care facilities operations, including the routine maintenance and improvement, real property asset management, realty, facilities environmental, staff quarters, and clinical engineering programs; (2) develops, implements, monitors and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for health care facilities operations; (3) serves as the principal resource for coordination of facilities operations and provides consultation to IHS and the Tribes on health care facilities operations; (4) maintains real property asset and quarters management systems; (5) maintains clinical engineering management systems; (6) maintains resources allocation methodologies for the Facilities appropriation Agency-wide based on supportable space and workload data; (7) maintains Agency-wide data on Federal and Tribal facilities for program budget justification; (8) develops and evaluates technical standards and guidelines for health care facilities operations; and (9) monitors the improvement, alternation, and repair of health care facilities.

Division of Facilities Planning and Construction (DFPC) (Gxxxx)

(1) Develops, implements, and manages the IHS Health Care Facilities Planning and Construction program, including the facilities planning process, facilities design process, facilities acquisition, and construction project management; (2) develops, implements, monitors, and evaluates Agency program activities, objectives, policies, plans, guidelines, and standardized data systems for health care facilities planning and construction; (3) develops and maintains construction priority systems, and with the Division of Engineering Services, develops project budget documents for the health care facilities construction program; (4) services as the principal resource in providing leadership, guidance, and coordination of health care facilities engineering activities for the IHS Headquarters, Area Offices, Tribal and Urban Indian health programs; (5) evaluates justifications for major improvement and alteration projects and other large scale construction activities; (6) develops and evaluates technical standards and guidelines for health care facilities construction.

Division of Environmental Health Services (DEHS) (Gxxxx)

(1) Develops, implements, and manages the IHS Environmental Health Services programs, including the Injury Prevention and Institutional Environmental Health programs to identify environmental hazards and risk factors in tribal communities and propose control measures to prevent adverse health effects; (2) serves as the primary source of technical and policy advice for IHS Headquarters and Area Offices on the full scope of environmental health issues and activities; (3) maintains relationships with other Federal agencies and Tribes to maximize responses to environmental health issues and maximize benefits to Tribes by coordinating program efforts; (4) provides leadership in identifying and articulating environmental health needs of AI/AN populations and support efforts to build Tribal capacity; (5) provides personnel support services and advocates for environmental health providers; (6) maintains, analyzes, make accessible, and publishes results from national databases; (7) manages resource allocation activities in accordance with established criteria based on workload; (8) develops and evaluates standards and guidelines for environmental health programs and activities; and (9) provide technical assistance and consultation to Federal and Tribal programs on a variety of program elements such as food safety, health housing, community facilities, community injury prevention, water quality, waste management, occupational safety in healthcare and non-healthcare institution, mass gatherings, vectorborne and communicable disease control, and emergency management.

Division of Engineering Services (DES) (Gxxxx)

(1) Administers the acquisition and project management of the design and construction of all IHS new construction health care facilities projects; (2) administers the acquisition of all IHS A/E services and construction contracts greater than $150,000, including maintenance and improvement, sanitation facilities construction, Medicare & Medicaid, Non-recurring Expense Fund, and other IHS-funded projects; 3) administers the Agency Lease Program, including the management of the Lease Priority System Committee, approval of all IHS space requests, and executing all Agency leases with GSA, and as authorized under P.L. 93-638 and P.L. 94-437, as amended; (4) serves as the source of engineering and contracting technical expertise for Agency programs/projects and other technical programmatic areas affecting the planning, design,

alteration, leasing, and construction of Agency health care and sanitation facilities for Indian homes and communities; (5) designated as the IHS Authority having Jurisdiction (AHJ) for all code interpretations required to resolve conflicts that arise from interpreting and applying various codes and other related criteria in all Agency facilities and design/construction projects.

Associate Director Intergovernmental Affairs (ADIA) (Gxx)

Office of Tribal Self-Governance (OTSG) (Gxxx)

Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS, under Title V of the Indian Self-Determination and Education Assistance Act, Public Law 93–638, as amended; (2) develops and recommends policies, administrative procedures, and guidelines for IHS Tribal self-governance activities, with maximum input from IHS staff and workgroups, Tribes and Tribal organizations, and the Tribal Self-Governance Advisory Committee; (3) advises the IHS Director on Agency compliance with self-governance policies, administrative procedures and guidelines and coordinates activities for resolution of problems with appropriate IHS and HHS staff; (4) provides resource and technical assistance to Tribes and Tribal organizations for the implementation of the Tribal Self-Governance Program (TSGP); (5) participates in the reviewing of proposals from Tribes for self-governance planning and negotiation grants and recommends approvals to the IHS Director; (6) determines eligibility for Tribes and Tribal organizations desiring to participate in the TSGP; (7) oversees the negotiation of self-governance compacts and annual funding agreements with participating Tribal governments; (8) identifies the amount of Headquarters managed funds necessary to implement the annual funding agreements and prepares annual budgets for available Tribal shares in conjunction with IHS Area and Headquarters components; (9) coordinates annual reconciliation of funding agreements with IHS Headquarters components, Area Offices, and participating Tribes; (10) serves as the principal IHS office for developing, releasing, and presenting information on behalf of the IHS Director related to the IHS Tribal self-governance activities to Tribes, Tribal organizations, HHS officials, IHS officials, and officials from other Federal agencies, State and local governmental agencies, and other agencies and organizations; (11) arranges national self-governance meetings to promote the participation by all AI/AN Tribes in IHS self-governance activities and program direction; (12) participates in meetings for Self-Governance Tribal delegations visiting IHS Headquarters; and (13) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolutions of audit findings as may be needed and appropriate.

Office of Direct Service and Contracting Tribes (ODSCT) (Gxxx)

(1) Assures that Indian Tribes and Tribal organizations are informed regarding pertinent health policy and program management issues; (2) assures that consultation and participation by Indian Tribes and organizations occurs during the development of IHS policy and decision making; (3) provides overall Agency leadership concerning functions and responsibilities associated with self-determination contracting (Title I of the Indian Self-Determination Act); (4) advises the IHS Director and senior management on activities and issues related to self-determination contracting; (5) monitors Agency compliance with self-determination policies, administrative procedures, and guidelines; (6) provides Agency leadership in planning and conducting a program of expert guidance, technical assistance, and

support to Indian Tribes that continue to receive their health services directly from the IHS; (7) administers a national grant program designed to assist Tribes and Tribal organizations in beginning and/or expanding self-determination activities; (8) provides Agency leadership in the development of policy; (9) discharges operational responsibilities, with respect to the contract support cost (CSC) program administered by the IHS; (10) provides advice to the IHS Director and senior management on Tribal issues and concerns by acting as liaison with Tribal leaders, national Tribal organizations, inter-Tribal consortiums and Area health boards; (11) provides leadership in the management process of receiving visiting delegations of Tribal leaders and representatives to IHS Headquarters and provides staff assistance to the Office of the Director with respect to Tribal meetings at locations outside of Headquarters; (12) provides overall Agency leadership with respect to policy development and issues concerning the Federal recognition of new Tribes; (13) supports Tribes in managing health programs; (14) coordinates available support from other public and private agencies and organizations; (15) maintains a central database on relevant information to contact Tribal leaders, health programs, etc.; and (16) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Office of Urban Indian Health (OUIHP) (Gxxx)

(1) Advises the IHS Director on the activities and issues related to the IHS' implementation of Title V, "Indian Health Care Improvement Act'", as amended, for IHS-funded urban Indian organizations; (2) develops and recommends policies, administrative procedures, and guidelines for IHS services and activities for urban organizations; (3) assures that urban Indian organizations are informed of pertinent health policies; (4) ensures that conferring with urban Indian organizations occurs during the development of IHS policy to the extent allowed by law; (5) supports urban Indian organizations in managing health programs; (6) coordinates support available from other public and private agencies and organizations; (7) advises the IHS Director on Agency compliance with urban Indian organization policies, administrative procedures, and guidelines; (8) maintains relevant information on urban Indian organizations; (9) coordinates meetings and other communications with urban Indian organization representatives; and (10) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, onsite reviews and compliance issues, and resolution of audit findings as may be needed and appropriate.

Associate Director Analysis and Evaluation (ADAE) (Gxx)

The Associate Director Analysis and Evaluation (ADAE) is responsible for (1) providing IHS-wide leadership, guidance and support for public health program and activities including strategic planning, evaluation, Government Performance and Results Act (GPRA), research, epidemiology, and statistics; (2) providing Agency-wide leadership and consultation to IHS, Tribal, and Urban Indian health programs on IHS goals, objectives, policies, standards, and priorities; (3) advocates for the public health needs and concerns of AI/AN and promotes quality health care; (4) manages and provides national leadership and consultation for IHS on assessments of public health or medical services, research agendas, and public health initiatives for the Agency; (5) supports and advocates for AI/AN to access State and local public health programs to build public health capacity; and (6) participates in cross-cutting issues and processes including, but not limited to emergency preparedness/security, budget formulation, self-

determination issues, Tribal shares computations and resolution of audit findings as may be needed and appropriate.

Office of Epidemiology and Disease Prevention (DEDP) (Gxxx)

(1) Builds public health capacity in Tribal communities through a network of Tribal Epidemiology Centers; (2) serves IHS and Tribal communities through disease surveillance, health data management, analysis and reporting, and providing technical support for a broad range of public health activities; (3) establishes and maintains core public health surveillance and related data systems to support situational awareness of chronic and infectious disease occurrence of public health importance and aligned with Agency priorities; (4) generates diverse public health data to support assessment of public health system performance and improvement for national IHS programs; and (5) determines and responds to contemporary and established public health problems among AI/AN populations and coordinates and integrates response with other relevant public health partners (e.g., CDC, NIH, Tribal, state and local health departments).

Office of Program Statistics (OPS) (Gxxxx)

(1) Plans, develops, directs, and coordinates an analytical statistical reporting program to provide data for measuring the health status and unmet health needs of the AI/AN population; (2) develops and coordinates the collection, processing, and analysis of demographic, health, and related spatial data for the Agency; (3) maintains, analyzes, makes accessible, and disseminates data from national AI/AN health centered geographic and service delivery related collections of data and analyses; and (4) provides statistical decision support and business intelligence to internal and external partners.

Office of Planning and Evaluation (OPE) (Gxxxx)

(1) Develops and aligns Agency strategic planning with performance measurement and program evaluation activities; (2) provides guidance and support for IHS-wide program evaluation with a focus on improving systems of care; (3)provides support for facilities and staffing planning and serves as liaison to Area and Tribal Planning Officers; (4) conducts regular reviews of progress on Agency strategic goals; (5) makes available to the public resources for planning and evaluation; and (6) supports data-driven decision-making and evidence-driven health system improvement through coordination of the collection and analysis of program data.

Office of Research and Analysis (ORA) (Gxxxx)

(1) Supports national health research activities, including community-oriented practice-based research, human subject research protections, and research related to health problems and the delivery of care to AI/ANs; (2) provides assistance in designing and conducting analytical studies to address a wide range of operational and management challenges; (3) provides decision support and analytics functions to the agency in the areas related to resource allocation, budget formulation, data/information quality, and business analytics; (4) helps to build capacity within the organization for using data and evidence to inform management decision-making; and (5) identifies and evaluates innovative strategies that lead to accessible, effective, and culturally appropriate care.

Associate Director for Healthcare Workforce Development (ADHWD) (Gxx)

The Associate Director for Healthcare Workforce Development (ADHWD): (1) oversees the IHS Scholarship and Loan Repayment programs; (2) provides expert advice and guidance related to strategic workforce development; (3) develops and manages partnerships with universities, states, and non-profits to provide student mentoring, residency, fellowship, and other programs designed to draw students to employment with the IHS;

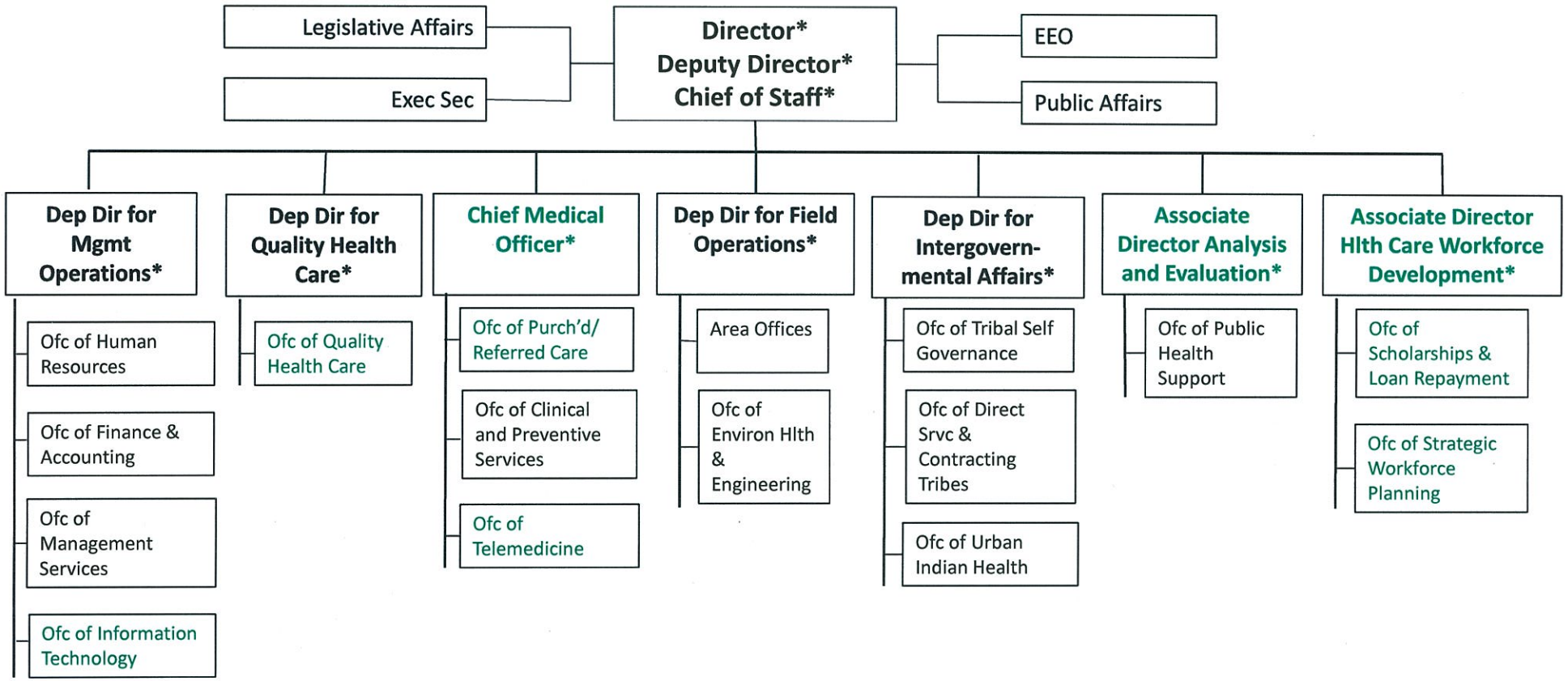
Office of Scholarships and Loan Repayment (OSLR) (Gxxx)

(1) Manages the Agency-wide scholarship and loan repayment programs; (2) coordinates HQ activities for residency and training programs; (3) partners with the National Health Service Corps (NHSC) program, including liaison and assignment of NHSC scholarship recipients to IHS; (4) coordinates the updating of Health Professional Shortage Area site scores IHS-wide; (5) coordinates placement of professionals with loan repayment and scholarship obligations; (6) serves as IHS coordinator for preparatory, pre-graduate and health professions IHS scholarship recipients; (7) processes waivers and defaults of participants in IHS scholarship programs and the IHS loan repayment program (LRP) consistent with authorizing legislation; (8) coordinates the debt management function with the HHS Program Support Center; (9) manages and supports health professions education programs and activities; (10) coordinates scholarship and LRP program administration in collaboration with the Division of Recruitment and Outreach with the IHS Area Office and Service Unit staff, including Chief Medical Officers, Clinical Directors, and professional recruiters; (11) develops, administers, and evaluates all IHS scholarship programs; and (12) coordinates the evaluation of scholarship and loan repayment priorities with the respective disciplines and national councils.

Office of Strategic Workforce Planning (OSWP) (Gxxx)

(1) Builds relationships with universities, non-profit, and state organizations to establish residency, fellowship, or other training programs for students to be placed in IHS; (2) coordinates with HRSA's National Health Service Corps (NHSC) program to ensure IHS site scores are updated appropriately to facilitate the assignment of NHSC scholars and loan repayment recipients to IHS and Tribe locations; (3) coordinates with the OHR Division of Recruitment and Outreach on recruitment strategies such as advertising, direct contacts, use of search committees, etc. for increasing applicants to vacancy announcements; (4)

INDIAN HEALTH SERVICE HEADQUARTERS



Interim organizational chart (October 2016)
***These positions comprise the Agency Senior Staff.**

HOBBS STRAUS DEAN & WALKER

806 SW Broadway, Suite 900
Portland, OR 97205

T 503.242.1745
F 503.242.1072

HOBBSSTRAUS.COM

MEMORANDUM

September 13, 2016

TO: NATIONAL INDIAN HEALTH BOARD

FROM: HOBBS, STRAUS, DEAN & WALKER, LLP Geoff Strommer BY:NAM

RE: ***Health Care Litigation Update***

This memorandum provides an update on recent litigation implicating the Affordable Care Act (ACA) and other health care related topics of particular interest to tribes and tribal health programs.

Litigation continues over the ACA, and recent and pending lawsuits have challenged the contraceptive coverage mandate and transgender protections on religious freedom grounds; put into question the ability of the Administration to make direct payments to health insurance issuers to offset required cost-sharing reductions; attacked the implementation and validity of the ACA "employer mandate"; challenged the Administration's decision to delay enforcement of the ACA's minimum standards for insurance coverage; and questioned the validity of the ACA and certain of its provisions on constitutional grounds. And while a lawsuit brought by legislators in Alaska challenging Medicaid Expansion in the state was abandoned this past year, a similar lawsuit in Arizona remains pending.

In addition, pending litigation arising under the Indian Self-Determination and Education Assistance Act (ISDEAA) addresses issues relating to mandatory lease funding; recurring base funding; the Secretary's duty to approve successor funding agreements; and contract support costs. Finally, a number of recent and pending cases raise other critical Indian health care issues including reimbursement under the Catastrophic Health Emergency Fund; reimbursement from the Department of Veterans Affairs for services to eligible veterans; and issues arising under third-party contracts.

I. Affordable Care Act Challenges

Litigation in opposition to the ACA has not entirely dissipated since the Supreme Court's landmark decisions in *National Federation of Independent Businesses v. Sebelius*, 132 S. Ct. 2566 (2012) [hereinafter *NFIB v. Sebelius*] and *King v. Burwell*, 135 S. Ct. 2480 (2015). In *NFIB v. Sebelius*, the Supreme Court upheld the ACA's individual mandate, which requires individuals to have health insurance that meets certain minimum standards or pay a "shared responsibility payment," as within Congress's valid taxing

authority. And, in *King v. Burwell*, the Court held that premium tax credits—which serve to ensure that low-income individuals can afford to comply with the individual mandate—are available on federally facilitated health insurance exchanges as well as state-based exchanges. Either case could have essentially upended the ACA, had the Court ruled the other way. But despite these rulings largely affirming the statutory scheme, additional challenges to discrete aspects of the law have continued in the lower courts, and in the case of religious exercise challenges to the ACA's requirement to provide contraceptive coverage, up to the Supreme Court yet again.

Religious Challenges to Contraceptive Coverage and Transgender Discrimination Protections

In the past two years the Supreme Court has issued two decisions in response to religious freedom challenges to contraceptive coverage requirements under the ACA. Specifically, the ACA requires applicable large employers to offer insurance coverage that includes preventive care and screening for women at no cost. 42 U.S.C. § 300gg-13(a)(4). The Department of Health and Human Services (HHS) has interpreted this requirement to include contraceptive coverage without any cost sharing requirements. *See* Coverage of Preventive Services Under the [ACA], 77 Fed. Reg. 8725 (Feb. 15, 2012). However, the HHS regulations provided a religious accommodation under which non-profit religious organizations could certify their objection and avoid having to pay for such coverage for their employees.[1] In *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014), the Supreme Court held that the regulatory requirement to provide free access to contraception violated the Religious Freedom Restoration Act (RFRA) when applied to closely held corporations whose owners had religious objections to providing such coverage. The Court found that the government had a less restrictive alternative to ensure employee access to contraceptive coverage with no cost sharing, as evidenced by the opt-out provision for non-profit religious organizations, and so was not justified in burdening the religious exercise of the families who own Hobby Lobby and similar closely held corporations.

Since *Hobby Lobby*, challenges to the contraceptive mandate have continued. In fact, there have been over 100 lawsuits challenging the mandate since the ACA's passage.[2] In several of these cases, employers allege that the requirement to fill out a form certifying their objection to providing contraceptive coverage is itself a substantial burden on their religious freedom under the RFRA. With the exception of the Eighth Circuit in *Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Servs.*, 801 F.3d 927 (8th Cir. 2015), the United States Courts of Appeals have held in these cases that the notice requirement is not a substantial burden on religious exercise in violation of the

[1] The regulations provide that when such an employer objects to contraceptive coverage, the insurance company rather than the employer must pay the cost of the coverage.

[2] National Women's Law Center, *Status of the Lawsuits Challenging the Affordable Care Act's Birth Control Coverage Benefit* (Oct. 27, 2015), https://nwlc.org/wp-content/uploads/2015/11/RR_RP_Status_of_Lawsuits_Challenging_Contraception.pdf.

RFRA. On September 6, 2015, the Supreme Court granted certiorari in seven of these cases and consolidated the cases for briefing and argument. *See Zubik v. Burwell*, 136 S. Ct. 444 (2015).[3]

The Supreme Court heard oral arguments in the cases on March 23, 2016. In an unusual move, following arguments the Court asked the parties to submit supplemental briefs "that address whether and how contraceptive coverage may be obtained by petitioners' employees through petitioners' insurance companies, but in a way that does not require any involvement of petitioners beyond their own decision to provide health insurance without contraceptive coverage to their employees." Docket Entry, *Zubik v. Burwell*, 136 S. Ct. 1557 (Mar. 29, 2016) (No. 14-1418). On May 16, 2016, the Court issued a per curiam opinion vacating the judgments of the Courts of Appeals and remanding for further proceedings in light of the parties' briefs, which the Court said confirm that such an option is possible and would not, in the Petitioners' view, infringe their religious exercise. The Court was clear that its opinion "expresses no view on the merits of the cases" and stated:

> Given the gravity of the dispute and the substantial clarification and refinement in the positions of the parties, the parties on remand should be afforded an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans "receive full and equal health coverage, including contraceptive coverage." ... We anticipate that the Courts of Appeals will allow the parties sufficient time to resolve any outstanding issues between them.

Zubik v. Burwell, 136 S. Ct. 1557, 1560 (2016). In total, more than a dozen cases including *Sharpe Holdings, Inc.* were sent back to the courts of appeals with these unusual instructions.[4]

Even more recently, on August 23, 2016, five States (Texas, Wisconsin, Nebraska, Kentucky, and Kansas) joined with several health care providers in bringing suit against the Secretary of Health and Human Services, challenging a recent regulation providing that discrimination on the basis of sex as prohibited under section 1557 of the

---

[3] The remaining six cases consolidated with Zubik were: *Priests for Life v. Dep't of Health and Human Servs.*, 772 F.3d 229 (D.C. Cir. 2014); *Roman Catholic Archbishop of Washington v. Sebelius*, 19 F. Supp. 3d 48 (D.C. Cir. 2013); *East Tex. Baptist Univ. v. Burwell*, 793 F.3d 449 (5th Cir. 2015); *Little Sisters of the Poor v. Burwell*, 794 F.3d 1151 (10th Cir. 2015); *Southern Nazarene University v. Burwell*, 2013 WL 6804265 (W.D. Okla. 2013) (consolidated with *Little Sisters of the Poor*, 749 F. 3d 1151, *supra*); and *Geneva College v. Sec'y of Health and Human Servs.*, 778 F.3d 422 (3rd Cir. 2015).

[4] In addition to *Sharpe Holdings, Inc.* and the seven cases consolidated in *Zubik*, the Court separately granted pending petitions for certiorari and remanded in light of *Zubik* the following cases: *Dordt College v. Burwell*, 801 F.3d 946 (8th Cir. 2015); *Univ. of Notre Dame v. Burwell*, 786 F.3d 606 (7th Cir. 2015); *Grace Schools and Diocese of Fort Wayne-South Bend v. Burwell*, 801 F.3d 788 (7th Cir. 2015); and *East Tex. Baptist Univ. v. Burwell*, 793 F.3d 449 (6th Cir. 2015).

ACA includes discrimination on the basis of gender identity. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016). The complaint alleges that the regulations are inconsistent with the ACA and other federal laws governing anti-discrimination and the provision of health care services, and that the regulations violate the First, Fifth, and Tenth Amendments as well as the RFRA. The case is *Franciscan Alliance, Inc. v. Burwell*, No. 7:16-cv-00108-O (N.D. Tex. filed Aug. 23, 2016).

House v. Burwell

A federal district court recently issued its decision in another high-profile challenge to the Administration's implementation of the ACA from the United States House of Representatives. *United States House of Representatives v. Burwell*, No. 14-1967, 2016 WL 2750934 (D.D.C. May 12, 2016) [hereinafter *House v. Burwell*]. The House of Representatives advanced two arguments in the case: First, the House argued that the Administration spent billions of dollars that Congress had not appropriated, in violation of Article I, § 9, cl. 7 of the U.S. Constitution,[5] in order to make direct payments to health insurance issuers to offset the expense of the cost-sharing reductions in the ACA. Second, the House argued that the Administration had effectively amended the ACA by delaying the implementation of the employer mandate and by issuing regulations that only impose penalties when large employers fail to offer coverage to a certain percentage of employees and their dependents, even though the ACA requires that *all* employees and their dependents be offered coverage.

On September 9, 2015, the court dismissed the House of Representatives' claims regarding implementation of the employer mandate but ruled that it had standing to pursue its appropriations-related claims. *United States House of Representatives v. Burwell*, 130 F. Supp. 3d 53 (D.D.C. 2015). Then, on May 12, 2016, the court ruled in favor of the House of Representatives on the appropriations question, finding that Congress has not appropriated funding for the cost-sharing reduction reimbursements and that the Administration had no authority to use funds from an existing permanent appropriation to make the payments. *House v. Burwell*, 2016 WL 2750934. The court granted an injunction prohibiting the Administration from utilizing the permanent appropriation to make the reimbursement payments, but stayed the injunction pending appeal. The Administration filed a notice of appeal on July 6, 2016 as to both of the district court's rulings, and the appeal is now pending before the United States Court of Appeals for the District of Columbia Circuit.

The district court decision in *House v. Burwell* does not mean that insurance issuers can stop granting cost-sharing reductions to qualified individuals. However, if the decision stands it will introduce a great deal of uncertainty as to whether and how

[5] Article I, § 9, cl. 7 provides, in relevant part: "No money shall be drawn from the treasury, but in consequence of appropriations made by law[.]"

insurance issuers will be reimbursed for the costs of those reductions. As the Administration pointed out in its briefs, this could lead to an increase in premiums (and thus federal spending on premium subsidies) or litigation against the Treasury by issuers seeking to recover losses resulting from compliance with the cost-sharing reduction requirements.

Employer Mandate Litigation

House v. Burwell is not the only ACA litigation with a focus the "employer mandate," which requires "applicable large employers" with 50 or more full-time employees to offer those employees and their dependents health coverage that meets certain minimum requirements. 26 U.S.C. § 4980H. Employers are assessed a penalty if they fail to provide such coverage and an employee or dependent then qualifies for a premium tax credit by purchasing insurance through an exchange. While the House of Representatives in *House v. Burwell* attacked the Administration's delayed and partial implementation of the employer mandate as contrary to the statute, other cases filed prior to the Supreme Court's decision in *King v. Burwell* raised claims that the statutory mandate itself is flawed.

Before the Supreme Court in *King v. Burwell* upheld the availability of premium tax credits on federally facilitated health insurance exchanges, the Oklahoma Attorney General as well as the State of Indiana and 29 Indiana school districts initiated lawsuits asserting that, because their states utilized federal facilitated health exchanges, tax credits were not available and therefore the employer mandate tax penalty could never be validly triggered by an employee qualifying for a premium tax credit in that state. The district court ruled in favor of the State of Oklahoma in *Oklahoma ex rel. Pruitt v. Burwell*, 51 F. Supp. 3d 1080 (E.D. Okla. 2014) but following the outcome of *King* the parties agreed that the district court judgment should be reversed, and on July 28, 2015, the Tenth Circuit issued an order reversing the district court's decision. Procedural Termination, *Oklahoma ex rel. Pruitt v. Burwell*, No. 14-7080 (10th Cir. July 28, 2015). In *Indiana v. IRS*, the plaintiffs have conceded that *King* disposed of their challenge to the IRS regulations allowing premium tax credits on federally facilitated exchanges. However, they continue to press their separate claims that the ACA violates the Tenth Amendment to the extent that it applies the employer mandate to states and their political subdivisions, because (they argue) the mandate amounts to a federal tax on the State. Joint Notice Regarding Further Proceedings, *Indiana v. IRS*, No. 1:13-cv-1612 (S.D. Ind. July 21, 2015). The case is now pending before a magistrate judge in the Southern District of Indiana.

Another pending employer mandate case relates specifically to tribal governments, and again targets the Administration's implementation. In 2014, the Northern Arapaho Tribe filed suit in federal district court in the District of Wyoming, challenging IRS regulations extending the employer mandate to tribal governmental employers. *Northern Arapaho Tribe v. Burwell*, No. 14-cv-247 (D. Wyo. filed Dec. 8,

2014). Although the ACA does not specifically apply the employer mandate to tribal governments, the IRS regulations define governmental entities for purposes of the mandate to include tribal governmental employers. 26 C.F.R. §§ 54.4980H-1(a)(23), 301.6056-1(b)(7). The Northern Arapaho Tribe argued that the regulations were invalid because they contravene the language of the statute. The Tribe also argued that Congress never intended the employer mandate to apply to tribal governmental employers, as evidenced by the fact that Congress exempted individual Indians from the individual mandate. The Tribe further asserted that the employer mandate would make insurance more expensive for tribal member employees because an offer of insurance from an employer would make them ineligible for the tax credits and cost-sharing benefits that they would otherwise be entitled to when purchasing insurance through an exchange.

On July 2, 2015, the district court dismissed the Northern Arapaho Tribe's case. *Northern Arapaho Tribe v. Burwell*, 118 F. Supp. 3d 1264 (D. Wyo. 2015). Among other bases for dismissal, the court found that the Anti-Injunction Act barred the lawsuit—a holding also reached by the Fifth Circuit in a different case alleging that the employer mandate violated the Origination Clause (discussed below) and constitutes a taking in violation of the Fifth Amendment to the U.S. Constitution.[6] *Hotze v. Burwell*, 784 F.3d 984 (5th Cir. 2015).[7] The court in *Northern Arapaho Tribe* also found, however, that in any event the ACA unambiguously expressed Congress's intent that the employer mandate apply to tribes. The court reasoned that if Congress wished to exempt tribes from the employer mandate, it needed to have done so explicitly. The Tribe appealed to the Tenth Circuit Court of Appeals on August 28, 2015, and briefing is now underway in that court.

Challenges to Implementation Delays

Nor is *House v. Burwell* the only case to challenge the Administration's delay of controversial ACA provisions. The D.C. Circuit recently affirmed dismissal of another case, *Virginia ex rel. Morrisey v. Department of Health & Human Services*, in which the State of West Virginia challenged the Administration's decision to delay enforcement of the ACA's minimum standards for insurance coverage. *W. Virginia ex rel. Morrisey v. United States Dep't of Health & Human Servs.*, No. 15-5309, 2016 WL 3568089 (D.C. Cir. July 1, 2016). The decision prevented the cancellation of existing insurance plans, allowing individuals to keep their current plans so long as states did not take action to bar the renewal of those plans. The State of West Virginia argued that in addition to violating the ACA, this "administrative fix" was an unlawful delegation of federal power to the states in violation of articles I and II of the Constitution and violated the Tenth Amendment by making states responsible for determining whether federal law should be enforced. On October 30, 2015, the district court dismissed the case, finding that the

[6] The Anti-Injunction Act prohibits suits to restrain the assessment or collection of a tax. 26 U.S.C. § 7421.

[7] In February of 2016, the Supreme Court declined to review the Fifth Circuit's decision in *Hotze*. *Hotze v. Burwell*, 136 S. Ct. 1165 (2016).

State of West Virginia had not suffered the kind of concrete injury normally required to confer standing in federal court. *State of W. Virginia v. United States Dep't of Health & Human Servs.*, 145 F. Supp. 3d 94 (D.D.C. 2015). The D.C. Circuit affirmed the district court's decision on July 1, 2016. 2016 WL 3568089.

Origination Clause Challenges

In early 2016, the Supreme Court denied certiorari in two cases challenging the ACA based on the Constitution's Origination Clause. *See Sissel v. Dep't of Health & Human Servs.*, 136 S. Ct. 925 (2016); *Hotze v. Burwell*, 136 S. Ct. 1165 (2016). The Origination Clause requires that bills for raising revenue originate in the House of Representatives, but the ACA originated in the Senate. The Court of Appeals for the District of Columbia rejected an origination challenge in *Sissel v. Department of Health and Human Services*, 760 F.3d 1 (D.C. Cir. 2014), on the grounds that the ACA was not a "bill for raising revenue" within the meaning of the clause. The Fifth Circuit did the same in *Hotze v. Burwell*, 784 F.3d 984 (5th Cir. 2015), on jurisdictional grounds. Those decisions stand as a result of the Supreme Court's refusal to hear the two cases.

States' Challenge to the Health Insurance Providers Fee

Another recent case, filed in 2015 by the State of Texas along with Indiana, Kansas, Louisiana, Nebraska, and Wisconsin in the U.S. District Court for the Northern District of Texas, challenges the Administration's implementation of the ACA's Health Insurance Providers Fee. *Texas v. United States of America*, No. 7:15-cv-00151 (N.D. Tex. filed Oct. 22, 2015). The Health Insurance Providers Fee, created under Section 1910 of the ACA, is an annual fee imposed on health insurance providers that was intended to generate revenue to help fund federal premium subsidies for low-income individuals. Though the fee is imposed on health insurance providers, the States allege that regulations implementing the fee shift the burden of the fee to the States in some instances, in violation of the ACA and the Tenth Amendment. The States, all of which provide Medicaid and CHIP services through contracts with managed care organizations (MCOs), point to regulations governing Medicaid and CHIP and requiring that capitation rates paid to MCOs be "actuarially sound," which, also by regulation, requires certification from an actuary employing standards established by the American Academy of Actuaries. In turn, standards adopted by the American Academy of Actuaries in 2015 require capitation rates to include recovery of the amount of taxes MCOs are required to pay. Thus, the States argue, the federal government has essentially required that the States reimburse MCOs for the fees if the States wish to continue receiving Medicaid and CHIP funding.

The States raise a number of constitutional and statutory claims, including that the fee is an impermissibly coercive exercise of Congressional authority and that it amounts to a tax on the States in violation of the Tenth Amendment. On August 4, 2016, the district court issued an order in response to the Administration's motion to dismiss the

case. Memorandum Opinion and Order, *Texas v. United States of America*, No. 7:15-cv-00151 (N.D. Tex. Aug. 4, 2016). The court dismissed the States' claims seeking a refund of the fees already paid on standing grounds, noting that it was the MCOs and not the States that actually paid the fees. However, the court declined to dismiss the States' claims for declaratory relief that would effectively bar collection of the fee from MCOs, as well as the States' Tenth Amendment claims, among others.

II. Challenges to Medicaid Expansion

The Alaska Legislative Council voted in June of 2016 to drop its lawsuit challenging Governor Walker's decision to expand Medicaid after losing in the state Superior Court. The suit, filed in state court in 2015, was *Alaska Legislative Council v. Walker*, No. 3AN-15-09208 (Alaska Super. Ct. filed Aug. 24, 2015). The Legislative Council had argued in the case that it alone, and not the Governor, had the authority to authorize additional groups of people to be eligible for Medicaid. The Governor, on the other hand, relied on language in the Alaska Medicaid statute extending eligibility to all state residents "for whom the Social Security Act requires Medicaid coverage," and argued that even though the penalty for noncompliance with Medicaid Expansion was struck down in *NFIB v. Sebelius*, the Social Security Act as amended by the ACA still textually requires expanded coverage. On March 1, 2016, the Superior Court ruled in favor of the Governor and dismissed the case. *Alaska Legislative Council v. Walker*, No. 3AN-15-09208 (Alaska Super. Ct., March 1, 2016). While the House initially attempted to pursue the appeal on its own, its motion for substitution of a party was denied on June 24, 2016. Shortly thereafter, the Alaska Legislative Council voted not to pursue the appeal.

In Arizona, lawmakers have also attempted to challenge their State's plan for funding Medicaid expansion. *Biggs v. Brewer*, No. CV 2013-011699 (Ariz. Super. Ct. (Maricopa) filed Sept. 12, 2013). The thirty-six legislators and three citizens who filed suit argued that passage of a "hospital assessment" that would fund Arizona's share of Medicaid Expansion was a tax and therefore required a two-thirds vote under state law rather than the simple majority with which it was passed. On August 26, 2015, the trial court granted the defendants' motions for summary judgment. Under Advisement Ruling, *Biggs v. Brewer*, No. CV 2013-011699 (Ariz. Super. Ct. (Maricopa), Aug. 26, 2015). The plaintiff legislators appealed, and the case is now pending before the Arizona Court of Appeals. *Biggs v. Betlach*, No. 15-0743 (Ariz. Ct. App. Div. 1).

III. Indian Self-Determination Act Litigation

ISDEAA Leasing Authority

On March 22, 2016, a federal district court judge for the United States District Court for the District of Columbia issued a ruling in *Maniilaq Association v. Burwell*, ordering the Indian Health Service (IHS) to negotiate full lease compensation under

Section 105(*l*) of the ISDEAA and implementing regulations for a proposed lease of Maniilaq Association's clinic facility in Kivalina, Alaska. *Maniilaq Ass'n v. Burwell*, No. 1:15-cv-00152, 2016 WL 1118256 (D.D.C. Mar. 22, 2016) (*Maniilaq II*). Section 105(*l*) provides that the Secretaries of Health and Human Services and the Department of the Interior "shall enter into a lease with the Indian tribe or tribal organization that holds title to, a leasehold interest in, or a trust interest in, a facility used by the Indian tribe or tribal organization for the administration and delivery of services" under the ISDEAA, at the request of the tribe or tribal organization. 25 U.S.C. § 450j(*l*)(a). Section 105(*l*) also states that the Secretary "shall compensate" the tribe or tribal organization for any lease under that section, but is not clear on its face regarding the required level of compensation. 25 U.S.C. § 450j(*l*)(b).

Maniilaq II is a follow-up to prior litigation regarding IHS' obligation to enter into and fully fund a Section 105(*l*) lease for Maniilaq's clinic facility in Ambler, Alaska. *Maniilaq Association v. Burwell*, 72 F. Supp. 3d 227 (D.D.C. 2014) (*Maniilaq I*). In that case, the IHS failed to respond to Maniilaq's Ambler lease request within 45 days, as required by statute, and eventually responded by rejecting the proposal on multiple grounds, including: (1) a lease under section 105(*l*) cannot be incorporated into an ISDEAA funding agreement; (2) Maniilaq must apply for a lease through the IHS Lease Priority System, which gives the IHS discretion to prioritize lease requests; and (3) IHS is not required to provide monetary compensation for Section 105(*l*) leases, and may offer "non-monetary compensation" only. Maniilaq challenged the rejection in federal district court. The district court held that a Section 105(*l*) lease may be incorporated into an ISDEAA funding agreement, and that Maniilaq's lease proposal was deemed accepted by operation of law when IHS failed to respond within the 45 days required by statute.

The court in *Maniilaq I* did not reach the question of lease compensation, however, since it ruled that the IHS was legally bound to enter into the lease as proposed. When Maniilaq later submitted a lease request for its Kivalina clinic facility, the IHS denied the proposed lease on the grounds that it was not required to pay lease compensation above the program amount that Maniilaq already received for the clinic in its ISDEAA funding agreement under a discretionary "Village Built Clinic" leasing program. Maniilaq's requested compensation amount, which was based on specific regulatory criteria options set out in implementing regulations at 25 C.F.R. Part 900, Subpart H, was significantly more, but the IHS argued that the regulations were discretionary. In its March 22, 2016 order, the court rejected the IHS's legal arguments and ordered the IHS to negotiate full lease compensation under the regulatory criteria. Following those negotiations, on July 27, 2016, the court ordered the IHS to enter into the lease and to pay the negotiated compensation amount—roughly an 825% increase over the amount that Maniilaq had received under the Village Built Clinic leasing program—pending any appeal of the underlying decision. Order, *Maniilaq Association v. Burwell*, No. 1:15-cv-00152 (D.D.C. July 27, 2016). The IHS has until September 26, 2016 to seek an appeal.

Recurring Base and Successor AFA Disputes

Another ongoing case involving contract funding under the ISDEAA was brought by the Seneca Nation of Indians against HHS in August 2014. *Seneca Nation of Indians v. Dep't of Health & Human Servs*, No. 1:14-cv-01493 (D.D.C. filed Aug. 29, 2014). The case essentially concerns whether the IHS must treat a court award of contract funding as part of a tribe's recurring base funding in subsequent years, but the case has a complicated procedural history. In previous litigation, the Tribe successfully established that a proposal to amend its FY 2010 and FY 2011 funding agreement to correct a user population count error and increase base funding by $3,774,392 was deemed approved by operation of law because the IHS did not issue a response within 90 days, as required by the ISDEAA. *Seneca Nation of Indians v. Dep't of Health and Human Servs.*, 945 F. Supp. 2d 135 (D.D.C. 2013). While that case was pending, however, the Tribe requested the same increase for FY 2012, and the IHS timely declined. The Tribe filed a claim with the Interior Board of Indian Appeals (IBIA) over the FY 2012 amount. *See Seneca Nation of Indians v. Nashville Area Chief Contracting Officer, Indian Health Service* (Docket No. IBIA 12-041).

After the original litigation concerning FY 2010 and FY 2011 was resolved by the district court in the Tribe's favor, and while the FY 2012 claim was still pending in the IBIA, IHS again rejected funding agreements for FY 2013, FY 2014, and FY 2015 that included the additional $3,774,392. In August 2014, the Tribe filed suit in federal district court in the District of Columbia challenging the 2013–2015 denials on the grounds that, under the ISDEAA and IHS regulations, the IHS may not reduce the Tribe's annual funding level except as provided by statute, nor reject a successor annual funding agreement that is substantially the same as the prior funding agreement. The IBIA stayed its proceeding on the FY 2012 claims pending resolution of the Tribe's district court suit over the 2013–2015 claims. However, HHS moved to dismiss the district court case in June 2015, arguing that it could not be resolved prior to resolution of the stayed IBIA case because the Tribe's arguments regarding non-reduction of funding and successor funding agreements hinged on the contents of its FY 2012 funding agreement. The district court agreed, but stayed the case pending resolution of the FY 2012 claim by the IBIA rather than dismiss the case. *Seneca Nation of Indians v. U.S. Dep't of Health & Human Servs.*, 144 F. Supp. 3d 115 (D.D.C. 2015).

The IBIA assigned the case to an Administrative Law Judge (ALJ), who issued a recommended decision in favor of the Tribe. The IHS appealed to the Health and Human Services Departmental Appeals Board (DAB), which issued a decision upholding the ALJ's recommendation on June 30, 2016. *Seneca Nation of Indians*, DAB No. 2715 (H.H.S. June 30, 2016). The DAB held that the funding increase became part of the Tribe's ISDEAA "base funding" when the Tribe's amendment proposal was deemed accepted by operation of law—or at the least, when the district court ordered the funding agreement amended—and that none of the statutory criteria for reduction of base funding applied. The DAB also upheld the ALJ's finding that the IHS was required to approve

the Tribe's FY 2012 funding agreement because it was substantially the same as the final FY 2011 funding agreement. The Tribe's FY 2013-2015 claims are now active again in the district court, and the Tribe has filed a motion for summary judgment on the basis of the DAB ruling.

In another case with an equally complicated history, the Sage Memorial Hospital brought suit in 2014 against the Indian Health Service after the Navajo Area Indian Health Service (NAIHS) declined to renew its 2010 ISDEAA contract, set to expire on September 30, 2013, and to enter into funding agreements under the renewed contract for FYs 2014 and 2015. On April 9, 2014, the district court entered a preliminary injunction requiring the IHS to continue funding the Sage Memorial Hospital according to the terms of the Hospital's 2010 contract and 2013 Funding Agreement until the case could be resolved on the merits. *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, 100 F. Supp. 3d 1122 (D.N.M. 2015). In granting the preliminary injunction, the district court found that, for purposes of preliminary relief, Sage Memorial Hospital had shown that the proposed contract and funding agreement were likely substantially the same as their predecessors, and thus the IHS was likely prohibited by regulation from rejecting them. The district court rejected arguments by the IHS that the proposals should be considered different from the previous contracts in light of a performance evaluation and audit report that the IHS had received suggesting misuse of federal funds—information unknown to it when it approved the predecessor agreements. The district court held that the IHS could only look to the contents of the contract documents themselves to determine whether they were substantially the same as their predecessors, and that the IHS may not use the contract proposal rejection criteria in place of the reassumption procedures where outside information suggests a problem with contract performance.

On August 31, 2015, the district court issued a decision on the merits of Sage Memorial Hospital's request for injunctive and mandamus relief ordering the IHS to enter into and fund its contract proposal. *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, No. CIV 14-0958, 2015 WL 9777785 (D.N.M. Oct. 26, 2015). The district court ruled in favor of the Hospital, again finding that the proposed contracts and the proposed FY 2014 funding agreement were substantially the same as their predecessors and that the IHS was therefore prohibited by regulation from declining the proposals. Though the district court found that the FY 2015 funding agreement was not substantially similar to its predecessor due to a significant increase in the funding amount proposed, the district court found that the IHS did not properly apply the statutory declination criteria to the Hospital's proposal and it was therefore deemed approved. As a result, the court ordered the IHS to enter into and fully fund the proposed contract and funding agreements. The court also agreed to schedule a hearing on damages claimed by the Hospital as a result of the IHS's actions.

In the meantime, the IHS also declined to enter into Sage Memorial Hospital's proposed FY 2016 funding agreement. The Sage Memorial Hospital again supplemented its complaint and filed a motion for summary judgment on the declination of the FY 2016

funding agreement, arguing that it is substantially the same as the Hospital's FY 2015 funding agreement, which has now been deemed accepted by the district court. The IHS has countered that the court's deemed approval of the FY 2015 funding agreement does not qualify as a "prior annual funding agreement" under the regulations requiring the Secretary to approve a successor annual funding agreement if it is "substantially the same as a prior annual funding agreement" because it was deemed accepted by the district court rather than negotiated and agreed to by the parties. That question is now pending before the district court.

Contract Support Cost Litigation

The Sage Memorial Hospital case also includes contract support cost-related claims, which have been addressed in two separate opinions by the district court and are still pending. First, the Sage Memorial Hospital alleged that the IHS violated the Contract Disputes Act (CDA) in responding to its claims for unpaid contract support costs for fiscal years 2009 through 2013 by responding with a form letter that was not responsive to the Hospital's specific claims and by identifying an unreasonable deadline for a final decision (roughly fourteen months from the date of submission) that was also contingent on the Hospital's "cooperation." On June 17, 2015, the district court ruled that by making the date of decision contingent on the Hospital's "cooperation," the IHS failed to identify a date certain by which a decision would be rendered, as required by the CDA, and therefore the claims were deemed denied. *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, 110 F. Supp. 3d 1140 (D.N.M. 2015). The court also found that the fourteen month time frame for issuing a decision was unreasonable under the Contract Disputes Act, which requires an agency to issue a decision within a reasonable amount of time.

Thereafter, the Sage Memorial Hospital amended its complaint, adding claims challenging the deemed denial of its contract support cost claims and seeking as damages the full amount of the claims. The IHS responded by issuing a "contracting officer's decision" and filing a counterclaim alleging that the Hospital in fact owed the IHS for indirect contract support cost funding that the IHS paid but that the Hospital did not spend on eligible activities. The Hospital filed a motion to dismiss the counterclaim, arguing that the "contracting officer's decision" (which provides jurisdiction for the counterclaim) was not valid because the agency lost the authority to issue an administrative decision on the claims once the claims became part of the litigation. The Hospital also argued that the decision was not valid because it provided several alternate bases for liability, but only one aggregate damages figure. On December 14, 2015, the district court rejected the Hospital's motion to dismiss the counterclaim, finding that litigation of the Hospital's contract support cost claims did not divest the contracting officer of authority to issue a decision on the *IHS's* claims to recover allegedly misspent funds, and that the contracting officer's decision provided the Hospital with sufficient notice of those claims. *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, 157 F.

Supp. 3d 1119 (D.N.M. 2015). However, the parties later stipulated to dismissal of the IHS counterclaim.

Following dismissal of the counterclaim, on August 1, 2016 Sage Memorial Hospital filed three separate motions for partial summary judgment. The first motion asks the court to hold unlawful the IHS's "allocation" of contract support costs between the portion of program activities funded by IHS appropriations and the portion funded by third-party revenues. This practice results in a reduction of contract support costs awarded because the IHS claims only to be liable for that portion of overhead costs allocated to program activities paid for with appropriated funds. The second motion asks the court to declare that the IHS's interpretation of 25 U.S.C. § 450j-1(a)(3)(A)—which states that contract support cost funding shall not duplicate any funding provided in the 106(a)(1) Secretarial amount—is overbroad and contrary to law. The IHS has taken the position that the duplication provision prohibits the IHS from awarding as contract support costs any additional payments for a *type* or *category* of costs that was included in the Secretarial amount, regardless of the actual amount that was included and regardless of whether or not that amount is sufficient to cover reasonable costs necessarily incurred by a tribe in that category. Finally, the third motion addressed various affirmative defenses raised by the IHS. Briefing is underway on these motions and the court has set a motions hearing for September 16, 2016.

IV. Other Indian Health Care Litigation

Catastrophic Health Emergency Fund & Purchased/Referred Care Eligibility

The IHS has recently taken the position in federal district court litigation that tribal self-insured plans are alternate resources for purposes of the Catastrophic Health Emergency Fund (CHEF), and for the underlying Purchased/Referred Care (PRC) program of which the CHEF is one component. The case, *Redding Rancheria v. Burwell,* Civ. No. 14-2035 (D.D.C. filed Dec. 2, 2014), was filed by the Redding Rancheria (Redding) after the IHS rejected a contract proposal by Redding intended to clarify interaction of the CHEF with Redding's tribal self-insurance plan. Redding uses its tribal self-insurance plan to supplement its PRC program, which it operates under a self-governance compact with the IHS under the ISDEAA. In order to maximize efficiency, Redding coordinates coverage under its self-insurance program with coverage under its PRC program, using PRC funds to access Medicare-Like Rates (MLR) where possible and tribal self-insurance to access network rates where MLR is not available through the PRC program. Redding's tribal self-insurance program thus includes language limiting its ability to cover care otherwise entitled to MLR, and also excluding services eligible for coverage under the CHEF.

The IHS denied several CHEF claims submitted by Redding, in part on the grounds that Redding's self-insurance plan was an "alternate resource" that should have paid for the care. The IHS then rejected a compact amendment proposed by Redding to

clarify that Redding had a right to coordinate care between its PRC and tribal self-insurance programs without impacting its eligibility for CHEF coverage. Redding exercised its right under the ISDEAA to appeal the IHS's rejection of its proposed amendment, and alleged that the IHS's actions violated its compact and the ISDEAA, as well as the IHS's own policy on tribal self-insurance plans.

In the case, IHS admits that its existing policy makes an exception to treating tribal self-insurance as an alternate resource, but argues that this policy was invalidated by the payer of last resort rule that was enacted as Section 2901(b) of the Affordable Care Act in 2010. Section 2901(b) provides that: "Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations ... shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary." 25 U.S.C. § 1623(b). The IHS argues in the Redding case to limit the payer of last resort rule in Section 2901(b) to IHS contracted or compacted Purchased/Referred Care (PRC) programs and thus tribal self-insurance must pay before IHS.

Cross-motions for summary judgment are pending with the court and oral argument has been requested in the *Redding* case.

Department of Veterans' Affairs Reimbursement

A recent case brought by the Gila River Indian Community in March, 2016 against the U.S. Department of Veterans Affairs (VA) challenges the reimbursement policies adopted by the VA under Section 10221(a) of the ACA, codified at 25 U.S.C. § 1645(c). *Gila River Indian Community v. Dept. of Veterans Affairs, et al.*, No. 2:16-cv-00772 (D. Ariz. filed Mar. 22, 2016). Section 1645(c) provides that:

> The [Indian Health] Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

The VA did not immediately implement this provision after its enactment in 2010. Instead, the VA entered into lengthy negotiates with the IHS, which ultimately resulted in an Inter-Agency Agreement and a template reimbursement agreement, released in 2012, designed to govern VA reimbursement to tribal health programs. Under the template agreement, reimbursement is prospective only, not retroactive to the ACA's effective date; is limited to direct care services and does not extend to PRC services; and does not extend to non-Native veterans receiving care at tribal facilities.

In an amended complaint filed on July 11, 2016, the Gila River Indian Community alleges that it was entitled to VA reimbursements beginning on the date of enactment of Section 1645(c) (March 23, 2010) as a matter of federal law, regardless of any agreement. The Community also alleges that the reimbursement limitations in the Inter-Agency Agreement and the template agreement violate Section 1645(c) and the ACA payor of last resort provision at 25 U.S.C. § 1623(b).[8] The Community asks the court to declare that the VA is in violation of these provisions of law and to compel the VA to comply with its statutory reimbursement duties. The VA has responded with a motion to dismiss, arguing that the Community's claims must be heard in the Court of Appeals for Veterans Claims under the Veterans' Judicial Review Act, and that the Community has failed to challenge a "final agency action" as required for judicial review. The VA also contests the Community's interpretation of Sections 1645 and 1623(b).

Third-Party Contract Dispute Cases

In April 2014, the Grand Traverse Band of Ottawa and Chippewa Indians sued Blue Cross and Blue Shield of Michigan (BCBSM) for violations of the Employee Retirement Income Security Act (ERISA) and breach of a contract under which BCBSM administers the Tribe's self-insured employee benefits plan. *Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross & Blue Shield of Mich.*, No. 5:14-cv-11349 (E.D. Mich. filed April 1, 2014). The Tribe alleged that BCBSM has been paying more than it should have under the contract for Contract Health Services (CHS) and under federal regulations capping the payments at the Medicare-like Rates. The Tribe also alleged that BCBSM was collecting an administrative fee from the money it used to pay claims in violation of the contract. The parties settled the issue of administrative fees while continuing to litigate the applicability of Medicare-like Rates. On July 17, 2015, BCBSM filed a third party complaint against Munson Medical Center, arguing that it breached its contract with BCBSM by failing to provide necessary information or charge rates. BCBSM argues that Munson Medical Center is responsible to the extent that BCBSM is found liable to the Tribe.

In two orders issued on May 19 and June 27, 2016, the district court dismissed the Tribe's federal ERISA claims without prejudice, but elected to retain jurisdiction over the remaining state law breach of contract claims. *See* Opinion and Order, *Grand Traverse Band*, No. 5:14-cv-11349 (E.D. Mich. May 19, 2016); Order Granting in Part Motion for Reconsideration, *Grand Traverse Band*, No. 5:14-cv-11349 (E.D. Mich. June 27, 2016). The Tribe has filed a motion for leave to file an amended complaint to clarify its federal

[8] Section 1623(b) provides:

> Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 1603 of this title) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

ERISA claims, which allege breach of fiduciary duty on the part of BCBSM due to its failure to take advantage of Medicare-like Rates. The Tribe's request to file the amended complaint is now pending before the district court.

The Alaska Native Tribal Health Consortium (ANTHC) sued Premera Blue Cross (Premera) in 2012 for failure to pay the higher of ANTHC's reasonable billed charges or the highest amount Premera would pay to a non-governmental entity as required under section 206 of the Indian Health Care Improvement Act, 25 U.S.C. § 1621e. *Alaska Native Tribal Health Consortium v. Premera Blue Cross*, No. 3:12-cv-00065 (D. Alaska filed Mar. 27, 2012). In September 2014, ANTHC moved for summary judgment, arguing that its billed charges should be deemed reasonable. Premera filed a cross motion for summary judgment, arguing that ANTHC's billed charges were not reasonable or, in the alternative, that Premera had paid ANTHC in accordance with the Alaska Usual and Customary Rate which is usually higher than ANTHC's billed charges. In July 2015, the court denied the motions for summary judgment, finding that questions remained over whether Premera had paid substantially less than ANTHC's billed charges. *Alaska Native Tribal Health Consortium v. Premera Blue Cross*, No. 3:12-cv-0065, 2015 WL 12159388 (D. Alaska July 2, 2015). Following additional discovery, ANTHC again filed a motion for partial summary judgment, arguing that Premera's allowed amounts were reasonable and that ANTHC has a right to recover, at a *minimum*, the difference between those allowed amounts and what Premera actually paid. Premera's brief in response is due by September 16, 2016, and a jury trial has been set for March 20, 2017.

V. Conclusion

There is a great deal of activity in the federal courts still as implementation of the ACA and the IHCIA reauthorization continues, and as tribes and tribal organizations continue to grow their health care programs under their sovereign tribal authority and that of the IHCIA and ISDEAA. We intend to keep tracking and reporting on these developments as they unfold.

If you have any questions about the cases discussed above, please contact Geoff Strommer at gstrommer@hobbsstraus.com or (503) 242-1745 or Caroline Mayhew at cmayhew@hobbsstraus.com or (202) 822-8282.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECRETARY'S TRIBAL ADVISORY COMMITTEE

October 14, 2016

Secretary Sylvia Mathews Burwell
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Secretary's Tribal Advisory Committee Follow up items from September meeting

Dear Secretary Burwell,

On behalf of the Secretary's Tribal Advisory Committee (STAC), we thank you and your staff for the productive meeting that was held from September 13-14, 2016. We appreciate the agency's willingness to hear our concerns and address key issues in a responsive and transparent manner and we look forward to working with you to advance many of these priorities in final months of this Administration.

The following letter presents the STAC's key issues from the September meeting. We hope to work with you to resolve these issues in a collaborative, and meaningful way. We are also eager to ensure that issues that cannot be resolved by the end of the year are given priority in a future Administration, and request your assistance in doing so.

Quality of Care issues at the Indian Health Service

Several Indian Health Service (IHS) operated hospitals continue to experience serious violations of patient welfare and safety resulting in not only dangerous patient situations, but diminished care and loss of critical third party revenues. This situation is unacceptable to the STAC and we urge you to do all in your power to see these situations rectified immediately. As recently as September 2016, IHS continues to violate the federal obligation to consult with Tribes on these issues, by announcing that it would move care at Sioux San Hospital in Rapid City to just urgent and outpatient services. As a result, American Indians in this region are losing access to vital services. Many have nowhere else to turn for example:

- The Winnebago Indian Hospital has been unable to collect reimbursements from the Center for Medicare and Medicaid Services (CMS) for over a year now. This has meant the loss of several millions of dollars for this facility, leading to rationed care for the Tribes it serves. HHS and IHS should rectify these issues immediately. The time it has taken to renew CMS certification at Winnebago Indian Hospital is just unacceptable. Please provide us with an update on when the CMS certification will be restored at Winnebago Indian Hospital.
- Tribes in the Great Plains Area have also been asking for a detail breakdown of the Tribal Shares allocation for every facility in the region since early 2016. Each Tribe has provided a request to IHS to release this information. Yet, IHS still refuses to provide

this information. As Tribes in this region consider moving to self-governance, it is critical that this be shared before the end of the year.

- What are HHS and IHS doing to ensure that the staffing needs of the Great Plains Area are met as soon as possible at both the Area and Service unit levels?

Tribal Budget Formulation Workgroup's Recommendations for the FY 2018 IHS Budget

For FY 2018, Tribes would like to see a minimum 37% increase for the IHS in FY 2018 so that our people can receive a level of care that is more in line with the healthcare taken for granted by other Americans. We also request that you begin putting in explicit budget request for the new authorities of the Indian Healthcare Improvement Act totaling $97 million. Additionally, the workgroup requests that HHS and IHS advocate that Tribes and Tribal programs be permanently exempt from sequestration and support Advance Appropriations for the Indian Health Service. Finally, we suggest several improvements to the Budget formulation process.

On June 20, 2016, representatives from the Tribal Budget Formulation Workgroup – which represents all 12 IHS areas – presented the Tribal recommendation for the Indian Health Service Budget. We were disappointed to see that neither Secretary Burwell nor IHS Principal deputy Director Mary Smith were present. Nor were other senior budget officials present. Before 2015, this meeting took place during the HHS Annual Tribal Budget Consultation (ATBC), but a separate meeting has been scheduled for the previous two years to allow the Workgroup adequate time to prepare their recommendation. Therefore, we **recommend** the following changes:

- Amend the HHS Tribal Consultation Policy to move the ATBC to the last week of March or April, and allow adequate time to prepare the BFWG national Tribal Budget Recommendations document and Tribal Leader presentation.
- Advocate for Tribal leaders to be active participants in all phases of the budget formulation process with HHS and the Office of Management and Budget (OMB), especially during the Congressional Justification (CJ) phase which has been embargoed to Tribes.

Office for American Indian / Alaska Native Programs at the Office of Management and Budget

For years, Tribal leaders have advocated for the creation of one office at the Office of Management and Budget (OMB) that would coordinate funding and policy for AI/AN programing throughout the various federal agencies. As we are all aware, programs serving the Tribes sometimes operate in silos leading to lack of information about needs, duplication, and inefficiency. Therefore, creating one single office that would have knowledge over all of these programs will ensure that resources directed to Tribes are being used in the most strategic and effective way possible.

- We **request** that you advocate with the President Obama and White House Council on Native American Affairs to create this office at OMB before the end of the Administration.

Advocacy on the Veterans' Administration Memorandum of Understanding

The VA and IHS signed a Memorandum of Understanding (MOU) on October 1, 2010 with the goal "to improve the health status of American Indian and Alaska Native (AI/AN) Veterans. By the end of FY 2014, VA had reimbursed over $13.1 million for direct care services provided by IHS and Tribal Health Programs (THPs) covering 4,500 eligible Veterans. The program provides eligible AI/AN veterans with access to care closer to their homes; promotes cultural competence and quality health care; and focuses on increasing care coordination, collaboration, and resource-sharing for eligible native veterans. On September 12, 2016, the Veterans Administration (VA) announced it would seek Tribal consultation on consolidating Tribal programs into one standard rate program at one standard rate. However, this plan will actually negate the positive impacts of the MOU and leave IHS and Tribal health providers with significantly lower reimbursements from the VA. The Choice Program does not pay the OMB-IHS rate and Choice requires preapproval as well as co-payments.

- The STAC **requests** that you advocate for IHS and Tribes and work with the Secretary of Veterans' Affairs to reject the consolidation of Tribal health programs into the Choice program.
- The IHS MOU expires on 12/31/2017. We **request** your support in assuring that the IHS MOU and Tribal Health Program's MOUs will be extended and renewed under the current terms for another five years into the next administration.

Implementation of Comprehensive Addiction and Recovery Act

Opioid abuse and addiction is a growing national epidemic in the United States and Indian Country is no different. However, due to the chronic underfunding of the Indian Health Care Delivery system, Indian Country does not have access to the same resources that the rest of the country has to combat this serious epidemic. Drug-related deaths among American Indians and Alaska Natives is almost twice that of the general population. On July 22, 2016, Congress passed the Comprehensive Addiction and Recovery Act (CARA) designed to address opioid abuse in the United States. However, much of the base funding will go directly to states, and not necessarily directly to Tribes. The following are **challenges** to respect the federal commitment to the Tribes:

- As the Comprehensive Addiction and Recovery Act is implemented how will HHS ensure that funding and resources reach Tribal Communities? Both for programs where Tribes are specifically authorized as grantees, and ones where they are not.
    - How will HHS require States to consult with and involve Tribes as they work on these issues?
- CARA requires the establishment of an inter-agency task force, composed of representatives from HHS, Veterans Administration, Department of Justice, the Centers

for Disease Control and Prevention and other federal agencies, as well as addiction treatment organizations and other stakeholder communities to develop best practices for pain management and pain medication prescribing. How will Indian Country be involved in this effort?

Senior Level HHS Position Dedicated to Coordinating Tribal Policies at ACF

The STAC appreciates that the Administration for Children and Families (ACF) has reviewed our request to establish a Senior Level Tribal Advisor with the ACF Assistant Secretary's Office. We appreciate your consideration of making the position a civil servant position and understand the difficulty with reconciling the new position with the duties of the ANA Commissioner. As a result, the STAC is in support of elevating the position of ANA Commissioner to the level of Deputy Assistant Secretary for Tribal Affairs at ACF.

- Before the Secretary moves forward on this approach, the STAC would like to **request** a position description and the opportunity to provide input on the roles and responsibilities of the new position.

Indian Child Welfare Act Implementation

The STAC greatly appreciates the efforts of the Administration for Children and Families and HHS leadership for the work you have done to improve the implementation of the Indian Child Welfare Act (ICWA). We are especially supportive of the anticipated inclusion of new ICWA data elements in the Adoption and Foster Care Analysis and Reporting System (AFCARS).

- We **request** that this continue to be a priority for the rest of 2016 and that it stay a priority for the next Administration. We **request** that the Department provide a date when we can expect the final rule to be published.

1115 Waiver Approval

The STAC requests an update on the waivers from Arizona, Oklahoma, and Wyoming that are still under review with the Centers for Medicare and Medicaid Services (CMS). In conversations with CMS, officials have indicated that there is concern with approving waivers that they interpret to be partial Medicaid expansion. These waivers should not be considered partial Medicaid expansion because the authority for these waivers existed long before the Affordable Care Act was made law in 2010. These waivers would expand access to thousands of American Indians and Alaska Natives, honoring the federal government's trust responsibility to provide healthcare. Politics are not an excuse for failing to honor the federal government's commitment to Tribes.

- The STAC requests an update on where CMS is at with review of these pending waivers.
- The STAC supports the State of Alaska's submission of its Medicaid waiver proposal and urges the Department to respond quickly and give a concrete timeline for

completion; this will be an essential tool to increase access to much needed substance abuse treatment in the state.

Transition Plan for the next Administration

The STAC is very appreciative of the work done during the Obama Administration to renew and strengthen Tribal consultation and the government-to-government relationship between the Tribes and the federal government. As a result of this relationship, federal agencies have a better understanding of the unique needs in Indian Country and how Tribes fit into the federal funding system. We hope to build upon these successes and continue this conversation for future administrations. This historic shift in attitude is appreciated but we still have a long way to go, especially as it concerns state-Tribal relationships. As equal partners in the Federal system, we hope that future administrations do more to encourage improved state-Tribal consultation. Tribes are still routinely left out of federal funding decisions or funds that flow to states are not making it to Tribal communities. Therefore, we request that the STAC be included in the development of the HHS transition plan to the next administration. Specifically:

- STAC **requests** that HHS make its transition plan available to STAC, and allow for collaboration when it comes to Indian Country's priority issues.
- We **request** that the transition plan include language around improving State-Tribal consultation.

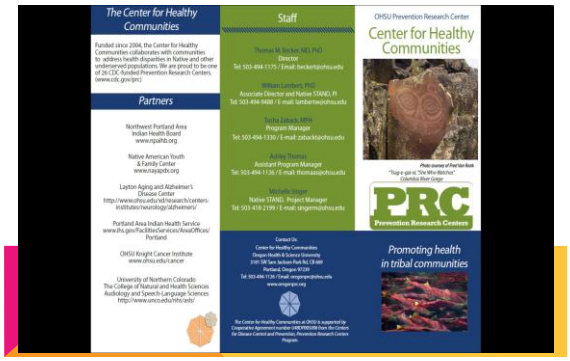
Conclusion

In conclusion, we would like to reiterate our appreciation for your willingness to work with us and for your prioritization and commitment to address our issues in Indian Country. We look forward to continuing a strong and respectful relationship with you and to your response to these requests.

Sincerely,

Chester Antone
Chairperson
Secretary's Tribal Advisory Committee

OREGON PRC: CENTER FOR HEALTHY COMMUNITIES



WORK WITH TRIBES & INDIAN COUNTRY

Native STAND
Students Together Against Negative Decisions

THE PROGRAM
NATIVE STAND

THE PURPOSE

- In Indian Country, tribal and community leaders are keenly aware of the challenges faced by their teens.
- Our challenge, in terms of community readiness is:
  - to move community leaders beyond recognition of the problem.
  - to commitment of resources to evidence-based interventions.

GENERATION INDIGENOUS

Native STAND

WE R NATIVE

FROM STAND TO NATIVE STAND

BACKGROUND

- STAND created by Mike Smith, Mercer University SOM, was the developer of the STAND curriculum.
- Reps. of National Coalition of STD Directors/I.H.S./CDC developed a work group.
- Native Work Group adapted the original STAND.
- Reviewed by Native Youth & Professionals.
- Validated in 4 BIE schools & 1 reservation community.

NATIVE STAND PROGRAM

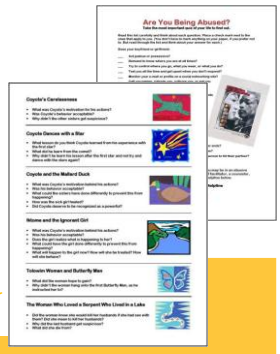
THE CURRICULUM	CORE ELEMENTS
1. Facilitator's Manual 2. Peer Educator Manual 3. Resource Manual • *29 ~ 90 min. sessions* ❖ *Culture and Tradition* ❖ *Honoring diversity / respecting traditions* ❖ *Healthy relationships* ❖ *Negotiation and refusal skills* ❖ *Decision making* ❖ *Being a peer educator*	• Uses active learning • Uses primary prevention techniques ➢ ***Non-judgmental attitudes*** ➢ ***Information sharing*** ➢ ***Advocating specific behaviors*** ➢ ***Positive role modeling*** ➢ ***Promoting personal commitment*** • Healthy, positive sexual expression in relationships

CULTURALLY TAILORED PROGRAM & CURRICULUM

➢ **Culturally Relevant**
- Stories/activities from various tribes
- Urban and Reservation
- Inter-Tribal

➢ **Expanded**
- Healthy Relationships
- Reproductive Health
- STIs/HIV/AIDS Prevention
- Early Pregnancy/Parenting

➢ **Created flexible format**
- 90 minute segments
- For use in boarding schools, after school programs, in-school, etc.



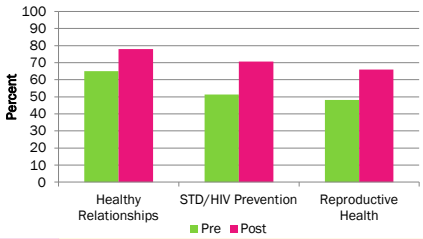
THE PROGRAM

Training
⇩
Hands-on Learning
⇩
Implementation Action Plan
⇩
Native STAND Activities
⇩
Teens Become Peer Educators

WHAT HAPPENED IN SELECT NATIVE SETTINGS?

1. Students demonstrated significant improvements in knowledge of:
   - STD/HIV/AIDS Prevention
   - Reproductive Health
   - Healthy Relationships
2. Tribal youth reported providing 1-on-1 peer education and referrals.
3. Adult facilitators learned how to better communicate & teach about sensitive topics.
4. Program was well received; recognition in addressing critical gaps in sexual health education.

FINDING: NATIVE STAND IMPROVES KNOWLEDGE!



Pre- n=70 youth Post- n = 34 youth

Native STAND
Students Together Against Negative Decisions

D & I PROJECT STUDY

OREGON HEALTH & SCIENCE UNIVERSITY

NATIVE STAND PROJECT CORE TEAM

OREGON PRC

Bill Lambert
Michelle Singer
Kavita Rajani
Tom Becker
Caitlin Donald
Brittany Morgan

NPAIHB

Stephanie Craig Rushing
Jessica Leston

**Adolescent Tribal Health*
**NW Tribal Epi Center*

OUTREACH & RESEARCH

Program is action oriented and empowers communities.

Project will measure & evaluate the adoption and impact in communities.

It is community driven!

PROJECT SIGNIFICANCE: RAISING HEALTHY NATIVE YOUTH

- 50+ educators and AI/AN organizations trained.
- Train-the-Trainer opportunities.
- Snowball Effect: Add new youth & allies over time.
- Pre- and post-questionnaire data on key indicators:

❖ (+/-) Changes in Youth
❖ Community Awareness & Engagement
❖ Capacity Building
❖ Leverage of Resources
❖ Culturally relevant health education

PROJECT COMMITMENT

"Natives Helping Natives"

- Build the capacities of tribal communities to engage in research.
- Allow individual communities to better access and understand data that would benefit their communities toward eliminating health disparities.

PROJECT PARTICIPANT BENEFITS

- 1-week of hands-on free training with curriculum materials.
- 2-year implementation funding ($5K each year)
- Technical assistance with Core Team, Coaches, Peers.
- Data on your youth, for your community, owned by your community!

PROJECT UPDATE –INDIAN COUNTRY & NATIVE STAND YEAR 1 & 2 COHORTS INTO ACTION!

30 Program Participants in 14 States, including Alaska!

- Tribes and AI/AN organizations
- Reservation/Rural Based & Urban/Metro Areas
- Mostly No Existing Adolescent Health Program
- Potential Implementation Host Sites Varies
- Projected Student Group Size Baselines: (10-19) and (20+)
- Diverse Educator Professional & Life Experiences

Native STAND
Students Together Against Negative Decisions

JOIN THE MOVEMENT!
YEAR 3 RECRUITMENT OPPORTUNITY!

LAST CHANCE!! NATIVE STAND 2017!

The Center for Healthy Communities is partnering with the NPAIHB to recruit 25 Tribes and American Indian/Alaska Native organizations!

a) If selected, 25 participants will receive the Native STAND Educator Training on the delivery of the Native STAND program; and,

b) If selected, a part of the Native STAND Project as the Year 3 Cohort and the collective effort.

EDUCATOR SUMMER TRAINING OBJECTIVES

1. Provide an overview of the Native STAND Dissemination and Implementation Project, including it's goals and objectives.
2. Prepare educators to teach an adolescent sexual health curriculum, with hands-on training using the Native STAND curriculum & program.
3. Prepare educators to recruit participants and implement the Native STAND curriculum in your community.

SUMMER TRAINING PROGRAM OPPORTUNITY

JUNE 26 TO JUNE 30, 2017

- 1 week in Portland – travel and lodging paid for.
- Native STAND curriculum materials provided.
- Hands-on Practice at THRIVE with youth.
- Human subjects protection training.
- Technical Assistance, recruitment and teaching tips.
- Evaluation, data collection and planning resources.
- Graduate and depart with action plans for home communities.

WHO SHOULD APPLY?

- Tribes and AI/AN organizations that serve high school age Native youth (grades 9-12, ages 14-18 years) are encouraged to apply.
- Examples of previous participants include Tribes, urban Indian organizations, Indian education departments, school districts and prevention programs.
- This training program is appropriate for educators and prevention specialists in the area of health, human/social services, education and juvenile justice.

WHAT ARE THE REQUIREMENTS FOR EDUCATORS AND HOST SITE?

- Identify an individual to serve as the Educator and to receive the Certified Training.
- The identified individual must provide assurance that they are able to attend the summer training.
- Have access to a setting to deliver the Native STAND Program.
- Provide support letters from your Tribe and/or organization.

HOW DO I APPLY?

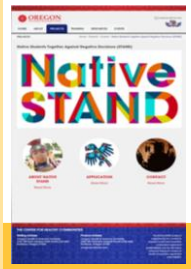
- ✓ It is recommended that interested individuals and organizations submit their application online.
- ✓ However, paper applications will also be accepted.

APPLY ONLINE at www.oregonprc.org

QUESTIONS OR TO LEARN MORE? VIEW THE WEBSITE

WWW.OREGONPRC.ORG

1. About Native STAND
2. Application for Educator Training Program & Project
3. Learn about the Certification as Native STAND Educator Training Program
4. Frequently Asked Questions (FAQs)
5. Resources
   - I. Presentations
   - II. Data Collection & Evaluation 101
   - III. Publications & Resource Articles
   - IV. Evaluation Reports
   - V. Native STAND Curriculum (3 Manuals)



IMPORTANT DATES IN 2016-17

NOW!	Applications Available
Nov. 17:	Informational Recruitment Webinar
March 1:	Application Deadline
April 1:	Site Selection & Notifications
June 26-June 30:	Certified Educator Training in Portland

LAST CALL FOR 25 FOR OUR FINAL YEAR!

www.oregonprc.org

Michelle Singer (Navajo), Project Manager

singerm@ohsu.edu

503-418-2199

Native STAND

Students Together Against Negative Decisions

Native STAND youth on field trip. Photo courtesy of Native STAND.

What is Native STAND?

Native STAND is a comprehensive culturally-appropriate curriculum for Native American high school students that promotes healthy-decision making. The curriculum is intertribal, drawing on teachings from many tribes and communities across the country. Native STAND focuses on positive youth development to support the prevention of sexually transmitted infections, HIV/AIDS, and to prevent teen pregnancy. The curriculum also addresses drug and alcohol use, suicide and healthy relationships. Native STAND is highly interactive.

Native youth at THRIVE Conference. Photo courtesy of Native STAND.

The 1.5 hour lessons are comprised of large group discussions, small group work, individual activities, and many lessons contain stories from tribal communities that ground learning in cultural teachings. The curriculum is flexible and can be easily adapted to include specific stories and traditions from the site where it is being implemented.

Native STAND consists of 27 sessions which focus on positive personal development, including team building, diversity, self-esteem, goals and values, negotiation and refusal skills, and effective communication. Sessions have been delivered in community centers, after-school programs, weekend retreats and various settings.

What is the Goal of the Native STAND Project?

The goal of the Native STAND Dissemination, Implementation, and Evaluation Project is to better understand how Tribal communities implement a program designed to help eliminate health disparities for high-school age American Indian/Alaska Native (AI/AN) youth.

It is important to understand the factors that affect adoption and use of the Native STAND curriculum by measuring and evaluating the impact of the program in AI/AN communities and key indicators of healthy behavior in AI/AN teens.

This study is funded by the Centers for Disease Control and Prevention (CDC) and the Indian Health Service (IHS). The project is a partnership between Oregon Health & Science University's Prevention Research Center, the Center for Healthy Communities, and the Northwest Portland Area Indian Health Board.

Participation in this project is open to all Tribes and AI/AN organizations across the United States.

Hands-on training. Photo courtesy of Native STAND.

Benefits of participating in this project:

- Free training (paid airfare and hotel costs) to gain knowledge and skills to become a Certified Native STAND Educator.
- Free curriculum materials, resources and supplies.
- Up to $10,000 in implementation support funding to deliver Native STAND in your community.
- On-going technical assistance and mentoring support.
- Strengthen your capacity to engage in research.
- Return data on your community for your use.

From a trained educator where Native STAND was implemented:

"Students have also been more open to talking about facts they learned from Native STAND with their peers and building a trusting relationship with their facilitators."

Center for Healthy Communities
OHSU, CDC Prevention Research Center

Feedback from former Native STAND youth participants about recommending it to their peers:

"I would recommend it to all of my friends because it teaches me many new things." - High school boy

"YES! Totally! Absolutely! I would recommend Native STAND to my peers, cause I really enjoyed it!" - High school girl

Native STAND Project Contact Information

Michelle Singer (Navajo), Project Manager
Native STAND
Center for Healthy Communities
Oregon Health & Science University
3181 SW Sam Jackson Park Road, CB 669
Portland, OR 97239

Tel: 503.418.2199
Fax: 503.494.7536
E-mail: singerm@ohsu.edu

Important Dates in 2016-17:

October 1:	**Applications Available**
March 1:	**Application Deadline**
April 1:	**Site Selection for Project**
June 26-June 30:	**Native STAND Training**

To Learn More and To Apply Visit

www.oregonprc.org

Educator graduation at Native STAND Training in Portland, Oregon. Photo courtesy of Native STAND.

Requirements for Participating Tribal Communities

In order for Tribes and AI/AN organizations to be considered for participation in this program, they will need to commit to the following:

- Identify and support an individual (such as a health educator or prevention specialist) to attend the free, one-week summer Native STAND Certified Training Program.
- Complete and submit a full online application.
- Applicants must ensure that they are able to attend and complete the entire one-week certification training in Portland, Oregon. Native STAND will provide airfare, hotel and meal per diem.
- Communities must demonstrate access to a setting conducive to implementing the curriculum (school, community center).
- A Memorandum of Agreement, local Institutional Review Board approval, and a valid W-9 IRS Form or appropriate Federal Tax ID will be required of sites before $5000 per year will be distributed.
- Tribes and AI/AN organizations must allow the trained health educator to implement the program through their current position.
- Accepted applicants will provide information to evaluators at the Center for Healthy Communities throughout the five-year duration of the project.

To learn more about the Native STAND Program, visit our website at www.oregonprc.org

To discuss eligibility requirements or for a program consult, please contact Michelle Singer, Project Manager at 503-418-2199 or singerm@ohsu.edu.

8B

CONTACT: Michelle Singer
singerm@ohsu.edu

Native STAND
Students Together Against Negative Decisions

Become A Certified Native STAND Educator!

One-Week Summer Training Program Opportunity in Portland, Oregon

Join us for a One-Hour Informational Webinar To Learn More!

November 17, 2016 or January 18, 2017

The Center for Healthy Communities is coordinating with the Northwest Portland Area Indian Health Board (NPAIHB) to recruit Tribes and American Indian/Alaska Native (AI/AN) organizations to receive training on the delivery of Native STAND (Students Together Against Negative Decisions), a healthy decision-making curriculum for enhancing and promoting positive youth development and well-being. This culturally appropriate health intervention for AI/AN teens is a school and community-based sexual health education program. There are two upcoming opportunities to learn more about Native STAND.

Native STAND Informational Live Webinar: A one-hour live webinar will be offered to those interested in learning more about the Native STAND training opportunity and program implementation in your home community.

Webinar Details

Date: Thursday, November 17, 2016 and Wednesday, January 18, 2017
Time: 11 a.m. Pacific

Webinar Objectives: At the end of the webinar, participants will be:

1. Familiar with the Native STAND curriculum and its contents;
2. Understand the goals and expectations of the Native STAND dissemination project;
3. Understand the Native STAND application process and training timeline.

Who should attend and apply: Tribes and AI/AN organizations that serve high school age AI/AN youth are encouraged to apply. Examples of previous participants include Tribes, urban Indian organizations, Indian education departments, school districts and Tribal prevention programs. This summer training is appropriate for educators and prevention specialists in the area of health, human/social services, education and juvenile justice.

Registration: This webinar is free and open to everyone and no registration is required. Simply follow the instructions below on the day of the presentation to be connected.

Connection Information

Go to**:** https://npaihb.adobeconnect.com/qip/
Select the "Enter as a Guest" option
Input your name (first and last) in the Name box
There is no passcode
Press the "Enter Room Button"
For Technical Assistance During the Call: Jessica Leston (907-244-3888, jleston@npaihb.org)

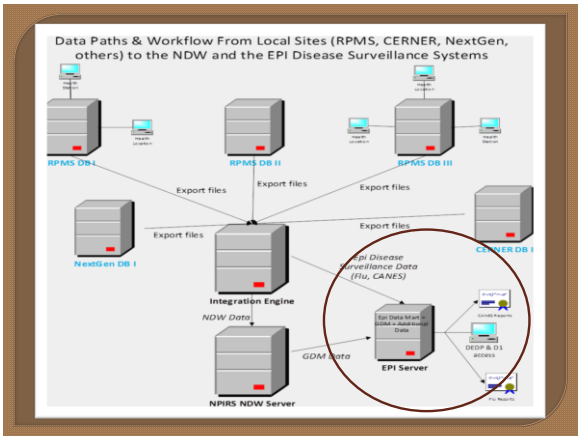
This activity is funded by the Centers for Disease Control Prevention Research Center and the Indian Health Service NW NARCH as part of the efforts to eliminate health disparities for Tribal youth.

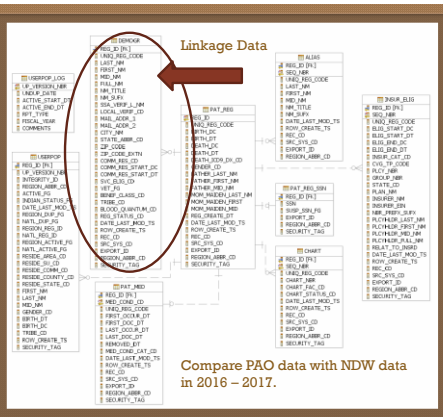
Data Repository/Data Movement

Victoria Warren-Mears, PhD, RDN, FAND
NWTEC Director
vwarrenmears@npaihb.org

Overview

- How does data flow to IHS?
- NWTEC Access
  - EpiData Mart
  - Linkage Projects
  - Research Projects
- Data Repository Progress
  - Data Stewardship





Progress on the Data Repository

HARDWARE		Actual	Retail
Dell PowerEdge R710 Server	(Refurb-Recertified)	$1,679.00	$1,679.00
Dell PowerEdge R710 Server	(Refurb-Recertified)	$1,679.00	$1,679.00
2 - Spare 3TB 7.2K 3.5" 6Gbps NL SAS Hard Drives		$416.51	$416.51
Cisco ASA 5512-x Security Plus Appliance		$500.00	$2,414.15
Quantum SuperLoader 3 Tape Backup Autoloader		$3,994.34	$3,994.34
20 - Pack of HP LTO-6 Tape Backup Cartridges		$866.99	$866.99
RapidRails for server rack installation (4)		$338.67	$338.67
Tripp Lite 8-Port Rackmount KVM Switch w/Built in IP		$720.99	$720.99
Dell SAS 6 GB NBA External Controller Card		$149.00	$149.00
SOFTWARE			
3 - Microsoft Windows Server 2012 Standard Licenses		$198.00	$3,972.00
50 - Microsoft Windows Server User Client Access Licenses		$100.00	$2,200.00
1 - Microsoft Exchange 2016 Mail Server License		$53.00	$1,062.00
50 Microsoft Exchange 2016 Server User Client Access Licences		$250.00	$5,100.00
25 - Cisco 5500 Series AnyConnect SSL-VPN Licenses		$100.00	$1,053.00
	TOTAL COSTS	$11,045.50	$25,645.65
	SAVINGS	$14,600.15	

Visioning the Future

- Finish Data Repository
  - Data stewardship of data developed and collected at the NWTEC
  - Data stewardship for other data
- Develop data portal for access by tribal leaders
  - Web based with unique tribal passcodes and protections

Questions and Discussion

WESTERN OREGON SERVICE UNIT

CAPT Laura Herbison, CEO
July 6-7, 2016
Direct Service Tribes Meeting
Portland, OR

Chemawa Indian Health Center

This year, 2016, Western Oregon Service Unit (Chemawa Indian Health Center) celebrates 37 years of comprehensive outpatient services to federally recognized American Indian and Alaska Native people and their descendants living in or visiting the service area. Located in Salem, Oregon, Chemawa Indian Health Center has grown to provide health care to over 6,000 patients that represent 299 tribes from all areas in Oregon and SW Washington. The clinic continues to work closely with Chemawa Indian School and Bureau of Indian Education to coordinate all aspects of patient care to the over 400 high school students living on campus.

Renew and Strengthen Partnerships with Tribes and Urban Programs

- Governing Board attendance by Grand Ronde Executive Director, Kelly Rowe
- Governing Board attendance by CIS Superintendent, Lora Braucher
  - Care Coordination Improvement team between CIS and WOSU
- NARA site visit, POS training, provider shadowing
- Site Visit by the U.S. Secretary of Veterans Affair, Robert A. McDonald
  - 267 registered Native American Veterans representing 78 tribes

Ensure Work Is Transparent, Accountable, Fair, and Inclusive

- GPRA
- Quarterly Director's Priorities Reports
- Governing Board charter to include data dashboard, policy/AAAHC crosswalk
- Quarterly budget reviews with Budget Analyst
  - Daily and weekly obligations / collections finance reports
- Monthly department reports
- QI projects – public drive – department and workgroup folders

Improve the Quality of and Access to Care

Strategic Planning Framework Summary

Chemawa Indian Health Center

Purpose

Chemawa provides a legacy of wellness as a trusted provider of choice.

Values

Core Values

Willingness | Learning | Compassion | Trust | Respect

Strategic Objectives

- Recruitment and Retention Transformation
- Enhanced Utilization of Technology
- Customer Service Excellence
- Access to Quality Care and Services
- Optimal Communication

Strategic Initiatives

- Promote continuous patient/staff feedback
- Expand opportunities for wellness
- Strengthen employee development program
- Recruit and retain exceptional staff
- Increase opportunities for learning and employee engagement
- Maximize our impact by stewarding and enhancing our resources
- Increase the capacity for effective communication
- Network with outside agencies, local partners, and tribes
- Empower staff to employ risk-taking change strategies
- Invest in IT capabilities
- Strengthen recruitment of high achieving students
- Embrace diversity of staff to strengthen the learning environment
- Increase opportunities for cross-disciplinary collaboration

Improvement Strategies

- Care Coordination
- Dental Referral
- Meaningful Use
- Medical Referral
- NPDB Query
- Uninsured Patients
- Dental Scheduling
- HIM Scanning
- Phlebotomy
- Lab Package
- Lab Ordering
- Employee Training
- Expand BO hours
- ITAC project
- Employee Orientation
- PIV Card
- OM Test Strips
- Scheduling Re-design

Improve the I.H.S

- Modernization
  - Project Schedule: 25% complete with construction
    - ADA compliance through out with new canopy entrance
    - Increase exam rooms, addition of 4th care team
    - Improved operational efficiency
    - Additional group mental health counseling rooms
- **Construction Complete: July 24, 2017**

CHEMAWA INDIAN HEALTH CENTER

PROGRAM SERVICES

Scheduled and Same Day Ambulatory Appointments
Women's Health, Family Planning, Well Child Exams
Pharmacy including mail order prescriptions
Dental, Optometry, and Lab
Mental Health Support
Alcohol and Substance Prevention
Public Health Nursing
Benefits Coordination in support of ACA
Group Diabetes Education and Self Management Courses

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.

Legislative/Resolution Committee

Tuesday October 18, 2016
Clearwater Casino & Resort, Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Chrishna Peters NDTI Prog. Director	NPAIHB	cpeters@npaihb.
2	Kim Zilkett - Health Dir	Skokomish Tribe	
3	Cheryle A Kennedy	NPAIHB - CTGR	
4	Greg Abrahamson	Spokane Tribe/NPAIHB	
5	Joe Finkbonner	NPAIHB	
6	Brent Simcosky	Jamestown	
7	Leslie Wosnig	Suquamish	
8	Tim Gilbert	Umatilla	
9	John Stephens	Swinomish	
10	Tino Batt	Shoshone-Bannock	
11	Dylan Dressler	Lower Elwha Klallam	
12	Ann Tom	Shoshon-Bannock Tribes	
13	Laura Platero	NPAIHB	
14			
15			
16			
17			
18			
19			
20			

Legislative Committee meeting: October 18, 2016

Attendees: Christina Peters, NPAIHB staff; Kim Zillyett-Harris, Shoalwater Bay; Cheryle Kennedy, Grand Ronde; Greg Abrahamson, Spokane Tribe; Joe Finkbonner, NPAIH Executive Director; Brent Simcosky, Jamestown; Leslie Wosnig, Suquamish; Tim Gilbert, Umatilla; John Stephens, Swinomish; Tino Batt, Shoshone-Bannock; Dylan Dressler, Lower Elwha K'lalam; Ann Jim; Shoshone-Bannock; Laura Plater, NPAIHB

One resolution was considered:

1. **Support of Community Health Aide Program National Expansion**

   This resolution supports expansion of the Community Health Aide Program nationally and in the Portland Area, and the development of regional certification boards with baseline standards for consistency of services provided by any CHAP program; and establishment of a full CHAP pilot project in the Portland Area.

   Motion by Spokane; second by Swinomish; and unanimous vote to pass the resolution to the Board for consideration.

There was also discussion about a resolution to support the CDC Opioid guidelines and the work in Oregon and Washington. Tom Weiser may be bringing this forward through his discussion in the Public Health Committee.

Behavioral Health Committee

Tuesday October 18, 2016
Clearwater Casino & Resort, Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Kevin Collins Health Director	Stillaguamish Tribe	KCollins@Stillaguamish.com
2	Tracey Rascon Interim Hlth Dir	Makah	tracey.rascon@ihs.gov
3	ALah Hamilton MPH, MSW, Grand Ronde Health Committee	Grand Ronde	alahhamilton@hotmail.com 503-949-2721
4	Darryl Scott B.H. Program Manager	Conf. Tribes of Warm Springs	541-460-8648 darryl.scott@wstribes.org
5	Caroline M. Cruz CTWS H&HS Dir	CTWS	541-615-0140 caroline.cruz@wstribes.org
6	Michael Stickler Health Policy Director	NARA NW	mstickler@naranorthwest.org
7	David Dickinson Regional Administrator	SAMHSA	david.dickinson@samhsa.hhs.gov
8	Marilyn M. Scott Tribal Council	Upper Skagit Indian Tribe	(360) 854-7039 marilyns@upperskagit.com
9	Vicki Lowe Executive Director	AIHC	(360) 460-3550 vicki.lowe.aihc@outlook.com
10	Keri Ellis Hlth Admin Coord	Lower Elwha	(360) 912-2239 keri.ellis@elwha.org
11	Naomi Jacobson Tribal Council Secretary	Quileute Tribe	naomi.jacobson@quileutenation.org
12	Emma Medicine White Consultant		emmamwc@gmail.com
13			
14			
15			
16			
17			
18			
19			
20			

NPAIHB Behavioral Health Committee – Meeting Minutes

Suquamish, WA – October 2016

- **Introductions**
- **Update on NARA's Youth Treatment Center**
  - Will provide integrated Treatment and Behavioral Health services with imbedded traditional healing practices
    - No detox, youth must be clean for a week
    - Michael will share the intake form with Committee members, if anyone else is interested in a copy
  - Will open in April 2017, and will serve youth and families 13-17 years old
  - Will be open to all NW Tribes to access
  - Tribes can do a direct referral, or go through Krissy, the Behavioral Health Consultant @ PA IHS
  - Space is near Gresham; Will try to get a waiver for the 16 bed rule; Space can accommodate more youth
  - Will have an outreach team (to: homeless youth and schools)
  - Still need to investigate/determine:
    - if/how they can get approval for WA Medicaid patients
    - while the length of stay should be determined by what is in the best interest of the patient, that doesn't align with 15-30 day rules
- **Update from the AIHC in WA:** AIHC is working on a carve out for a Tribal encounter rate for mental health services. (Currently just includes CD services).
  - Will take effect July 1, 2017
  - In WA, they are requesting that 100% of FMAP savings return to tribal programs.
  - In OR, the saving is split with the Tribes
- **Question re: Medicaid Reimbursement for Peer Behavioral Health Counselors**
  - All three states do reimburse and Tribes are using the program… counsellors need to be certified:
    - OR: https://www.oregon.gov/oha/amh/pd/Pages/approved-training.aspx
    - WA: https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/peer-support

        - ID: http://healthandwelfare.idaho.gov/Medical/MentalHealth/PeerSpecialistsFamilySupportPartners/tabid/2935/Default.aspx

- **Still need more regional Coordination in Behavioral Health Services...**
    - **Question**: What happened to recruiting Dale Walker?
        - Joe Finkbonner is meeting with him on Friday. More detail to come.
    - **SAMHSA Grants:** Want to make sure we create opportunities for coordination and resource sharing.
- **Caroline Cruz provided an update on Oregon's Tribal Best Practices**
    - They have approval from OR State to use Tribal Best Practices using state funds for intervention/prevention programs
    - Currently includes 22 Best Practices
    - A workgroup meets quarterly to review/add Tribal Best Practices; which is meeting at NARA next Monday
    - Link to website: https://www.oregon.gov/oha/amh/Pages/ebp.aspx
- **Tribal Behavioral Health Agenda:** http://store.samhsa.gov/TBHA/feedback/
    - Comments are due by October 30th
    - Wonderful to see coordination between IHS, SAMHSA, NIHB and tribes in the making of this document. The *need* for this interagency agenda is great and long overdue.
    - David: Hope to roll it out before the end of the current Administration (December)
    - Committee: Would like to support the positive momentum.
        - Board could pass a joint resolution in support of the Agenda.
- Handout: Obama Administration Commitments and Accomplishments re: **Violence against Indigenous Women and Girls**
    - Stephanie will forward the email to Committee members
- **New Issuance IHM 3-31 - Intimate Partner Violence**
    - The following directive was signed by the Principal Deputy Director, on October 4, 2016: Indian Health Manual, Part 3, Chapter 31 - Intimate Partner Violence
    - Please distribute to all employees within your area of responsibility: https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c31

Personnel Health Committee

Tuesday October 18, 2016
Clearwater Casino & Resort, Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Cassandra Skeen	Quileute Tribe	
2	Angela Weaver	NPAIHB	
3	Shawna Gordon	Upper Skagit	
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Minutes

October 18, 2016

Start Time: 12:00 pm

Members Present: Cassandra Sellards-Reck, Shawna Gavin

Members Absent: Bonnie Sanchez

Staff Present: Andra Wagner

- Personnel update was read by Andra Wagner
    - 1 new hire
    - 2 promotions
    - 1 transfer into new position
    - 1 volunteer
    - 0 resignations
- No open positions
- Constant Contact Training was given to staff on Oct 4th
- Criminal Background checks for current staff and new hires was discussed, the management team consulted with attorneys and the policy is being written and will be sent to delegates as soon possible

Youth Committee

Tuesday October 18, 2016
Clearwater Casino & Resort, Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Danielle Stensgar Business Operations Director	Healing Lodge of the Seven Nations	(509)533-6910 ext. 369 [redacted] danielles@healinglodge.org
2	Leland Bill	Yakama Nation Tribal Council Member	(509) 388-3437 Leland-bill@yakama.com
3	J Potts	Suquamish Tribe	jpotts@suquamish.nsn.us
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Youth Committee
Tuesday October 18, 2016
Clearwater Casino & Resort Suquamish, WA
NPAIHB Quarterly Board Meeting

Attendees
Healing Lodge of the Seven Nations- Danielle Stensgar, Business Operations Director
Yakama Nation- Leland Bill, Tribal Council Member
Suquamish Tribe, Jo Potts
NPAIHB, Nanette Star, Project Director

Discussion
- Introductions
- Previous Youth Committee meeting
    - Inviting tribal youth to QBM – possibly from surrounding tribes of host area
    - Big brother big sister type of support for youth through QBM and/or Youth Committee
    - Direction of committee: youth come together, leadership, delegates bring a youth if able and/or parent
- Future Youth Committee agenda
    - Would like to hear what youth would like to discuss
- Details on Healing Lodge in Spokane: 45 beds, male & females served, ages 13-17, native and non-native youth
- Andy Joseph Chairman

Action Items
- NPAIHB connect with Youth Ambassadors in Chehalis area for youth attendance at January 2017 QBM

Veterans Health Committee

Tuesday October 18, 2016
Clearwater Casino & Resort, Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

None Nobody Showed

Elder Committee Meeting Minutes
October 18, 2016
Suquamish Clearwater Casino Resort
Suquamish, WA

In attendance: Andy Joseph- Colville, Dan Gleason—Chehalis, Gladys Hobbs and Sally Petite—Grand Ronde, Patty Gaiser- Cowlitz, Luella Azule, NPAIHB staff

Andy Joseph provided opening Prayer.

August 2016 Elder committee minutes: **Correction**: Dan Gleason stated he did not make motion to approve April 2016 Minutes. Andy Joseph called for approval with the minor correction. Patty seconded, passed unanimously.

Tribal Updates:

Grand Ronde

October 26 Gladys stated Grand Ronde Elders are going to Siletz for a Halloween Party. Siletz and Grand Ronde alternate hosting party. There will be a Halloween Costume contest.

November 11-12th The Tribal Market Place will be at the casino and again on November 18-20th during Restoration. Most vendors are native but anyone can sell.

On 2nd and 4th Saturday there is an elder's gathering at the Elder Activity Center. The 2017 Elder's Honor Date is currently unknown.

December 2-3rd Christmas Bizarre.

December 6th Tribal Christmas Party.

December 16th,Tribal Elders Christmas Party

Grand Ronde uses Title 6 funds to host a lunch and Harvest Event to get whatever is ripe at the time.

One time monthly there is a Nutrition Bingo with prizes.

In January 2017, Chehalis Tribe will host the NPAIHB QBM and ATNI at Great Wolf Lodge.

Cowlitz Tribe

Patty stated she also attended NICOA and National Indian Health Board conferences. There will be a Christmas Bizarre the 1st Saturday in December at St. Mary's in Toledo. She is donating items to the raffle. Although they have an enrollment of 4000 members, they only get about 250 for meetings. Puyallup is hosting a Public Health Summit.

October 7, Cowlitz hosted an Elders Honor Day. At least 10 tribes sent their elders. Patty estimates there were approximately 350 elders.

The Elder Committee asked about Clarice. I stated she will return January 2017 for the Chehalis QBM. The Elder committee wishes her a speedy recovery.

Public Health Committee

Tuesday October 18, 2016
Clearwater Casino & Resort, Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Danna Drum Strategic Partnerships	OHA-PHD	971-673-1223 danna.k.drum@ state or. us
2	Jonny Fokom	Lummi Nation	360-384-1656
3	Shana Radford	CTWS (Warm Springs)	541 310 9185 shana.radford@ wstribes.org
4	Tom Welsh	Med Epi PAOIHS	
5	Hazle Pacquette HB COOR	Suquamish Tribe	hpacquette@suquamish.nsn.u 360-394-8528
6	Jim Steinbucc Health admin.	Tulalip Tribes	(360) 716-5610 jsteinbucke@tulaliptribes-nsn.go
7	Fauna Larkin Assistant Health + Human Services Administrator	Coquille Indian Tribe	541-888-9494 ext. 2010 fauna.larkin@coquilletribe.org
8			
9	TIM NOE, CENTER ADMIN. PREVENTION + HEALTH PROMOTION	OHA/PHD	TIMOTHY.D.NOE@STATE.OR.US 971-673-1139
10	Sarah Hatcher CDC EISO	NPAIHB	shatcher@npaihb.org
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Public Health Committee
October 18, 2016
Suquamish Clearwater Resort and Casino

Opioid Epidemic
Oregon Washington Health Moderization

In Attendance:
Danna Drum – OHA-PHD
Jerry Folsom – Lummi Nation
Shana Radford – Warm Springs
Tom Weiser – HIS PAO
Hazel Pacquette - Health Benefits Coordinator, Suquamish Tribe
Jim Steinruck – Tulalip Tribes
Fauna Larkin – Coquille Tribe
Tim Noe – OHA- PHD
Sarah Hatcher – CDC EIS Officer
Victoria Warren-Mears, Staff NWTEC

On Epic at Tulalip from RPMS –good relationship connectivity with Providence and other large health systems. Expensive but good.

Opioid Epidemic – Tom Weiser
Working with OR advisory board, roll out OR guidelines for opioid prescribing.
Tribal specific issues/other entities
Not many unique issues; rurality issues in pain speciality and physical therapist
Lack of providers in the rural area
Financial barriers seem less problematic
Distance is an issue at this time.
CDC guidelines supported in OR, endorsement by the Board of Guidelines
Washington is also moving on this; Federal Gov has new initiatives around this.
Report – more to digest prior to endorsement.
Illicit opioid where do they get there. How does medication get to patients?
- Street versus prescription.
- Drug culture on Border is influenced by Canada.
- Majority of Oxycontin in Lummi is from Canada
- IHs should outreach to Canada

People in coos bay go to Eugene for pain management – what is the recommendation for areas with lack of access. Not just meds but CBT, etc. Southern OR pain consortium.
"De-escalation" how do we decrease the amount used. There are guidelines. Is there a part of discussion to increase services in rural areas?
Exercise recommendations can be implemented clinically.
Risk of addiction versus pain treatment

Canada and LA Problem – Advocacy for Canadian border
Going to relatives; can't just stay away from relatives.
Fentnyl is trickling down in Warm Springs, from Canada

A lot of the chronic issues are due to pain and trauma. People don't know why they are in pain.

Programmatic capacity: Lots of resources are needed to marshal response to pain.
Does CDC include recommendations for trauma informed care perspective?
Stress reduction strategies.

What is tribal capacity to deal with prescription medication addictions? Support changes in root causesi

Youth leadership portrayed and supported in substance abuse. Tribal representative at local schools for potential for access. With high suicidality, everyone is paying more attention to youth. Depression is actively paid attention to. Redirecting kids to the right path. Variety of events through the youth center; fun and tutoring. Increasing positive connections with the kids and the community. Built policies and relationships. Reinforced community relationships. (Suquamish example)

Addiction theory. Increase connections that are positive. Layering of disfunction. Geographical differences. If closely located to outside connections. Close relationship with LHJ. Community problem, not tribal probem. Willingness to work with one another. Snohomish Co public health and Tulalip are connected. Trust building and building personal relationship. Four community meetings. Mel Sheldon, Hannah Means and elders. Deaths in immediate family.

Resourced related to facility size. Knowledge is there; guidelines are great. IHS needs to cover additional services to support recovery. Billable solutions….

Source of the medicine is coming from licensed providers
Tribal law regarding prescription of addictive substances.
Traditional health workers are underutilized in Oregon –

Public health is underserved and clinics don't have a lot of specialist. High utilization among PRC patients.

Summit at Mill Casino – slow to gain traction.

Provider opioid system – only 30% using.

Prescription drug monitoring in OR. Know who are providing opioids. Statute does not allow information to be shared in OR. Potential to revoke license if overprescribing. Comprehensive provider education. Guidelines are being trained on. OR integrate PDP and emergency room access. Every provider with DEA should be registered and use PDP.

Marijuana as a public policy question. Alternative to taking anything stronger. Pain alternatives may be more addictive. Medical marijuana; testing have prescription. CDC guidelines – include marijuana. Marijuana is still a schedule 1 drug.

Suquamish also has traditional foods and medicine. Traditional foods and medicine providers. How to help people function. With chronic pain, it is important to find the root of the pain. How do we honor patients wishes to not use RX.

Naltraxone/naloxone – every person that treats patients, uses over and over again. Tribe takes liability for the medication.

- Next steps model that are working in rural and urban areas
- Need examples – first responders working (Tulalip Fire/Marysville Fire)
- Can we pull this together?

CHRs and nurses are acting as case managers for people in Suquamish.

Oregon Public Health Modernization:

Danna Drum – Oregon process. Similar to Foundational Public Health Services in Washington State. What has tribal leader's in Washington experience been?
Jim (Tulalip) recently has found on committee. Has been on several calls. Tulalip is going (Community Health Program – not public health). Two RN, LPN, 3 CHRs, who were not well focused. Transported people and putting out fires. Program for homebound. More homecare versus home care. Sunrise services in Everett took over home care. Patient didn't like Sunrise Services, gradually transitions. Have a coordinator for services at Elder Services. Starting on true community health program. Have a case manager are adding another. Adding an MPH and a director for the program for community health. Generally well received by the Board. Three nursing professionals are doing nursing services, including wound care and hospital tribal liaison at Providence for ED and inpatients on discharge planning and culturally sensitivity training. Many concerns; documented services for people who are addicts, due to Epic data exchange.

Following people back into community. So handoff is providing enhanced patient care. Tying in sanitation, communication, housing, and healthcare. Housing is an important. Transportation, nutrition, housing, etc.

CHRs have a long history in Indian Country. CHRs are health care providers. (medical provider) Traditional medicine expansion. Trying to make an expansion in a small place. Need to make a good strong transition.

Two questions regarding mental health. Destimatization of questions. Pass off for problems to the appropriate referals. Team of individuals. Group meetings. One person added to meetings one at a time. Health benefits coordinator. Team effort for case management. Suquamish may have a clinic.

Health care system seems siloed in some ways. Finance was with clinic now moved to finance department. Long house with clinic on one side. Behavioral health will be on the other side. Getting ready to do remodel at the Tulalip clinic. Distigmatization of the mental health system. Mind is part of the body. Just like mouth is part of the body. Health services for the Tulalip tribe.

Depression in males – how is it handled? Told to "man up" and discuss information.
Importance of availability of services. Need peers to support issues. Youth council helps with this.

Health care services is part of community health.
The work "public" does not resonation with the tribes. What word should be used to describe community public health? Need a tribal word for it. Community health has other connotations for the state. How do you communicate across tribe/LHJ what it is.

Who can we work with CCOs and ACOs? Some tribes have worked successfully.

People may not like answering questions need to norm more questions. Need mental health data per community.

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 #: 17-01-01
Supporting Standing Rock Sioux Tribe and Opposition to Dakota Access Pipeline

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 prevention of harm to the health and well-being of Indian people is an essential aspect of the purpose of the NPAIHB; and

WHEREAS, the Standing Rock Sioux Tribe has been engaged in a legal battle to stop the Dakota Access Pipeline from impacting it's cultural, water, and natural resources; and

WHEREAS, the Dakota Access Pipeline is a 1,168-mile long crude oil pipeline that will transport nearly 570,000 barrels of oil each day from North Dakota to Illinois; and

WHERAS, the Army Corps of Engineers has not carefully analyzed the impact of an oil spill on the Standing Rock Sioux Tribe or fully satisfied the National Historic Preservation Act, various environmental statutes, and its trust responsibility to the Standing Rock Sioux Tribe; and

WHEREAS, the current proposed pipeline route crosses under Lake Oahe, just a half mile up from the Standing Rock Sioux Reservation; and

WHEREAS, the NPAIHB has determined that it supports the Standing Rock Sioux Tribe and other tribes in their opposition to the Dakota Access Pipeline.

THEREFORE BE IT RESOLVED, that the NPAIHB supports the Standing Rock Sioux Tribe and opposes the Dakota Access Pipeline;

BE IT FURTHER RESOLVED, that the NPAIHB encourages its member Tribes and Indian Tribes and Nations nationally to stand united against the Dakota Access Pipeline.

CERTIFICATION

NO. 17-01-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 3 **for,** Ø **against,** Ø **abstain on** September 21, **2016.**

Andrew C. Joseph Jr.

Chairman

September 21, 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

2121 SW Broadway
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

Resolution # 17-01-02
Support of Community Health Aide Program (CHAP) National Expansion

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

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

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

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

WHEREAS, American Indians and Alaska Natives (AI/AN) have very limited access to health care services and are disproportionately affected by oral and behavioral health disparities and these disparities are directly attributed to the lack of health professionals in Indian communities, which has caused a serious access issue and backlog of many health services for Indian people; and

WHEREAS, many of our member Tribes have great difficulty and face significant challenges in recruiting health professionals to work in their communities that results in further challenges in ensuring continuity and comprehensive health care for Indian people; and

WHEREAS, the Alaska Community Health Aide Program (CHAP) has been in existence since 1964 as a program of the Indian Health Service; and

WHEREAS, the federally authorized Community Health Aide Program Certification Board (CHAPCB) was established and charged with formalizing the process for maintaining the Community Health Aide/Practitioner training and practice standards and procedures; and

WHEREAS, CHAP has been an effective method for diminishing the health disparities of Alaska Natives by promoting access to health services for Alaska Natives residing in rural and remote communities; and

WHEREAS, CHAP grows providers from within Tribal communities who provide patient-centered quality care that comes from providers that understand the history, culture and language of their patients; and

WHEREAS, CHAP provides patient-centered primary care and delivers more care in the community rather than an acute care setting; and

WHEREAS, CHAP provides routine, preventative and emergent health care through Community Health Aides (CHA/Ps), Behavioral Health Aides (BHA/Ps), and Dental Health Aide Providers (DHA/Ts); and

WHEREAS, CHAP providers provide continuity of care in communities that face recruitment and retention challenges; and

WHEREAS, the Indian Health Service issued a Dear Tribal Leader Letter and draft policy statement on June 1, 2016 to solicit input from Tribes on their interest in expanding the existing CHAP and the creation of a national certification board for CHAs in the IHS system; and

WHEREAS, our member Tribes would benefit from expansion of the CHAP to the Portland Area.

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board does hereby support expansion of the Community Health Aide Program nationally and in the Portland Area; and

BE IT FURTHER RESOLVED that the Northwest Portland Area Indian Health Board supports the development of regional certification boards with federal baseline standards for consistency of services provided by any CHAP program; and

BE IT FURTHER RESOLVED that the Northwest Portland Area Indian Health Board supports the establishment of a full CHAP pilot project in the Portland Area.

CERTIFICATION

NO. 17-01-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 25 **for,** 0 **against,** 0 **abstain on** October 20**, 2016.**

Andrew C. Joseph Jr.

Chairman

October 20, 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

2121 SW Broadway
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

RESOLUTION # 17-01-03
SUPPORT ENGAGEMENT OF YOUTH AND DEVELOPMENT OF YOUTH TRACK

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

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

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

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

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

WHEREAS, the development of our youth in leadership will benefit the communities and because the youth are our future;

WHEREAS, many of our member Tribes have active youth councils and other means for the youth to voice their opinions and priorities in shaping the future; and

WHEREAS, regional and national Tribal organizations (ATNI and NCAI) also embrace a youth track, or separate activities to engage youth populations into leadership development and initiation of policy; and

WHEREAS, developing leadership skills of our younger populations will provide the opportunity to improve health services and policy in a more inclusive and diverse manner; and

WHEREAS, Tribal populations tend to have a large percentage of their populations below the age of 25 than the general population; and

WHEREAS, engaging our youth in the development of approaches to wellness and solutions to their health issues is more likely to ensure their participation and have better outcomes.

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board does hereby support the development of a youth track and engagement of the youth of our member Tribes in leadership development and priority-setting for health issues impacting their age group as an investment in improving the lives of future generations to come; and

BE IT FURTHER RESOLVED, the Northwest Portland Area Indian Health Board encourages our member Tribes to expand involvement of youth in policy development and in setting priorities that address the issues important to their youth populations.

CERTIFICATION

NO. 17-01-03

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 25 **for,** 0 **against,** 0 **abstain on** October 20**, 2016.**

Andrew C. Joseph Jr.

Chairman

October 20, 2016
Date

Gregory J. Abrahamson
Secretary

Health News & Notes

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

A Publication of the Northwest Portland Area Indian Health Board

October 2016

A NEW APPROACH TO CHRONIC DISEASE PREVENTION

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

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

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

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

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

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

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

WEAVE-NW Tribal Projects

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

Food Systems and Policy

To improve food systems, some projects are

continues on page 10

IN THIS ISSUE:

Chronic Pain

ISSUES IMPACTING TRIBAL HEALTH PROGRAMS

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

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

FY 2017 Continuing Resolution and the IHS Budget

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

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

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

ISSUES IMPACTING TRIBAL HEALTH PROGRAMS

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

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

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

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

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

continues on page 4

IMPACTS ON TRIBAL HEALTH PROGRAMS

continued from page 3

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

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

IHS Seeks Tribal Comments on Proposed Rules and Policies

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

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

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

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

Contract Support Cost Developments

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

IMPACTS ON TRIBAL HEALTH PROGRAMS

important improvements to the policy.

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

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

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

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

IHS Headquarters Realignment

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

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

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

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

Reimbursement from the Veterans Administration for Direct Care Services

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

continues on page 11

CURING HEPATITIS C

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

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

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

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

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

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

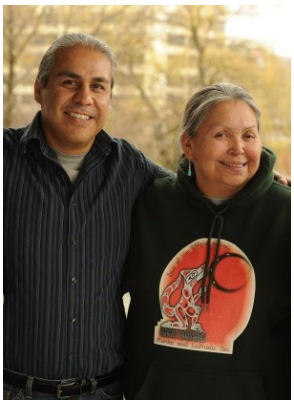
In order to better understand HCV among NW Tribes, Project Red Talon performed Electronic Health Record (EHR) audits to determine caseload and awareness of HCV disease in the Portland Area. The project identified persons in EHRs with a probable HCV diagnosis, age, antibody and RNA test results, genotype,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

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

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

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

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



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

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

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

CURING HEPATITIS C

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

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

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

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

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

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

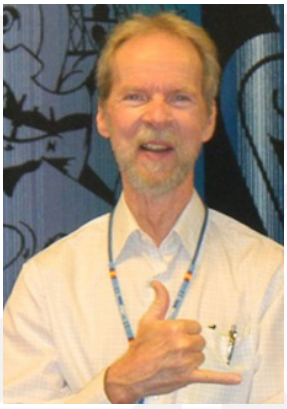
Additionally, two providers completed the University of Washington Hepatitis C Online course (http://www.hepatitisc.uw.edu/) which is free to the public and provides continuing education for clinicians. This course was comprehensive and tailored to providers of all types, including RN's and pharmacists.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

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

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

continues on page 9

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

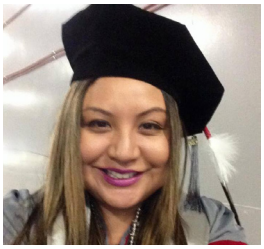


By Dr. Tom Becker
NW NARCH & Cancer Project Director

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

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

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



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

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

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

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

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

What would you share with others who are seeking

continues on page 9

(NW NARCH) FELLOW HIGHLIGHTS

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

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

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

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

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

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

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

CURING HEP C

continued from pg. 7

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

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

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

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

WEAVE - NW

continued from cover page

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

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

Health System Improvements

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

Youth Leadership and Engagement

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

Community Health Assessments

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

Tobacco Prevention

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

Future Direction of WEAVE-NW

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

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

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

IMPACTS ON TRIBAL HEALTH PROGRAMS

continued from page 5

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

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

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

IHS Declines to Appeal Ruling Requiring Full Compensation for ISDEAA Lease

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

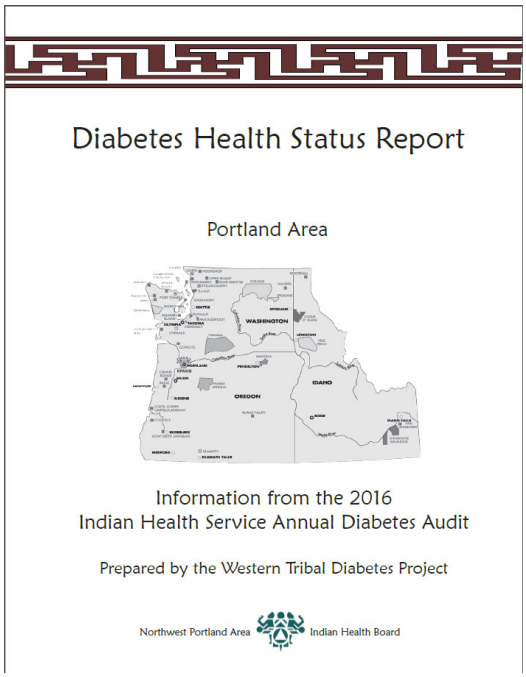
As a district court decision, Judge Bates's ruling in the Maniilaq case is persuasive but not binding legal precedent on other federal courts. The reasoning of Judge Bates's opinion, however, applies broadly to any Section 105(l) lease request for any facility used by an Indian tribe or tribal organization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

DIABETES HEALTH STATUS REPORT FOR NORTHWEST PROGRAMS COMPLETED

By Don Head
WTD Project Specialist

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

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



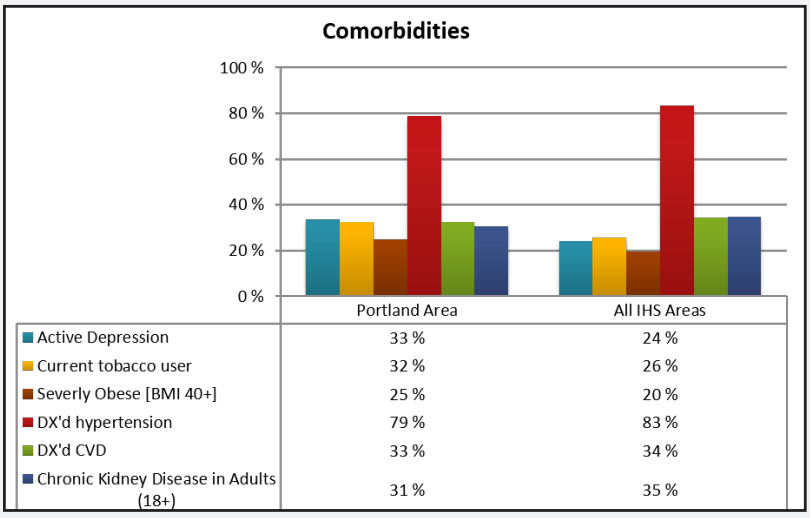
The Health Status Report (HSR) was created by the WTDP to visually represent the data within these reports in graph form. With access to multiple years of data, the WTDP saw an opportunity to show the SPDI grantees how their patient population is doing with respect to the Standards of Care over time.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

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

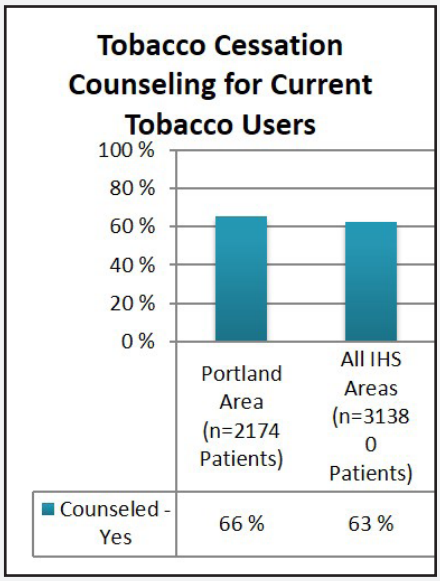
The other section, the comparison report, compares each program's Audit indicators for 2016 to the results of all the reporting programs in the Portland Area. In the cases of some of the indicators, notes have been included from the Standards of Care for Patients with type 2 diabetes, to provide more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

DIABETES HEALTH STATUS REPORT FOR NORTHWEST PROGRAMS COMPLETED

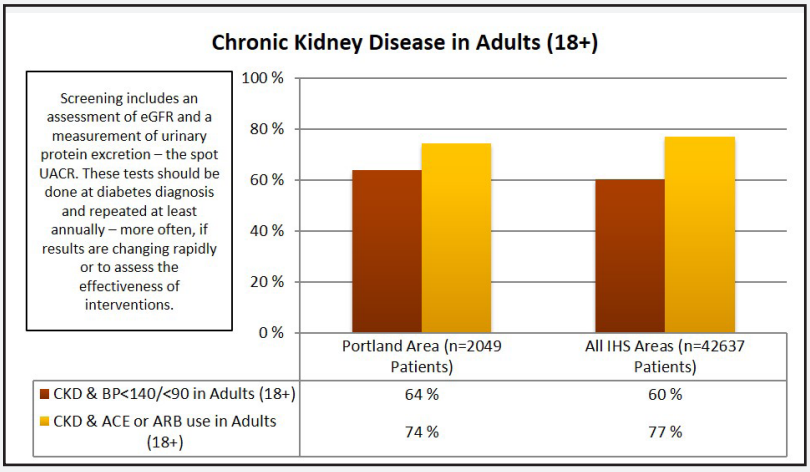
The WTPD also has created a HSR for the Portland Area, which shows the trends of the reporting SPDI grantees in the Portland Area, and compares the Portland Area's results to all of IHS programs nationwide. You can view and download this report on the NPAIHB website.



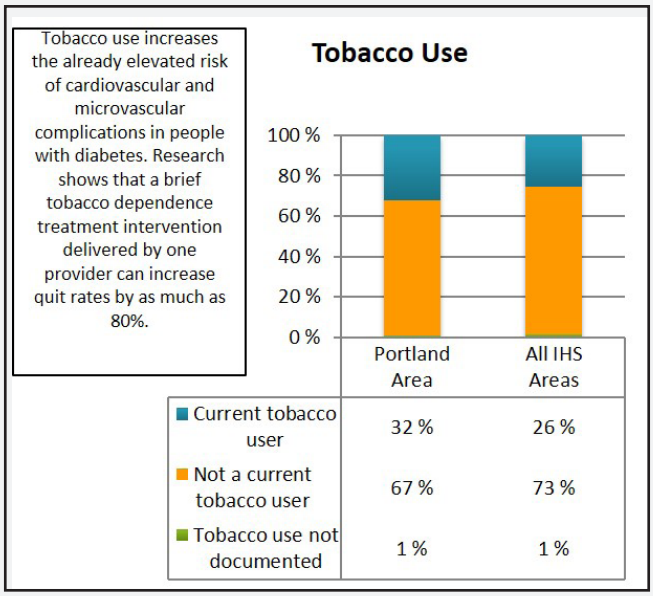
	Portland Area	All IHS Areas
Active Depression	33 %	24 %
Current tobacco user	32 %	26 %
Severly Obese [BMI 40+]	25 %	20 %
DX'd hypertension	79 %	83 %
DX'd CVD	33 %	34 %
Chronic Kidney Disease in Adults (18+)	31 %	35 %



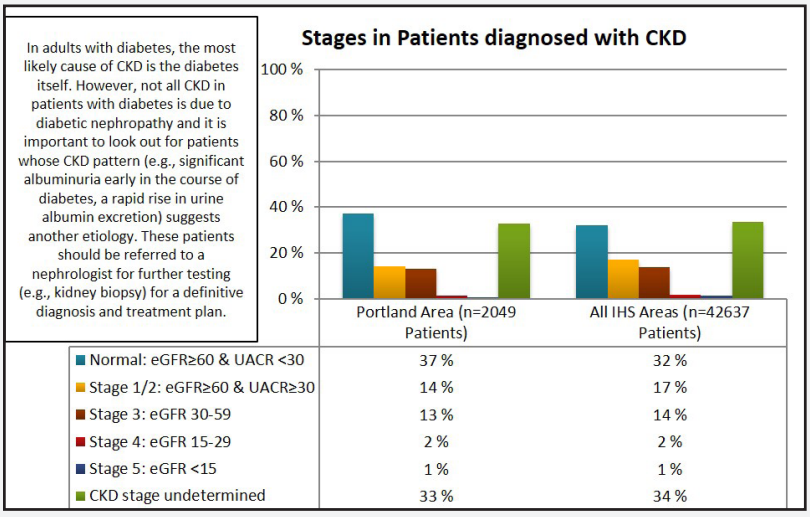
	Portland Area (n=2174 Patients)	All IHS Areas (n=31380 Patients)
Counseled - Yes	66 %	63 %



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



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



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

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

WWW.HEALTHYNATIVEYOUTH.ORG

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

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

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

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

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

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

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

NPAIHB GATHERINGS/ANNOUNCEMENTS

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

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

Native Fitness XIII (13)

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

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

INDIAN DAY / DANCING IN THE SQUARE POWWOW

Thank you to our Sponsors!

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

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

Registration will open the first week in April 2017!!

WHO: For American Indian and Alaska Native Youth
- Limit of 4 youth (13-19yo) per Tribe or Urban Area.
- Limit of 1-2 Chaperones per group registering.
- Registration is free!

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

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

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

#WeNeedYouHere

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

THRIVE

Native CARS ATLAS
Native Children Always Ride Safe

save the date

January 10-12 2017

Ready to do a child safety project in your tribe?

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

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

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

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

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

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

UPCOMING EVENTS

OCTOBER

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

NOVEMBER

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

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

November 7-9
Tribal Interior Budget Council
Washington, DC

November 8-10
GONA Facilitator Training
Las Vegas, NV

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

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

UPCOMING EVENTS

DECEMBER

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

JANUARY

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

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

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

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

2121 SW Broadway • Suite 300 • Portland, OR 97201

Return Service Requested

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

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
OCTOBER 2016 RESOLUTIONS

RESOLUTION #16-04-01
NW NARCh 9 Program

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

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING

January 17-19, 2017

Hosted by the Chehalis Tribe at

GREAT WOLF LODGE

20500 Old Highway 99 SW
Centralia WA 98531

Reservations: 1.866.941-9653

Rooms are blocked under the group name of **"1701NPAIHB"**. Hotel rooms are $109 plus tax and resort fees. Each individual guest must make their own reservations by calling the toll-free Central Reservations Department at **1-866-941-9653** by **Saturday December 17, 2016,** to receive the group rate. Reservations received after this date will be accepted on a space available basis and at the regular room rate. If you have any questions, please contact Lisa Griggs, Executive Administrative Assistant at (503) 416-3269 or email lgriggs@npaihb.org