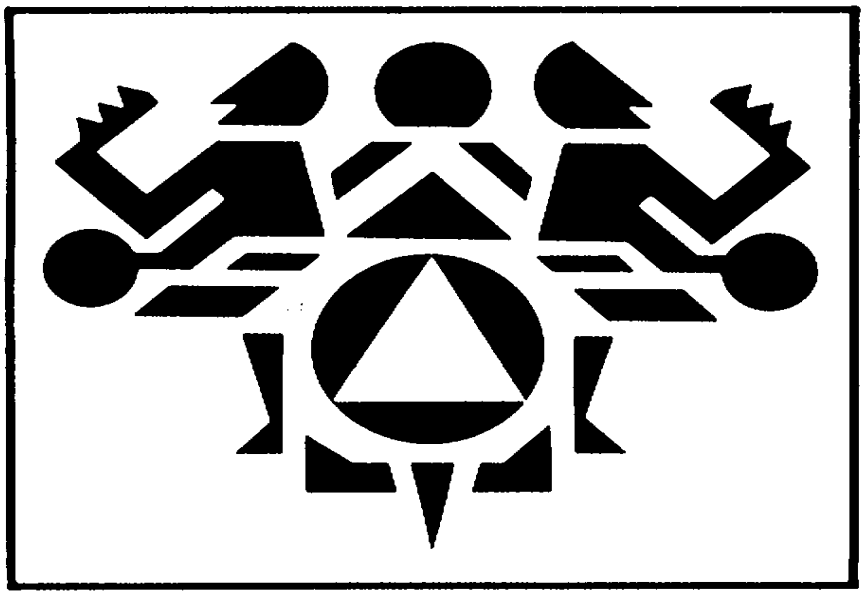
MINUTES

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD



QUARTERLY BOARD MEETING

APRIL 17-19, 2017

QUINAULT BEACH RESORT
OCEAN SHORES, WA

Northwest Portland Area Indian Health Board
April 2017 Quarterly Board Meeting
Quinault Beach Resort – Ocean Shores, WA
April 17-19, 2017
Summary of Minutes

Issue	Summary	Action	Follow-Up
TUESDAY APRIL 17, 2017			
Area Director Report Dean Seyler, Area Director	See transcript and attached PowerPoint		
Psychotropic Medications and Youth Presentation Dr. Shawn S. Sidhu	See attached PowerPoint		
Executive Director Update Joe Finkbonner	See attached PowerPoint		
NARCH and PRC Program Update Dr. Tom Becker	See attached PowerPoint		
Legislative Update Laura Platero	See attached PowerPoint		
American Indian Health Commission (AIHC) for Washington State Lou Schmitz	See attached PowerPoint		
Hepatitis C Mortality Among AI/AN in the Northwest 2006-2012 Sarah Hatcher	See attached PowerPoint		
WEDNESDAY APRIL 19, 2017			
WEAVE-NW Nanette Yandell	See attached		

Summary of Minutes

NATIVE CARS **Tam Lutz**	See attached PowerPoint		
Opportunities Presented by CMS Guidance Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility Bruce Goldberg, MD and Laura Platero, Government Affairs/Policy Director	See attached PowerPoint		
Medicaid Data Ed Fox	See attached PowerPoint		
Tribal Updates	1. Makah 2. Nez Perce 3. Warm Springs Service Unit Update		
Washington Medicaid Integration of Physical and Behavioral Health Services and Administration Jessie Dean	See attached PowerPoint		
THURSDAY APRIL 20, 2017			
Chairman's Report **Andy Joseph, Jr.**	See attached Report		
Committee Reports	**Elders –** Given by Dan Gleason, Chehalis Tribe (A copy of the report is attached)		

	Veterans – Given by Rhonda Metcalf, Sauk-Suiattle Tribe (A copy of the report is attached) **Public Health -** Given by Victoria Warren-Mears, NPAIHB (A copy of the report is attached) **Behavioral Health – (**A copy of the report is attached) **Youth –** Given by Nanette Yandell, NPAIHB (A copy of the report is attached) **Personnel –** Given by Cassie Sellars-Reck, Cowlitz Tribe (A copy of the report is attached) **Legislative Report** – Given by Laura Platero, NPAIHB		
RESOLUTIONS:	13-03-01 Preservation of Indian Health Care Improvement Act **Ratified, motion by Shawna Gavin, Umatilla; seconded by Cassie Sellards-Reck, Cowlitz, MOTION CARRIES** 13-03-02 Supporting Native Expectant and Parenting Teens, Women, Fathers, and their Families **Ratified, motion by Andy Joseph, Jr, Colville; seconded by Leland Bill, Yakama: MOTION CARRIES** 13-03-03 "Office of Minority Health Partnerships to Achieve Health Equity Competitive Grant" Improving Data and Enhancing Access-Northwest (IDEA-NW) **Ratified, motion by Shawna Gavin, Umatilla; seconded by Cassie Sellards-Reck, Cowlitz: MOTION CARRIES** 13-03-04 Letter of Support Dr. Grim for Director of the Indian Health Services, Department of Health and Human Services		

	Ratified, motion by Dan Gleason, Chehalis; seconded by Cassie Sellards-Reck, Cowlitz: MOTION CARRIES 13-03-05 Northwest Native American Research Center for Health" renewal **Motion by Rhonda Metcalf, Sauk-Suaittle; seconded by Gerald Hill, Klamath: MOTION CARRIES** 13-03-06 Approval and Adoption of Health Reimbursement Arrangement for Employees of NPAIHB **Motion by Cassie Sellards-Reck, Cowlitz; seconded by Rhonda Metcalf, Sauk-Suaittle: MOTION CARRIES** 13-03-07 Opposition to FY 2018 Budget Cuts to U.S. Department of Health and Human Services **Motion by Andy Joseph, Jr, Colville; seconded by Rhonda Metcalf, Sauk-Suiattle: MOTION CARRIES** 13-03-08 Support of Reauthorization of the Special Diabetes Program for Indians **Motion by Dan Gleason, Chehalis; seconded by Theresa Lehman, Jamestown: MOTION CARRIES**		
MINUTES	**Motion by Dan Gleason, Chehalis, Tribe; 2nd by Cassie Sellars-Reck, Cowlitz Tribe, MOTION PASSES**	**MOTION**	**PASSED**
FINANCE REPORT	**Given by Eugene Motif, NPAIHB motion Cheryle Kennedy, Grand Ronde Tribe; 2nd by Ronda Metcalf, Sauk-Suiattle Tribe, MOTION PASSES**	**MOTION**	**PASSED**
SDPI Report	Given Cassie Sellars-Reck and Sharon Stanphill		
ADJOURN at 10:00 a.m.			

QUARTERLY BOARD MEETING

Quinault Beach Resort – Ocean Shores, WA
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MINUTES

TUESDAY, APRIL 18, 2017

Call to Order: Andy Joseph, Chairman,

Invocation: Hazel Rosander, Quinault Tribal Elder

Posting of Flags: Quinault Veterans posted the flags.

Welcome: Tyson Johnson, Quinault Indian Nation Vice-President

Roll Call: Shawna Gavin, Secretary, called roll:

Burns Paiute Tribe – **Present**	Nisqually Tribe – **Absent**
Chehalis Tribe – **Present**	Nooksack Tribe – **Absent**
Coeur d'Alene Tribe – **Present**	NW Band of Shoshone – **Absent**
Colville Tribe – **Present**	Port Gamble Tribe – **Present**
Grand Ronde Tribe – **Present**	Puyallup Tribe – **Absent**
Siletz Tribe – **Present**	Quileute Tribe – **Present**
Umatilla Tribe – **Present**	Quinault Nation – **Present**
Warm Springs Tribe – **Present**	Samish Nation – **Absent**
Coos, Lower Umpqua & Siuslaw Tribes – **Absent**	Sauk Suiattle Tribe – **Present**
Coquille Tribe – **Present**	Shoalwater Bay Tribe – **Present**
Cow Creek Tribe – **Present**	Shoshone-Bannock Tribe – **Present**
Cowlitz Tribe – **Present**	Skokomish Tribe – **Present**
Hoh Tribe – **Absent**	Snoqualmie Tribe – **Absent**
Jamestown S'Klallam Tribe – **Present**	Spokane Tribe – **Present**
Kalispel Tribe – **Present**	Squaxin Island Tribe – **Present**
Klamath Tribe – **Present**	Stillaguamish Tribe – **Present**
Kootenai Tribe – **Present**	Suquamish Tribe – **Absent**
Lower Elwha Tribe – **Present**	Swinomish Tribe – **Present**
Lummi Nation – **Present**	Tulalip Tribe – **Present**
Makah Tribe – **Present**	Upper Skagit Tribe – **Present**
Muckleshoot Tribe – **Present**	Yakama Nation – **Present**
Nez Perce Tribe – **Present**	

There were 34 delegates present, a quorum is established.

AREA DIRECTOR REPORT, DEAN SEYLER PAO, IHS

0:11:30.8. DEAN SEYLER: Good morning everyone. Jump right into giving you the latest information updates as far as the senior leadership at Headquarters in Rockville I'm sure many of you can tell already, but in the case of those of you that haven't heard, our acting director is the RADM Chris Buchanan. Ever since the inauguration, he has been the acting director. His permanent position is deputy director for the agency. So it's just getting as acting until such time the Administration names a Director. Elizabeth Fowler, she remains as the Deputy Director of Management Operations. She's been in that position for years. Some of you know her. CAPT Michael Toedt, MD he's the Acting Chief Medical Officer for the agency. His permanent position is the chief medical officer for the Nashville area. So he's step into that position now. The one position that impacts the Portland Area directly is Johnathan Merrell who is our director of clinical support of the area office. He supervises the pharmacy consultant, dental consultant, behavioral health consultant, those positions. He's also heavy on assisting me on implementing strategic changes in the area. But his talents are observed by folk in Headquarter. And so they have tapped him for Director of Quality Health Care. That's in the acting position. Ben Smith was promoted to the Deputy Director of Intergovernmental Affairs. Many of you remember RADM Patea (SP?) that was the position she had. And then my direct supervisor is RADM Kevin Meeks Deputy Director of Field Operations, and then the new acting chief of staff RADM Kelly Taylor, heavy on the Admirals, but that the way it is. There is a link there at the bottom if you want to take a look at their bios. The Chief Contracting Officer which impacts many of you, Title I contractors, Martha (--) has been retired for at least two years. Is that about right, Terry? Contracting officers are very hard to find for the federal -- anywhere in the United States government. We are fortunate that we found Elida Monroe. She transferred to us from the Forest Service here in Portland. So that helped me save money. Federal contractors are really hard to find. And then one position that we need to deal with is Contract Support Cost/Indian Self Determination… Wes Simmons he left about a year? About a year and a half? So we filled that position with Jason Davis. Is Jason here with us today? Okay. So he'll be involved with future trainings, he's an engineer by trade. So thank you Rich, for allowing Terry to select him. He's gonna be focusing a lot on the contract support cost calculations. And one thing I wanted to never bet against is his engineering and math skills. So I think it's gonna be a big benefit not only to us but to you.

So patients are the center of everything we do, with our focus on mission, so mission of the Indian health service being to raise physical, mental, social, spiritual health of American Indians/Alaska Native to the highest levels. Keep that in mind. About two months ago all the Area Directs and Medical Officers had a meeting back in Headquarters. To take a look at the agencies priorities. Working with RADM Buchanan we came up with these four focus; people, partnerships, quality, and resources. People has to do with recruiting staff, developing staff that you may want to try to recruit in the future, and our dedicated, our competent care work force. We find that to be an issue not only to be true in the Portland Area but throughout the agency, where folks have a hard time to recruit competent staff for all the different jobs here at within

our organization, so that will be one of our priorities.

Partnerships. To build, strengthen, and sustain collaborative relationships that advance the IHS mission. Our collaboration partnership with the 43 Tribes here in the Portland Area, the Health Board, collaborations we want to do to support you where we can to help you deliver the health care at your locations.

Quality and excellence in everything we do. To ensure a high performing health system. IHS, but again, providing support, information leads to the prize which is to help them with their health systems And then resources to secure and effectively manage the assets needed to promote the IHS mission. These are all around the mission of the agency, and to make sure that we maximize the use of our federal dollars, and for the six federal sites and then also to make sure that we're billing quarterly and not let any money fall off the table. And interestingly enough, and we didn't realize this, or I didn't realize it until the end of our meeting back there, was that Secretary Price's priorities are people, partnerships, and patients. So we align with his too.

Quick update, someone asked some questions about the latest work had at the Funds Distribution work group. We've already proposed CHSDA, the Portland Area CHSDA expansion pilot project. There was a draft proposal. I tweaked it, not much, and sent it on out. But after lengthy discussions with several folks at Headquarters that wasn't something I was able to get through before Mary Smith left office. Since then, the Funds Distribution Workgroup has met. I know we're kinda scratching our heads on how much of this do we change, and the impact. I do have another version of what they came up with. I'm currently looking it over. I may try to tweak it a bit 0:18:39.2 [INAUDIBLE] lawyers was that the CHSDA expansion process is already spelled out. The agency has a policy regarding Tribes quest to expand the CHSDA, I was trying to explain to him that that doesn't really fit the needs of the tribes, and went ahead and looked at how we could make this process faster, and one that pretty much all the Tribes would agree to. So I will continue to work on that and provide updates on them as it develops.

I wanted to share with you year to date CHEF we are midpoint of the fiscal year, and we haven't got our budget numbers yet. Hopefully they'll be here soon. The 28th if Congress passes a budget. But $150,000 0 submitted, at 100% reimbursement rate. I tip my hat to Peggy Ollagard, many of you have talk with her. She was very very good at reviewing the documents for Tribes so far. And this pretty much all Tribal dollars. Not sure if the Federal sites have request yet. documents first time was 0:20:12.4 [INAUDIBLE.] The current balance at Headquarter is $46,801,410

I want to share with you some dates. Some of this has changed. Next week is the Tribal Self Governance Annual Conference; RADM Chris Buchanan will be here. We are currently working on some site visits. We're come out to Colville to tour the clinic there and meet with the tribe. And then I'm also setting up meetings with the NATIVE Project, the urban clinic in Spokane.

And the Healing Lodge of the Seven Nations. So those are the three locations we're going to take him for site visits.

The direct service Tribe advisory committee has changed since I sent this Friday. 0:21:03.2 [INAUDIBLE.] It's no longer 0:21:07.8 [INAUDIBLE] committee. That is May 3-4 is the current location at the Radisson hotel. We are currently working with Emmalani at Headquarters' on the agenda. And it looks like we should have a really good the session.

The Area's Director's recognition of excellence ceremony following that. It will be at Embassy Suites in downtown Portland. A lot of great work as usual. And hopefully you'll be recognizing May 12th really went above and beyond. I'm always asked what I look for and unfortunately sometimes the way people write these nominations, they're describing a person's job description. And I'm looking for excellence, to recognize that, the people go above and beyond that job description, who go outside their realm of responsibilities and make an impact on patients' lives. So that's happening and we usually have a good turn out and hopefully that will continue.

The IHS director's awards ceremony on July 28th in Rockville. They will be combining 2015 & 2016. 0:22:22.2 [INAUDIBLE] recognizing the prior calendar year. So they did not recognize the 2015 folks, and they're going to combine those and make it more economical.

The Direct Service Tribes national meeting has changed. So you can see I listed 26th and 27th, which 0:22:42.5 [INAUDIBLE] for me to just pop down to Boston that night. But they changed it to August 2nd and 3rd. And it will still be in Massachusetts, but it's gonna be in Danvers. I'm not sure how far that is out of Boston. But anyway, unfortunately, that is August 2nd and 3rd, that is at the same time that we're having our 638 orientation. We've had the date saved for quite a while. And we've received a lot of positive responses from Tribes So unfortunately for this year, I am gonna have to Headquarters know that there will be no Portland area staff represented at the Direct Service Tribes meeting because these last two orientation trainings that I've had have been very successful, had very positive feedback from tribes and the staff. I found it very beneficial including my staff to have that one-on-one connection with your staff. That has made a big difference in the administration of contracts previous staff will fully understand the ins and outs of those contracts. Because those can be confusing at sometimes. I've had to scratch my head myself. So it's good to have certified experts in the room to work with everyone.

I wanted to give you an update on the Oregon YRTC contract that we have with NARA. As we can see, the construction is ongoing in all phases. The building is projected to be completed and signed off in mid-May. I know that Jonathan who is the main administrator, the main contact with NARA. A tour of the facility. It's a 16 bed facility but we'll be expanding to 24 once they get the staff and the supplies. They've hired YRTC manager. And she's a psych nurse, is that right? Yeah, a psych nurse. A Commission Officer who has worked in the field for years.

And interviews are in process for the other positions. Jonathan has been working more on the planning for ongoing medical services, school services, and treatment curriculum for two or three months.

So with that here are some pictures we're getting close to the startup date they are shooting for.

One thing I wanted to share with folks who are Medicare or Medicaid, participating in that program, deals with the CMS final rule that was placed back in September 2016, that comes enforceable, and that's what you want to pay attention to. It becomes enforceable November 16th, 2017. So it's coming up here soon. It has to deal with risk assessment in emergency planning. It has to do with policies and procedures for what organizations are going to do in an event of an emergency. Communication plan. While you're in that declared disaster. And training and testing, initial and annual refresher drills. Part of the take away is that the six federal sites that are AAAHC accredited are fully complaint with this final rule. Because of having that accreditation that's something that they have to provide the surveyors as they come out. For tribe health clinics not accredited and Commander Matthew Ellis did an gap analysis and they indicated that tribal facilities may not meet the requirements that use CMS to meet emergency preparedness rule. So this is not an IHS rule. I'm just sharing information with you. If you have any questions, or how to become compliant, if not, become complaint by November. I could provide Matthew Ellis contact information. And I'd be more than happy to share information with you on the next steps you need to take. Again, the federal site and there are clinic that are AAAHC accredited you are fully compliant for this part of CMS.

Another update here. IHS Program Maximum space. Back in November of I send a letter out to Tribes for those who left those shares for us to work with, and they take a look at updating their space in our documents. We contacted six Tribes and the staff is going to work with three of They have seen an increase up to 41% So in the future that impact, that increase is gonna be beneficial to the tribes.

Apologies that Dr. Webb could not be here today. As you know, I'm trying to incorporate Chief Medical Officer to provide direct patient care type information with you when we meet. We had one slide this year, he sent out this information about a grant opportunity to all the Clinical Directors both tribal and Federal Directors On top of that, he went through this in some detail at a recent clinical director's meeting that was really well attendant by the Tribal Clinical Director and the Federal Clinical Directors. So there's a deadline of May 17th. It has 0:29:20.0 [INAUDIBLE] colorectal cancer screening. So he has 0:29:29.0 [INAUDIBLE] any questions on that, I'll try to answer what I can. He was supposed to be here to answer any questions. I'm not sure if you know any information on those, but feel free to reach out to either one of us.

Okay, so dealing with the Tolowa Dee-ne nations CHSDA expansion requests. That Tribe is located in Northern California, they have asked for several years to expand their CHSDA to up

into Oregon. Up into Curry County specifically. There are two tribes in Oregon that are directly impacted because they share that county and they share the affiliated county. I have consulted with both those Tribes. There is more consultation that needs to occur. And currently there is a tribal register that's posted asking for input. I think one Tribe has asked that it be extend it. Whether they do or not, I'm not sure. I'll find out from Headquarters. But there is a May 1st deadline for this initial posting for anyone to provide comments to Headquarters regarding this and I proved the link if you want to take a look at it.

Then the second that I wanted to cover is the perception of significant amount of IHS funds returned. I think it was a Congressman from North Dakota made a statement that IHS returned millions and millions of dollars back to the Treasury. Well, it's true we did return millions of dollars to the Treasury. Like every other Federal agencies return millions of dollars. When it comes to appropriations and law Congress has implemented what we call a current year funding so like your services that we distribute to you under your contract. For Federal sites what are consider current year funds and we can only spend within that year that its appropriated. We are as a Federal agency allowed to hold on to those funds for five years for the purpose of closing out contracts. Many of you administer contracts and realize that when it comes time to reconcile those contracts, sometimes what cost a dollar really cost a dollar or what you thought cost a dollar really cost two dollars and you have to find more money to supplement that contract. So at the end of those five years the agency goes and takes a look at our bottom line budget when it comes with single year appropriations and dose its reconciliation and any balances left money left has to by law has to be return Treasury. The only funds that don't go back are specifically identified what Congress identifies as next year funds that roll from year-to-year. Such as Special Diabetes that rolls and can be used [INAUDIBLE]. So I've provided the link I don't have it memorized INAUDIBLE]. There are several millions of dollars that are return every year that is very minor compared to the several billions of dollars we get every year.

So any questions or comments…?

Q: Cassandra Sellards-Reck, if you could go back to the beginning of your slides Contract Support Services Area expansion possibility what does that mean? It appears that you're going to give us the ability to cover our people where ever they are which isn't necessarily a bad thing. Where's the funding coming from?

A: Dean Seyler, what that means is that I've met with several Tribes who have asked for CHSDA expansion I always get the comment that there gotta be a better way of doing this. So what we work on in the Funds Distribution Workgroup, came up with a plan, what it is…no Tribe will be required to participate, it's an opted in opt out you can opt out at any time. It's like a second layer like PRC that will be funded by the Tribe if they wish to outside their original CHSDA. What I was purposing was the entire Portland Area be determined to be CHSDA. A Tribe with a resolution want to opt in what that would do is is pay for it [INAUDIBLE] PRC rates. The intent

was to stretch the dollar. Unfortunately, [INAUDIBLE] PRC funds would be extended outside the area. Again it'd be the Tribes choice if that's some a Tribe wants to do and opt out at any time.

Q: Cassandra Sellards-Reck, has there been any discussion being able to…for example like the Cowlitz we're a disburse Tribe, we have Tribal members all over and we'd love to cover them and their ability to cover Tribal members or cover all the Tribes that come to our Area. Is there a way to increase that funding? Or that isn't part of the discussion, or it's just to cover your people where they are at?

A: Dean Seyler, No, that's not part of it.

Q: Cassandra Sellards-Reck, but it could be part of the discussion…we could start discussion about it. I think that would be a good way to remedy Tribal people and where there at and being able to cover their health care cost since we probably cover it less than 50% and we have people all over who aren't covered.

A: Dean Seyler, right but we're just trying to stay with the latest PRC Workgroup Andy, John and Jim Sherrill. To me that's a discussion at the National level cause [INAUDIBLE] very good point. But, its something that has a global national effect [INAUDIBLE]

Q: Cassandra Sellards-Reck, Thank you

Q: Greg Abrahamson, my question is on the funds, do you have an amount if we return any back to Federal, the last point, on the amount of funds returned in regards to the Portland Area?

A: Dean Seyler, I don't have that at my fingertips, but I'll work with Captain Ardent, work with finance to get an answer for you.

Q: Cheryle Kennedy, alone those same lines while the letter minimums the amounts that are returned. We can understand that over 5 years example that could be 12 million and million from each area, that isn't small that's significant and so I'm wondering, I know through the administrative processes the federal government there are certain policies that are set forth, so it looks like we need to seek some kind of exemption in light of the level of need, the debt deficiency on the level of need funded and I think we need to come forth with a resolution or a dialog with the Director with this so we can see how we can come about changing that.

A: Dean Seyler, Certainly, are you going to be in Spokane? That's a perfect time; there are some Tribal time slot available. If that's something the Health Board would like to do please let me know and I'll work with you guys to secure a time. [INAUDIBLE] I can't say for sure. I would venture to say yes, I'll say a tentative yes. Because it services money [INAUDIBLE] Funds, I don't

think they are, Rich are they? No [INAUDIBLE] there are service AGC [INAUDIBLE] and share that are left at the office and at Headquarters [INAUDIBLE]

Q: Rhonda Metcalf, Good morning my question is about the interactions and the billing with NARA for the youth treatment. Here's my question is that treatment facility going to stay for native youth treatment? Because right now today to get an adult into treatment at NARA is next to impossible because a majority of their beds go to the State…so I'm wondering if is the same thing going to happen at the youth treatment center and with IHS putting so much money into it. And I'm kinda aggravated to know that that IHS dollars aren't evening going to NARA when they're not even fulling there mission now in Native treatment.

A: Dean Seyler: Please recall best of my knowledge [INAUDIBLE] work with the office on Oregon YRTC [INAUDIBLE] …I made it clear to Jackie and the contract that the nine Oregon Tribes are the first primary recipients and that it's open up to all the rest of the Portland Area Tribes, then open to the nation. Will there be non-natives there? There is a possibility of that happening. They are looking at all aspects to make it profitable and why it hasn't been profitable in the past and trying to find that balance. Like Healing Lodge taking on non-native but it's very minimal and that's part of business and being able to provide care American Indians/Alaska Natives incorporating the private sector.

Q: Cassandra Sellards-Reck, are they getting preference? Are Native people getting preference at NARA?

A: Dean Seyler, yes

Q Cassandra Sellards-Reck, can we see reports from NARA? Or statics on who they serve so we can be reassured. You do change the flavor of your program if you have a high not native participants which I think NARA does and Native will feel like its less focus on them and their mission and how they practice, if that was a true point that Rhonda brings up and happening and that need to be brought to your attention. The true mission is to serve Native people and if we not doing that, that needs to be considered and have a part that's non-native. I think having beds full is important but it should be native preference and they should look at their mix. Because Native people need something different that's focused on them and non-native people sometimes don't connect with that and we know that. Keeping your medicine a certain way so Rhonda brings up a really good point its even more so with our kids, our youth are really important, those are the ones really, really, really struggling. I do have the same concerns how you staff and mix the people. I know there is a high number of non-native seen at NARA cause I see them in the ER all the time, I know they see a lot of native people and that good. So I would be good to know what their statics are of the people that they serve and how they are serving them…because you know it's native. Thanks!

A: Dean Seyler, I agree and what I'll do is contact Jackie about providing an update to the group. I'll work with Joe to see when we can schedule at a future Board meeting. They are a Title V contractor with my office. Let me get with Acquisitions and Denise and take a look at their contract as far as how much I can leverage with her to say do this versus [INAUDIBLE]

Q: Lisa Guzman, I would encourage that people go do a site visit with NARA, we went to [INAUDIBLE] focusing on treatment centers at NARA. The Directors and Kristi Woodard the consultant for behavior health. From what I seen at NARA there were majority native. Their busting at the seams. There were even families there, I saw a young man there with his two children who were native, I seen couples. There trying to accommodate different tracks and that was one of our own discussions at [INAUDIBLE] how do we increase our Native American population to [INAUDIBLE] at 100 % they are diligent at trying to work that out. But, at the same time their busting at the seams in the facility and need support. [INAUDIBLE] at the Healing Lodge, that's the criticism, that Healing Lodge gets as well that were not a 100% Native American. We need to take a look at the daily operations of these facilities these facilities are having to promote resources that there culturally competent, changing the designs to of the program to meet the needs of our Native American participants. They need a lot of assistance all the changes with the drugs, all the co-concurring. The Healing Lodge has had to expand to increase mental health because of the need of co-concurring. I would really encourage if you want to get your people in NARA, go take a look, go meet with the staff because we met with the staff their highly trained. I sad that this lady was old, it's sad that they didn't have a high level of staff to support the demand of our people. Their busting at the seams, I think their doing good work with what they have. It's pretty sad when you start listening to single parents with their children they were all Native, I saw a high number of Native families.

A: Dean Seyler, Thank you for that. I recently met with Healing Lodge with Rebecca and staff. I had asked Rebecca to work closely with Jackie and this YRTC in Oregon and she's pledge to do that and vicea versa also. I was also good to see California was approved [INAUDIBLE] they have opened up their Northern YRTC and they are working on their second one further south, I'm not sure the location. So it's good to have those options of our youth. Thank you.

Q: Caroline Cruz, remember about two years ago we were at risk of probably losing these dollars, and brought it up before here in terms of what we can do with those dollars, we had IHS dollars and we had State of Oregon dollars devoted to Youth Residential care. And so we brought it up here and agree to pursue in Oregon in making sure those dollars were protected. So there is a lot of work behind the scenes in order to make this happen. So I would a lease like to give NARA the opportunity to go forward, which we agreed to do, and have the come here and give regular reports so, there is total transparency, so if there are some things that need to be corrected, that we can do it with NARA present. I don't think there's the perfect program out there and a lot of people that NARA serve they don't know sometimes what degree of Indian they are because they are Urban Area a lot of them have lost their heritage because of historical history. NARA doesn't close the doors and I'm not saying that there perfect and I

don't think any of our programs are, I know there's been a lot of problems ---but we've been meeting through Oregon Indian Counsel on Addiction for more than 30 years. There have been times when we've had NARA and have shared concerns with them and they always been very transparent and tried to correct those. So I would like to give them the opportunity to open up their doors, and have their grand opening soon, and for us to give them the opportunity to prove themselves, but then again to kinda a check and balance and monitor that, because we have had two youth programs in the state of Oregon that did the best they could under the circumstances and really tried make sure we were serving our Indian youth and for many reason they had to close their doors. So in this third attempt, in order to keep those services in Oregon, Oregon would be a priority but we also agreed here at this meeting that it was going to be for the Northwest. Not only Tribes in Oregon but other Tribes in other States. 15 beds the demand is probably going to be more than that…but, for right now we should be supportive of NARA and give them the opportunity to prove that they are going to be able to handle this. Thank you.

A: Dean Seyler, Thank you.

Q: Rhonda Metcalf, I have one more thing to say, just so you all know I was a kid in Portland and the development of NARA and when to all the meetings as a young teenager. And when it started my group was charger [INAUDIBLE] NARA was about Indians help Indians getting sober. That's what it was about, it was about treatment. NARA was the first in the nation to have family treatment. Because it's not just the alcoholic or the drug user that need treatment it's all the people in the family and the enablers. My whole point is that its hard enough for us to get people into treatment and Washington State was left out of all this and sure the focus was Oregon but, Washington also needed something like that. I didn't see IHS even be willing to share those funds and so I'm going to express my concerns because I believe Sauks-Suiattle was one of the first Tribes to write you for some of those funds and you weren't happy. Didn't meet your deadline, but to bad, but we did and not to be consider for any of those funds and I really have a hard time with this because this wasn't a right situation, it wasn't a fair situation in my opinion or my Tribal Councils opinion because we discuss this a lot. In Washington Tribes are still left out of it and it's very difficult to get a Native into a Native facility such as NARA and I just wanted to say that.

A: Dean Seyler, Thank you for those comments. Just for clarification I didn't say too bad. I did take all the comments that were submitted by Tribes, I reviewed them, talked with staff about them. At the end of the day, looking at, there is a big need for treatment, a huge need, a million dollars, I'd love to have a million dollars in my account. That's not enough for our programs. I choose to stay with [INAUDIBLE] which was they had the Oregon YRTC. I think you need to take a look at [INAUDIBLE]…any other questions or comments?

BREAK

PSYCHOTROPIC MEDICATIONS AND YOUTH PRESENTATION, DR. SHAWN S. SIDHU

Objectives

Upon completion of this session, participants will be able to better understand:

1) When medications are worth considering
2) Non-medical approaches worth trying
3) Risks and benefits of certain medication groups

When Might You Urgently Consult a Mental Health Provider?

Acute/Precipitous Change in Functioning
Concerns Over Safety of Home Life
Suicidal/Homicidal Statements
Concerns of Psychosis/Hallucinations
Concern for Abuse

When Are Medications Generally Necessary?

"Inability to function"

Poor academic functioning (failure)
Poor social functioning in the classroom
Significant classroom disruption
Concerns about emotional/mental wellbeing

Core Ethical Dilemma

Provider Beneficence versus Patient Autonomy (in the case of children Patient Autonomy is most often represented by the wishes of the parents)
State laws vary significantly

Discussion with Parents

First get the family's opinion on how the child is doing and what they think would make things better

Next, discuss non-medical solutions to improve the child's level of functioning:

Behavioral Classroom Interventions
School/Individual/Family Counseling
Speech & Language/OT/Academic Skills
Social Skills Training

Parent: "What Do You Think About Therapy?"

The potential reaches of therapy are even broader than medications
In non-emergent cases, and especially in children, often therapy is the best first approach

For most conditions, the best results are obtained when therapy is combined with medications
Sometimes medications allow the facilitation of therapy

Parent: "Do Medications Even Work?"

- Each medication class is given a grade of evidence for a particular condition
- More experimental medications will have a lower grade of evidence
- Each child is unique and not all individuals respond the same way to medications
- May need to try several medications before you find the right one for each child

Parent: "How Long Will My Child Need to Take Medications?"

- Depends on the condition and the student's progress
- ADHD course typically stabilizes by mid-20s
- Depression/Anxiety: risk of remission reduces greatly with approximately 1 year of treatment (some studies showing as little as six months)
- Cases of severe psychosis/Schizophrenia or Bipolar Disorder may require lifetime medications

Philosophical Approach

- Start Low, Go Slow (especially in kids)
- Find the lowest possible therapeutic dose
- Avoid polypharmacy whenever possible (maximize single agents before combining agents)
    - Difficult to assess effectiveness of any one agent
    - Drug-drug interactions increase the risk of side effects

Psychotropics and Street Drugs/Alcohol

Some medications are more harmful to use with street drugs/alcohol than others. Similarly, some street drugs are more dangerous to use with psychotropic medications

Meth/Cocaine + stimulants: cardiac/stroke
Meth/Cocaine + anti-depressants: serotonin syndrome
Opiates (heroin) + anxiolytics: dangerous drops in blood pressure
Alcohol + Lithium: risk of kidney failure

Psychotropic Medications

- Diagnosis is INCREDIBLY important
    - Input from teachers is VERY valuable in diagnosing children (teachers see children more than parents)
- Wrong Diagnosis = Wrong Meds
    - Decreases trust with parents
    - Unnecessarily exposes children to unneeded meds

Common Psychotropic Medications

- Anti-Depressants
- Anxiolytics
- Stimulants/Non-Stimulants
- Mood Stabilizers
- Anti-Psychotics

*All of these groups have newer and older meds

Common Side Effects

- Headache, upset stomach, and sleep changes are common in most psych meds
- All psych meds can theoretically lower the seizure threshold
- Many psych meds can alter heart rhythms, especially mood stabilizers and antipsychotics
- Some psych meds interact with other meds
- Stimulants cause reduced appetite and insomnia

More Serious Side Effects

- Although rare, need to make sure the psych meds are not making depression/SI worse
- Anti-psychotics and mood stabilizers are known to cause significant weight gain, blood cell problems, endocrine problems, and even hormonal problems. These medications should only be used when absolutely necessary

Summary

- In the end, if a child's level of function has deteriorated consider medications as a PART, but NOT the entire solution
- Ask the Psychiatrist if both medical and non-medical alternatives exist. Be sure to voice your opinion if you feel the plan revolves too much around medications rather than a comprehensive approach.
- Many mental health diagnoses look similar, but have very different treatments. For example, Bipolar Disorder is traditionally over-diagnosed in children, and the medications have many side effects.
- Some culturally-appropriate beliefs may appear abnormal to a Psychiatrist who is unfamiliar
- Ask Psychiatrists for a detailed description of the child's diagnosis and choice of medications
- Never underestimate the power of a child's environment on his/her mental and emotional well-being
- Often times helping families communicate in a healthier way can be incredibly helpful

- Cultural ceremonies/rituals and involvement can also be very helpful for children and families

Executive Director Update, Joe Finkbonner:

Personnel

- New Hires:
  - Rosetta Minthorn, On-Call Assistant
  - Elisabeth Stanphill, On-Call Assistant
- Temps/Interns:
  - Shalaya Williams, Temp BRFSS Interviewer
  - Rosamaria Frutos, Temp BRFSS Interviewer
- Recognition:
  - Jenine Dankovchik, 10 Years of Service

Meetings

April

- Washington Dental Service Foundation Meeting (April 4)
- CMS I/T/U Training, Seattle, WA (April 4-5)
- Region 10 Consultation, Suquamish, WA (April 12th)
- 2017 Annual Tribal Self-Governance Conference, Spokane, WA (April 26-27)

May

- DSTAC Quarterly Meeting, Portland, OR (May 3-4)
- WDSF Strategic Planning Meeting (May 12th)
- ATNI Mid-Year, Portland, OR (May 23-26)

June

- DHAT Graduation, Anchorage, AK (June 2nd)
- NIHB PHS, Anchorage, AK (June 5-8)
- NCAI Executive Winter Session, Mohegan Sun, (June 12-14)
- NWIC Foundation Quarterly Board Meeting, Lummi (June 15th)
- PHAB Board meeting (June 21-22)

Review National Committee List

NARCH AND PRC PROGRAM UPDATE, DR. TOM BECKER

Recognition

- I would like to recognize and thank the Quinault Nation and their elders…past and present…for hosting me at this gathering.
- I would also like to thank the delegates for allowing me to present to you today.

Main Components of NARCH (Native American Research Center for Health)

- Narch 3: scholarship program
- Narch 4: Summer Institute

- Narch 5: Monitoring Abuse of Drugs
- Narch 5 supplement: HIV prevention
- Narch 6, 7: Continues scholarships and Summer Institute
- Narch 8: Dental follow up study of 'tweens'

Accomplishments in past year

- Continued support of prior year's fellows
- Identified several new fellows (150 total)
- Added Board-based scholars
- Identified and hired an intern to help with tribal BRFSS projects
- Hosted summer institute with 84 participants (1085 total)
- Wrote Narch 9 grant
- Now writing Narch 10 grant

Coming up this year

- Continue fellow/scholar support
- Next summer institute June, 2017 (classes full)
- Submit new NARCH grant for round 10
- Attend and present at conferences on Indian health and on public health nationwide and worldwide

Prevention Research Center Update - Funding from CDC to OHSU, to partner with the Board and member tribes in health projects

Main Topics:

- preservation of sight and hearing via community-based research projects
- avoidance of risky decisions by tribal youth

Additional Activities:

- regular seminar series on Indian health
- classes in epidemiology of health conditions in tribal people
- assisting with Board projects
- provided funding for expansion of HPV vaccine

We seek your support

- For the Narch 10 application, including three components…two that extend the fellowships and Summer Institute, one on use of texting to avoid alcohol-related violence among tribal young people
- Draft resolution is in your hands
- Thanks much

Working Committee Meeting Lunch

Legislative Update, Laura Platero

Report Overview

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

Status of IHS Budget

- Congress enacted a second continuing resolution (CR) for FY 2017 for the period of December 10, 2016 to April 28, 2017.
  - Based on FY 2016 levels and under the authority and conditions of the FY 2016 appropriations.
- Congress is working on a FY 2017 Omnibus Appropriations Bill for last five months.
- On March 27, 2017, Administration proposed cuts to domestic discretionary spending which included IHS prevention programs (*submitted late, likely not considered*).
- Another CR is possible if Omnibus Appropriations Bill is not enacted.

FY 2018 IHS Budget

- President's FY 2018 "Skinny Budget" was released on 3/16/17
  - Proposes a 17.9% decrease to HHS
  - Mentions that budget supports services delivered by IHS because services provided to "low-income and vulnerable populations."
- Detailed budget anticipated in May, 2017.
  - Based on FY 2016 enacted levels.

FY 2019 IHS Budget

- National Tribal Budget Formulation Workgroup's Recommendations to IHS for FY 2019
  - Available at: http://www.nihb.org/legislative/budget_formulation.php
  - Fully fund IHS at $32 billion phased in over 12 years
  - HHS/IHS Budget Tribal Consultation on March 30, 2017 in DC
- FY 2019 Evaluation/FY 2020 Planning meeting
  - April 24-25, 2017 in Spokane, WA

New Administration
Presidential Actions

- Memorandum for the Heads of Executive Departments and Agencies – Hiring Freeze, 1/23/17
- Executive Order (E.O.) No. 13765: Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, 1/24/17
- E.O. No. 13771: Reducing Regulation and Controlling Regulatory Costs, 1/30/17

- E.O. No. 13777: Enforcing the Regulatory Reform Agenda, 2/24/17
- Executive Order No. 13781: Comprehensive Plan for Reorganizing Executive Branch, 3/13/17
- E.O. No. 13784: Establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis , 4/30/17

Letter from HHS Secretary & CMS Administrator to Governors

- Letter (dated 3/14/17) focused on improving collaboration with states for more effective program management in these areas:
  - Improve Federal and State program management
  - Support Innovative Approaches to Increase Employment and Community Engagement
    - See Judicial Review of Medicaid Work Requirements under Section 1115 Demonstrations, dated 3/28/17
  - Align Medicaid and Private Insurance Policies for Non-Disabled Adults
  - Provide Reasonable Timelines and Processes for Home and Community-Based Services Transformation
  - Provide States with More Tools to Address Opioid Epidemic

Current & Pending Policy Issues

CMS 4 Walls Limitation

- CMS determined that If a Tribal facility is enrolled in the state Medicaid program as a provider of clinical services under 42 CFR 440.90, the Tribal facility may not bill for services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility.
- Per CMS, under FQHC designation there is no requirement that the services be provided within the 4 walls.
- Section 1905 of the SSA recognizes outpatient Tribal clinics as FQHCs.
- In order to not have any revenue losses, Tribal health programs have to work with their respective Medicaid agencies to change their designation to an FQHC.
- CMS FAQ released January 18, 2017.
- *Deadlines*:
  - January 18, 2018: Notify state of intent to change provider status
  - January 30, 2021: Effective date

CMS Market Stabilization Proposed Rule (CMS-9929-P)

- Proposed rule proposes changes designed to help stabilize the individual and small group health insurance markets.
- Specifically, it proposes to amend:
  - Standards relating to special enrollment periods, guaranteed availability, and timing of annual enrollment period in 2018 plan year;

  - Standards related to network adequacy and essential community providers for QHPs; and
  - Rules on actuarial value requirements.
- Interim final rule or final rule forthcoming.

Indian Health Service

- IHS Notice to Propose the Re-Designation of the Service Delivery Area for the Tolowa Dee-ni' Nation (Smith River Rancheria), dated March 31, 2017
  - Comments due May 1, 2017
- IHS Dear Tribal Leader Letter on Return of Funds to Treasury, dated March 28, 2017

Other Brief Updates

- IHS Contract Support Costs
  - New CSC Policy approved in October, 2016
  - IHS has resumed settling past-year CSC claims
- IHS Catastrophic Health Emergency Fund (CHEF)
  - Final regulation not issued
  - Update on *Redding Rancheria v. Price*
- IHS Tribal Premium Sponsorship Program
  - No update on circular
- IHS Community Health Aide Program
  - Work group being convened.
- IHS Lease Proposals Under 105(l) of ISDEAA
  - Two USDC-DC decisions state that 105(l) of ISDEAA and implementing regulations require IHS to fully-compensate lease with tribe or tribal organization**.**

Legislation in 115th Congress

- Repeal and Replace of Affordable Care Act
- Reauthorization of the Special Diabetes Program for Indians (S. 747)
- Independent Outside Audit of the Indian Health Service Act of 2017 (S. 465)
- Tribal Veterans Health Care Enhancement Act (S. 304)
- Trauma-Informed Care for Children and Families Act of 2017 (H.R. 1757)
- Other:
  - Access to Insurance for All Americans Act (H.R. 1408)
  - Indian Health Service Hiring Freeze Exemption Act (H.R. 981)
  - IHS Advanced Appropriations Act of 2017 (H.R. 235)

Indian Legislative Bills in 115th Congress

- Repeal and Replace of Patient Protection and Affordable Care Act (ACA)
  - American Health Care Act (pulled 3/24/17)
  - The fight is not over!

  - Tribes must continue to let their representatives know priorities in any health care reform: benefits of Medicaid expansion, no block granting, 100% FMAP, Indian Health Care Improvement Act, Indian provisions in ACA and AI/AN cost sharing protections in Marketplace, etc.
  - ACA can also be undermined through administrative and regulatory process.
- S. 747 – Special Diabetes Program for Indians Reauthorization Act of 2017
  - Introduced by Sen. Tom Udall (D-NM) on 3/28/17.
  - $150 million for FY 2018
  - Reauthorizes the Special Diabetes Program for Indians (SDPI) from FY 2019-FY 2024 with medical inflation rate increase.
  - 3/28/17: Referred to Committee on Health, Education, Labor and Pensions.
- S. 465- Independent Outside Audit of the Indian Health Service Act of 2017
  - Introduced by Sen. Mike Rounds (R-SD) on 2/28/17 with co-sponsors Sen. James Lankford (R-OK) and John McCain (R-AZ).
  - Requires an independent outside audit of the Indian Health Services with report to Congress.
  - 2/28/17: Referred to Committee on Indian Affairs
- S. 304 – Tribal Veterans Health Care Enhancement Act
  - Introduced by Sen. John Thune (R-SD) and Sen. Mike Rounds (R-SD) on 2/3/17.
  - Amends the Indian Health Care Improvement Act to allow the Indian Health Service to cover the cost of a copayment of an Indian or Alaska Native veteran receiving medical care or services from the Department of Veterans Affairs, and for other purposes.
  - 3/29/17: Referred to Committee on Indian Affairs.
- S. 774 & H.R. 1757 – Trauma Informed Care for Children and Families Act of 2017
  - Introduced by Sen. Heitkamp (D-ND) on 3/29/17 and Rep. Davis (D-IL) on 3/28/17.
  - Addresses the psychological, developmental, social and emotional needs of children, youth, and families who have experienced trauma, and for other purposes.
  - Establishes task force to develop best practices, training, Native American Technical Assistance Resource Center and grant funding.
  - *Actions*:
    - S. 774: 3/29/17- Referred to HELP Committee
    - H.R. 1757: 4/12/17- Referred to Subcommittee on Crime, Terrorism, Homeland Security, and Investigations

National & Regional Meetings

HHS Tribal Consultation

- National HHS Budget Tribal Consultation- March 30, 2017 in DC
- Region 10 Tribal Consultation- April 10, 2017 in Suquamish

HHS STAC Meeting Update

- Last meeting was March 7-8, 2017

- Tribal leaders met with HHS Secretary Tom Price.
  - "Patients, people and partnerships"
- Tribal Leaders made several requests, including:
  - Honor Tribal Consultation and Government-to-Government Relationship
  - More federal funding beyond IHS
  - Expand ISDEAA Self-Determination and PL 477
  - Assist in Treating Opioid Abuse and Addiction
  - Provide Continued Support for Special Diabetes Program for Indians
  - Maintain Medicaid expansion for AI/AN and 100% FMAP

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) – face-to-face meeting February 28th; last conference call was on April 5th
  - Face-to-face strategy session is May 16-17, 2017.
- CMS TTAG – face-to-face meeting March 1st -2nd; last conference call was on April 12th
  - Next conference call June 14, 2017.
  - Face-to-face meeting is June 12-14, 2017 in DC

Americana Indian Health Commission (AIHC) for Washington State, Lou Schmitz

Community Emergency Preparedness Assessment Project
Goals of Today's Presentation

- Provide an overview of the AIHC's Community Emergency Preparedness Assessment Project
- Invite delegates to share information and encourage Washington state tribes to participate in the project

AIHC Tribal Community Emergency Preparedness Toolbox
Background

- In 2014, AIHC hosted a series of 8 regional meetings with tribes - 59 representatives from 24 tribes participated
- Tribal representatives identified the need for technical assistance to better understand what components are needed to prepare their communities for public health emergencies and other disasters (for example, plans training, equipment, etc.)

In 2016, the AIHC developed a toolbox designed specifically for tribal communities to:

- Assess their preparedness status
- Document assets and identify gaps
- Plan strategies to strengthen community preparedness

What is in the Toolbox?

- AIHC Tribal Community Emergency Preparedness Self-Assessment
- AIHC Asset Map and Gap Analysis Workbook
- Resources

- Models and Examples
- Tools
- Training

http://www.aihc-wa.com/aihc-healthprojects/community-preparednesstoolkit/

AIHC Community Emergency Preparedness Assessment Project
Project Goal:
The project's goal is to assist 2 Washington state tribes in strengthening their preparedness status, by facilitating a process to document community assets, identify gaps, and develop plans to strengthen capabilities

Approach
1. Announce the opportunity to tribes
2. Request statements of interest from tribes
3. Select 2 tribes

Facilitate a series of meetings with each tribe's community preparedness leadership group, using the AIHC Tribal Community Preparedness Toolbox to complete:
• AIHC Tribal Community Emergency Preparedness Self-Assessment, and
• AIHC Asset Map and Gap Analysis Planning Workbook

To Participate

Step 1:
– Establish Tribal Government's support for engaging in the project

Step 2:
– Identify the members of your Community Preparedness Leadership Group

Step 3:
– Complete the Statement of Interest

Step 4:
– Submit the Statement of Interest

The "Asks"
1. Please share materials with others at your tribe (Tribal Council, Medical Directors, Clinic Managers, Emergency Managers, Planning Directors, etc.)
2. Please complete the "Statement of Interest"

AIHC Mutual Aid Project Update
The American Indian Health Commission (AIHC) will facilitate a collaborative process to develop Mutual Aid Agreements (MAAs) between interested tribes and local health jurisdictions in Washington's Public Health Emergency Planning Regions 1 and 3. The project will also facilitate a process to revise the operational plan for Region 2's existing Tribal-Public Health Mutual Aid Agreement. Funding for the project comes from Tribal Reinvestment Funds from the Washington State Department of Health (DOH) and is set for completion by June 2017.

Project Objectives
- 22 tribes will have had the opportunity to participate in a regional MAA
- Agreements and operational plans that reflect lessons learned by 7 tribes and 3 LHJs (in Region 2) will be in place in 3 Regions
- Training materials will be available online

Project Activities

1. Conduct outreach and site visits to tribes to obtain tribal input
2. Facilitate in-person kick-off meetings with representatives from tribes and LHJs at each region
3. Facilitate ongoing webinar meetings with Region 2 to collaboratively revise operational plan
4. Facilitate ongoing webinar meetings with Regions 1 and 3 to collaboratively develop MAAs and operational plans
5. Develop, distribute, and post training materials for each MAA

BREAK

Hepatitis C Mortality Among American Indians and Alaska Natives in the Northwest, 2006–2012, Sarah Hatcher, PhD, Epidemic Intelligence Service Officer, Northwest Portland Area Indian Health Board

Hepatitis C Virus (HCV) Infection
- Hepatitis C virus, or HCV, infection can be acute or chronic, as seen in this graphic which shows the progression of disease over time from normal liver through hepatocellular carcinoma –HCC – and end stage liver disease – ESLD.
- Following acute infection, approximately 75-85% of adolescents and adults will develop a chronic infection.
- Over time and without treatment, people who are chronically infected can develop cirrhosis, which can progress to end stage liver disease. Chronic HCV infection can also lead to hepatocellular carcinoma over time.
- In addition to liver disease-related deaths, HCV infection significantly increases the risk of death from all causes and non-liver related diseases.

Hepatitis C Mortality is increasing in the United States

In recent years the number of hepatitis C deaths has exceeded the number of deaths from 60 other infectious conditions.

Disparity in Hepatitis C Mortality—United States, 2010–2014
- But HCV-related mortality is not distributed equally across the population in the United States

– This graph shows the HCV mortality rate from 2010-2014 for American Indians and Alaska Natives, the overall U.S. population, and non-Hispanic Whites. As you can see, the HCV-related mortality among AI/AN is roughly 2 times that of the Overall U.S. and non-Hispanic white population.
– But, we know that there can be significant regional differences in AI/AN health outcomes, so regional analyses can sometimes provide more relevant information for practitioners and decision-makers.

Racial misclassification
– And most national analyses do not account for American Indian and Alaska Native racial misclassification, which, as you know, is common in Northwest public health datasets.
– This bar chart demonstrates the percent misclassification for a selection of public health datasets that the Epi Center has linked with

Assess the health disparity in AI/AN hepatitis C-related mortality in the Northwest
Given the national disparity in Hepatitis C mortality for AI/AN, and the lack of racial misclassification-corrected analyses, our goal was to assess the health disparity in AI/AN hepatitis C-related mortality in the Northwest**.**

Methods
Additional graphics in PowerPoint
- Idaho, Oregon, and Washington death certificates, 2006–2012
- HCV deaths were counted from death certificates from Idaho, Oregon, and Washington. We restricted the analysis to the years 2006-2012, the years for which data were available for all three states.
- Corrected for racial misclassification using the Northwest Tribal Registry using LinkPlus v.2
- And we corrected for racial misclassification of AI/AN race in the death certificates by linking the death certificates with the Northwest Tribal Registry, using a publicly-available software called LinkPlus

Northwest Tribal Registry
- A list of AI/AN patients in the Northwest
- As a reminder, the Northwest Tribal Registry is a list of American Indian/Alaska Native patients seen at Indian Health Service, Tribal, and Urban Indian Health clinics in the Idaho, Oregon, and Washington since the mid-1980s.
- So if an individual is included in the Northwest Tribal Registry, we consider their race to be American Indian/Alaska Native.

Hepatitis C-Related Death
- International Classification of Diseases, 10th Revision codes
- Hepatitis C-related deaths were classified ICD-10 codes.

- A hepatitis C related death was defined as a record with ICD-10 codes for acute or chronic hepatitis C in the underlying cause of death field or one of the contributing cause of death fields.

Mortality Rate and Rate Ratio

- Age-adjusted mortality rate for AI/AN and non-Hispanic whites (NHW) separately
- Rate ratio comparing AI/AN mortality rate with NHW mortality rate

Result

Additional graphics in PowerPoint

Limitations

- Death certificates might underestimate HCV mortality
- Representativeness of Northwest Tribal Registry

  A few limitations should be mentioned. One is that death certificates might underestimate HCV mortality. Researchers have estimated that only 20% of persons with HCV who die have HCV recorded on their death certificates.

  In addition, the Northwest Tribal Registry does not represent the entire Northwest AI/AN population because it only includes AI/AN patients who have sought health care services at an IHS, Tribal, or Urban Indian health clinic.

  Both of these limitations would lead to and under-representation of AI/AN HCV-related mortality.

Strengths

- Regional analysis
- Data source

  The strengths of this study include that the regional analysis provides useful information to clinicians and public health practitioners in the Northwest, and that our analysis was conducted using a data source that corrected for AI/AN racial misclassification

Conclusion

- HCV-related mortality is greater among AI/AN compared to NHW
- Health disparity persists over time

  We demonstrated that HCV-related mortality is greater among AI/AN compared to non-Hispanic whites in the Northwest, and may exceed the disparity observed at the national level.

  In addition, the analysis demonstrated that the health disparity appears to persist over time.

National Viral Hepatitis Action Plan 2017-2020

The Department of Health and Human Services' 2017-2020 National Viral Hepatitis Action Plan was recently released. Its third goal addresses health disparities, explicitly stating the need for "expanded access to diagnosis, treatment, and cure." Prevention of new viral hepatitis infections – the first goal – is also an important tenant of viral hepatitis eradication.

Recommendations

- Prevent new HCV infection and transmission through harm reduction programs
- Expand access to HCV screening and treatment for American Indians and Alaska Natives
- Support providers in the Northwest in treating HCV

Executive Session

Recess at 3:57 pm

WEDNESDAY, APRIL 19, 2017

Call to Order: Cheryle Kennedy, Vice-Chairwoman

Invocation: Dan Gleason, Chehalis Tribe

WEAVE-NW, NANETTE STAR YANDELL, MPH, WEAVE-NW PROJECT DIRECTOR AND QUINAULT NATION

Webinars, Trainings, Workshops

- Monthly webinar series
- WEAVE-NW Annual Gatherings
- Health Data Literacy Trainings
- Research, Policy, and Advocacy in Indian Country
- Nike Native Fitness Collaboration with Western Tribal Diabetes Project

2017 Tobacco Project Goals

In-progress

- ✓ Piloting Youth Tobacco Prevention training
- ✓ Tribal tobacco policy toolkit, youth and community driven
- ✓ Second hand smoke facts sheets
- ✓ Clinical broachers

Goals 2017

- ➢ Traditional methodologies cessation workbook/trainings
- ➢ Create cessation curriculum for Tribes of Idaho, Oregon and Washington
- ➢ Increase tribal media campaigns –Tribally specific
- ➢ Assist with implementation and analysis of **Youth Risk Behavioral Survey (YRBS): Tobacco Specific**

2017 Core Project Activities & Objectives

- 14 Subawards at $25,000
    - Workplan evaluation
    - 2 site visits a year
- List-Serv and monthly mailings
- Face-to-face collaboration
- Monthly Webinars (lead by tribes)

Community Supported Resources Library (Fall 2017)

- Facilitate Trainings
- Health Profile Factsheet (Fall 2017)
- Negotiate Data Sharing Agreements
- Technical Assistance for All Tribes

Technical Support for ALL Tribes

- ✓ Evaluations & Assessments
- ✓ Cultural adaptation of resources
- ✓ Tobacco prevention & intervention activities
- ✓ Policy development, including youth focused
- ✓ Strategic planning
- ✓ Data analysis
- ✓ Enhancing collaborations
- ✓ Survey design, implementation, and analysis
- ✓ Health system change

What is New?

- Implementation Funding: Request for Award **OPEN AUGUST 2017**
  Between $1000 – 10,000 to Portland Area Tribes for Policy, Systems, and Environment (PSE) focused activities (see attached sheet)
- NW Food Sovereignty & Policy Coalition
- More Workshops in your area focused on sustainable approaches to improve community health: grant writing, strategic planning, and evaluation strategies

Quinault Master Gardener Program

Where We Are… Taholah, Queets, and Aberdeen
Urban Farm Model

- Increases Food Security by having access to and being able to afford nutritious, safe food—and enough of it.
- Creates a Sense of Stewardship and planning for the next generations.
- Produces Healthy, & Nutritious Food You Can Respect.
- Provides Education, Training & Employment Opportunities.
- Makes Efficient Use of Land.

More graphics on PowerPoint Presentation

NATIVE CARS, TAM LUTZ TOTS2TWEEN & CARS PROJECT DIRECTOR

The Native CARS Atlas: Addressing Disparities in Motor Vehicle Fatalities through Improving Child Passenger Restraint Use

Child Motor Vehicle Fatalities

Unfortunately, this is also true for American Indian children. Even now, American Indian children are 40% more likely to die from a motor vehicle fatality than the general population and have the highest motor vehicle fatality rates of any race.

Why the Disparity?

- Difference in road safety?
- Difference in types of vehicles driven?
- Longer EMS response time?
- Is it an urban/rural phenomenon?
  - 71% of American Indians live in urban areas, according to the 2010 US Census
- Difference in restraint use?

Child Restraint Use

To find out if a difference in child restraint use contributed to the motor vehicle death disparity in children, we collected data on 1,598 children age 8 and younger traveling in motor vehicles in six different Northwest Tribes. 73% were using some type of restraint. Compare this to 89% of restrained children nationwide this same year (2009), and an even higher percentage of restrained children in the western US (94%), which is where these communities are. Clearly, there was a greater proportion of American Indian children riding unrestrained in motor vehicles, putting them at increased risk for death in the event of a crash

Native CARS: Overall Goal

Design, implement and test effectiveness of tribal interventions to improve the use of child safety seats among AI/AN children via community-based participatory research (CBPR)

Native CARS: Study Design

- Early beginnings, 2003 observation survey
  - Age and size-appropriate child safety seat use ranged from ***25% - 55% by tribe***
- Six tribes
  - 2 each in Idaho, Oregon, and Washington
- ***All tribes*** developed and implemented their own multi-faceted interventions
  - Staggered implementation
  - Controlled community trial
- Vehicle observation surveys at 3 time points – 2009, 2011 and 2013

All Facets of the Study are Community Driven

- Tribally initiated grant proposal
- Tribes hired staff person to lead study at local level
- Tribal Research Assistants, Site Coordinators, NPAIHB staff conduct child seat observations
- Tribes facilitated qualitative research
  - Elicitation interviews
  - Focus groups
- Tribes design community interventions based on both quantitative and qualitative data
- Tribes implemented interventions
- Tribal review and approval of results dissemination

Why Tribe-Specific Data?

- Need to identify appropriate approach
  - Do we need to ***build awareness***?
  - Should we add to existing ***health or safety practices***?
  - Is the community ripe for ***policy change***?
- Need to understand ***community practices***, norms, beliefs, ***strengths, barriers***
- Need to know which children are at ***highest risk***
- Need to know if what tribes were doing at the start of Native CARS intervention addresses issues suggested by vehicle observation data
  - Do people ***need child safety seats***?
  - Is current information ***reaching drivers***?

Methods

- Sequential Explanatory design
- Quantitative
  - Measured child passenger restraint use
  - Determined Children most at risk
- Qualitative
  - Helped explain, elaborate on the quantitative data
  - Examined facilitators and barriers of CSS use
  - Described social norms

Vehicle Observation Survey

First, we collected quantitative data. We conducted vehicle observations to determine what percent of children were riding properly restrained, incorrectly restrained, or unrestrained in the vehicles, and to determine risk factors for riding inadequately restrained.

Percent of properly restrained children age 0-8, six NW tribes, 2009

Among six different Northwest tribes – two in each Oregon, Idaho, and Washington, the percent of properly restrained children age 0-8 ranged from as high as 70 percent to as low as 24 percent. By "properly restrained" we mean in a seat appropriate for the child's age and size. This was in 2009. Clearly, we had work to do.

Risks for Inadequate or Unrestraint

- Booster seat age
- Weak or no law
- Unrestrained driver
- Not with own parent
- Close to home

Data Driven Community Interventions

- Informed by community data

  - Review observation and elicitation data
    - Associations with use and non-use
    - Barriers
    - Facilitators
    - Community strengths
- Developed by community
  - Site Coordinator, their supervisors, advisory members
  - Focus Groups
- Implemented by community

Impact Evaluation

- Did Awareness Increase?
  - 77% - 87% of Native drivers reported *seeing at least one of the Native CARS media materials*
  - Awareness of a tribal law
  - Awareness of techs, car seat availability
- Did opinions change?
  - Drivers who thought kids 7 & under could safely use seat belt
    - 2009: ***43%***
    - 2011: ***26%***
- Did reported reasons for not using a seat change?
- Did we observe seats from a tribal program?

Did proper restraint increase?
More graphics in PowerPoint presentation

We observed increases in proper restraint across the board from 2009 to 2011. Although Round 2 tribes were in a control period for this study, it does not mean that they were not doing child passenger safety efforts in another capacity. Tribe F, for example, used their baseline data to secure Tribal Transportation Program money for a child safety seat program, which you can see had some success. Also, just being out in our yellow vests doing the surveys is an intervention activity in and of itself. It sends the message that the tribe cares about child passenger safety and people are paying attention, which is true. We know the act of measuring can change behavior.

Did intervention tribes increase more than control tribes?

We formally tested the difference in intervention tribes compared to control period tribes using a regression model that adjusted for child's age and accounted for the fact that children riding in the same vehicle are not independent of each other. Children in intervention tribes were about 2-and-a-half times more likely to be properly restrained in 2011 than 2009, while children in control period tribes were 30% more likely to be properly restrained. We conclude that proper restraint increased more in intervention tribes than in control tribes. The p-value is for the difference between these odds ratios**.**

Properly restrained kids by age & year

This is all the data pooled together, round 1 and round 2. We had success in most every age group, but especially in booster seat age children, which was the primary focus of most of the tribes' efforts. The 2013 dip in 2-3 year old children were the early booster seat users. The dip in 0-1 year old children was children turning forward-facing too early, despite the new recommendations issued in 2011 for children to ride rear-facing until age 2. For consistency, we said children must ride rear-facing until 1 year old and 20 lbs because these were the recommendations when the study started in 2009. Even with this more lenient definition of proper restraint, some children are turning forward-facing before age 1 and 20 lbs. These two age groups graduating to the next seat too early account for the dip in proper restraint use in Round 1 tribes. It may not be ideal, but they didn't go from using something to using nothing. They just started graduating early. At the end of the study period, half of kids age 9-12 were properly restrained, compared to only 1/3 when we started. In our proper restraint definition, we only required that these children wear a seat belt and be seated in the back seat if a back seat position was available, although if they're shorter than 4'9" tall, which most of them were (57%), they ideally would be in a booster seat. By 2013, most of the improperly restrained 9-12 year olds were in a front seat when a rear position was available (28%). 20% were unrestrained**.**

Did we reach our intended audience?

Since this study was about decreasing a health disparity, part of the evaluation is to see if we had an impact in the intended audience. As you can see, we had some success in closing the gap between Native and non-Native child passengers in the same communities. We closed the gap by 14 points. (We asked drivers their race and asked if any children in the vehicle were American Indian) The top line is children traveling in vehicles with no Native people, the dark green line is percent of properly restrained children in vehicles with one or more Native person.

Did risk factors change over time?

Did risk factors change over time? We saw a 10 point increase among children riding with their own parent and a 16 point increase among those riding with someone else. This remains a risk factor for inadequate restraint.

We saw a 7 point increase in proper restraint for kids traveling more than 5 minutes from home, compared to a 15 point increase in those making a very local trip, 5 minutes from home or less, closing the gap by 8 points.

Native CARS: CBPR Success

- Native CARS tribes carried out interventions that improved child passenger restraint use
  - Focused on interventions that ***strengthened community*** and ***enhanced tribal capacity***
  - Promote long-term sustainability
- The tenets of CBPR were absolutely essential to the success of the program
  - The value of community knowledge and input

- Site coordinators broadened their own skill sets - ***"local experts"***

Native CARS: Dissemination Phase Goals

- Demonstrate that Native CARS interventions can be ***translated to other tribes***.
- Use the ***Native CARS Atlas*** as a blueprint to address child passenger safety concerns in tribal communities
- ***Reduce the number of fatalities and injuries*** from motor vehicle crashes among tribal children

Atlas Content Outline

- Build and organize your coalition
- Check your community's readiness
- Collect data
- Make data-driven plans to improve use
  - Create an awareness campaign
  - Provide education
  - Create a distribution program
  - Utilize EHR alerts to connect education with distribution
  - Policy & law enforcement interventions
- Demonstrate progress & success

Quick Links

- Get ideas about where to start
- Link my distribution program to RPMS
- Download posters for printing
- Browse media samples
- Learn how to become a CPS Tech
- Collect data to apply for a grant
- Install electronic alert to help health providers provide CSS education

4: Why & How to Collect & Use Data

- Find and use existing data resources
  - FARS, WISQARS, etc.
- Collect community-specific data
  - Do vehicle observations to determine the proportion of properly restrained kids
  - Determine groups at risk
  - Conduct Elicitation Interviews
  - Conduct focus groups
  -

5: Make Data-Driven Plans to Improve Child Passenger Safety

- Pinpoint mode of intervention: awareness, education, behavior change, public health practice, policy

- Create & evaluate an intervention

6: Create a Data-Driven Awareness Campaign

- Determine messages & audience
- Create specific types of media
- Download Native CARS media, both ready to customize and ready to **print**

9: Got Seats? Child Safety Seat Distribution Programs

- Partner with an existing distribution program
- Identify funding for car seat resources
- Start a car seat distribution program
- Consider daily operations of distribution program
- Improve or expand your distribution program

10: Install Electronic Alerts and provide consults on HER

- Downloading and installing the Electronic Health Reminder file for Car Seat Education.
- Using the EHR software

11: Develop Policy and Law Enforcement Interventions

Native CARS: Acknowledgements

- NPAIHB tribal delegates
- NW NARCH leadership
  - Early work funded via NIH grant # U269400013
- *Site coordinators !!!!*
- Vehicle survey data collectors
- Native CARS Study Group
- Members of participating tribes
- Intervention and Dissemination Phases funded via
  - National Institute of Minority Health and Health Disparities, grant # R24MD002763

Tribal Site Resources and Partners

- Washington Safety Restraint Coalition
- Washington Traffic Safety Commission
- Safe Kids
- Indian Health Service
- Tribal Target Zero Program
- Tribal Health Programs
- Tribal Early Childhood/ Head Start Programs
- Tribal Police
- Tribal Attorneys
- Tribal Health Boards
- Tribal Workgroups
- Neighboring Police Departments
- Fire and EMS Departments

BREAK

Opportunities Presented by CMS Guidance Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility, Bruce Goldberg, MD and Laura Platero, Government Affairs/Policy Director

Prior to February 26, 2016 Guidance

- States could claim 100% federal funding for services provided at an IHS/Tribal facility and furnished to Medicaid eligible AI/AN's
- States reimbursed for services provided to Medicaid eligible AI/AN's outside of an IHS/Tribal facility at a state's regular FMAP rate (~70/30 – 50/50 depending on state

New Guidance – Feb. 26 Letter

- CMS has reinterpreted the scope of services considered to be "received through" an IHS/Tribal facility for purposes of eligibility for 100% FMAP
- Now includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules and that are also covered under the approved Medicaid state plan – also includes any services established in the future as a state plan benefit
- This includes long-term services and supports (LTSS) and Emergency and Non-Emergency Medical Transportation (EMT and NEMT).
- This produces overall savings to the state.
- Allows 100% federal funding for services "received through" an IHS/Tribal facility and furnished to Medicaid eligible AI/AN's
- 100% federal funding now available for care provided to AI/ANs in private sector
- Opportunity for a state to claim 100% federal funds in circumstances where they had been paying 30-50% of the bill, thereby creating the possibility of substantial state fund savings

To be Eligible for 100% FMAP Services:

- An IHS/Tribal facility must request the service
- There must be a care coordination agreement between the IHS/Tribal facility and the provider
- There is a relationship between the patient and the IHS/Tribal provider

Care Coordination Means

- The IHS/Tribal provider requests the service and sends the information to the provider receiving the referral
- The provider receiving the referral sends information back to the IHS/Tribal provider
- The IHS/Tribal provider continues to assume responsibility for the patient
- The IHS/Tribal provider puts the referral information in the patients' medical record

Opportunity

- For a state to consult with Tribes and work together with them to improve the health of Tribal members by assuring that savings available through this program are reinvested in Tribal communities.
    - For example, create a Tribal Health Improvement Fund:
        - To improve access to care
        - Provide mental health services
        - Other health related issue

For Private Sector Providers

- No change in how they bill for and are paid for Medicaid clients.
- Potential funding to work with IHS/Tribal programs, and possibly urban programs, on projects of mutual interest

Some of What Is Needed

- Agreement with state to share funds made available through this program!!
- Care coordination agreements with providers
- Mechanisms to track/coordinate care and administer the referrals
- Mechanisms to: track funding, invoice and receive funds
- Audit and compliance for Tribal organizations
- Compliance documentation for State claiming:
    - Service delivered to eligible AI/AN who is patient of an IHS/Tribal provider per written referral request
    - Service is within scope of care coordination agreement
    - Rate of payment is authorized under State Plan
    - There is no duplicate billing

Oregon Experience To Date

- 9 Tribes and urban program working collaboratively with the state to implement this program
- First claims have been submitted
- State working with CMS to gain clarity on implementation

Governor Brown's Commitment

"I am committed to investing the savings from this change to Medicaid policy into Tribal programs and services that improve the health of American Indian and Alaska Native communities."
Governor Kate Brown (September 7, 2016)

Progress

- Starting with hospital claims – as these are relatively low volume but high cost
- Expand to other providers
- Care Coordination agreements in place with 9 hospitals

- Procedure in place with Medicaid agency for claiming
- First claims submitted
- Currently a manual process – need to automate
- Working with CMS to clarify their policies
    - Initially CMS staff have taken a very literal and burdensome approach to claiming

Submitting Claims, Billing and Tracking: Tribal and Non-Tribal Providers

- Non-IHS/Tribal provider bills for the services for the Medicaid member referred by the IHS/Tribal facility and sends a copy of the billing to the IHS/Tribal provider.
- IHS/Tribal provider completes the "Care Coordination Episode Tracking Template" and submits to OHA.
- OHA acknowledges receipt of Care Coordination Episode Tracking Template from IHS/Tribal provider.
- OHA processes claim manually, completes claim adjustment to a 100% FMAP claim (This will be automated-no completion date yet)
- Pending discussion and agreements between State and Tribes regarding specifics regarding methodology, return the savings to IHS/Tribal providers

Additional graphic in PowerPoint

A Word about Documentation
The documentation must be sufficient to establish that:

- The item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner;
- The requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care;
- The rate of payment is authorized under the state plan and is consistent with federal requirements; and
- There is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

Is 100% FMAP Available for Services to AI/AN Medicaid Managed Care Members?

- Yes, if:
    - The service is furnished to an AI/AN Medicaid beneficiary enrolled in the managed care plan;
    - The service meets the same requirements to be considered "received through" an IHS/Tribal facility as would apply in the fee-for-service system;
    - The managed care plan maintains auditable documentation that those requirements are met;

- The non-IHS/Tribal provider is a network provider of the enrollee's managed care plan; and
- The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider's contractual agreement with the managed care plan**.**

Submitting Claims, Billing and Tracking: OHA
Interim process:

- OHA inserts patient/provider/date information in the MMIS.
- OHA pulls reports on a defined timeline.
- OHA completes prior period adjustments on claims that change claiming to 100% FMAP.
- MMIS automatically reviews and uses claims data.
- MMIS automatically claims 100% federal match.
- OHA calculates savings.
- OHA distributes savings to IHS/Tribal providers in a manner to be determined.

100% FMAP Going Forward

- OHA is currently in the process of identifying IT systems changes and will move to implement processes that will simplify and streamline the 100% FMAP process as quickly as possible.
- Tribes are discussing how to disburse the savings.
- Ongoing work with CMS.

For more information:

Bruce Goldberg
brucegoldberg955@gmail.com
503-975-8932

Medicaid Data, Ed Fox, PhD

Please PowerPoint presentation with graphics

LUNCH

Tribal Updates

1. Makah
2. Nez Perce
3. Warm Springs Service Unit Update

Washington Medicaid Integration of Physical and Behavioral Health Services and Administration, Jessie Dean, WA HCA, Administrator, Tribal Affairs & Analysis, Division of Policy, Planning & Performance

Please PowerPoint presentation with graphics

Recess at 2:55 pm

THURSDAY, APRIL 23, 2014

Call to Order: Andy Joseph, Chairman, called meeting to order at 8:33 am

Invocation: Sam Penny, Nez Perce

Chair Report, Andy Joseph

In my role as Chair, I attended several meetings this quarter:

I attended NIHB Board Meeting on January 24-26, 2017 in Washington, DC. In addition to our regular board business, we spent a significant amount of time setting legislative and policy priorities related to the new administration.

From February 13-16, 2017, I attended NCAI's Executive Council Winter Session in Washington, DC. I also made about 10 Hill visits with Board staff and spoke with Congressional Representatives for Washington, Oregon and Idaho and had meetings with majority and minority staff of the Senate Committee on Indian Affairs. We advocated for preservation of Medicaid expansion and 100% FMAP, opposition to block granting, and preservation of the Indian Health Care Improvement Act and Indian provisions in the Affordable Care Act. We also advocated for permanent authorization and increased funding for the Special Diabetes Program for Indians, IHS Advance Appropriations, IHS Exemption from Sequestration, parity with VA funding for Hepatitis C treatment, among many other requests.

I then attended the FY 2019 IHS National Budget Work Session from February 16-17, 2017 in Crystal City. I was re-nominated as co-Chair and look forward to continuing in this role. At the meeting, IHS acknowledged Portland Area's request for full funding at (42%). There was also an inquiry to Acting Director Chris Buchanan as to unspent IHS funds being returned to the Treasury. Acting Director Buchanan will provide a detailed response in the future.

On March 9, 2017, I testified at an Oversight Hearing for the Subcommittee on Indian, Insular and Alaska Native Affairs (under the House Committee on Natural Resources) on "Improving and Expanding Infrastructure in Tribal and Insular Communities." I asked the Subcommittee to do everything in its power to ensure that Congress addresses Indian health facilities needs when it drafts legislation to implement the expected Trump administration infrastructure initiative. I also asked the Subcommittee to direct the IHS to distribute a significant portion of any facilities construction funds that may be available under an infrastructure initiative through an Area Distribution Fund to ensure that all IHS areas have an opportunity to address facility needs.

On March 30, 2017, I attend the U.S. Department of Health & Human Services, 19th Annual Tribal Budget and Policy Consultation. Tribal leaders from across Indian country attended the

meeting to discuss budget and policy concerns with leadership from several federal agencies. As a co-Chair of the National Tribal Budget Formulation Workgroup, I made a needs-based budget request to IHS of $32 billion to be phased in over a 12-year period. I also discussed the impact of cuts to the Low Income Home Energy Assistance Program (LIHEAP), the Meals on Wheels Program, and the Low Income Student Foods Assistance Program; recent passage of bill in Washington state allowing dental health aide therapists (DHATs) to work in Tribal communities, and need to get DHATs approved for reimbursement under Medicaid; Indian country's oral health disparities, the need for DHATs, and the Indian Health Care Improvement Act's restriction on use of DHATs without state authorization; importance of Head start; funding for traditional healing and the Tribal Behavioral Health Agenda; and other concerns. For the Colville Tribe, I talked about working with the State on obtaining the inpatient encounter rate for our convalescent center and in-home care and long term care needs. HHS Secretary Tom Price attended the consultation during the last hour. I was able to speak directly with the Secretary and reiterate several of the concerns that I expressed to the federal agencies.

Last week, on April 10, 2017, I attended the HHS Region 10 Tribal Consultation hosted by the Suquamish Tribe. Representatives from the various federal agencies were at the meeting. I brought up the need for Hepatitis C Treatment, the prevalence of cancer in our communities, concern about the cut to LIHEAP funding, the CMS 4 Walls Limitation, and the need for funding for elders for in-home and long-term care.

Committee Reports

Elders – Given by Dan Gleason, Chehalis Tribe (A copy of the report is attached)

Veterans – Given by Rhonda Metcalf, Sauk-Suiattle Tribe (A copy of the report is attached)

Public Health - Given by Victoria Warren-Mears, NPAIHB (A copy of the report is attached)

Behavioral Health – (A copy of the report is attached)

Youth – Given by Nanette Yandell, NPAIHB (A copy of the report is attached)

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

Legislative Report – Given by Laura Platero, NPAIHB

RESOLUTIONS:
13-03-01 Preservation of Indian Health Care Improvement Act
Ratified, motion by Shawna Gavin, Umatilla; seconded by Cassie Sellards-Reck, Cowlitz, MOTION CARRIES

13-03-02 Supporting Native Expectant and Parenting Teens, Women, Fathers, and their Families
Ratified, motion by Andy Joseph, Jr, Colville; seconded by Leland Bill, Yakama: MOTION CARRIES

13-03-03 "Office of Minority Health Partnerships to Achieve Health Equity Competitive Grant" Improving Data and Enhancing Access-Northwest (IDEA-NW)
Ratified, motion by Shawna Gavin, Umatilla; seconded by Cassie Sellards-Reck, Cowlitz: MOTION CARRIES

13-03-04 Letter of Support Dr. Grim for Director of the Indian Health Services, Department of Health and Human Services
Ratified, motion by Dan Gleason, Chehalis; seconded by Cassie Sellards-Reck, Cowlitz: MOTION CARRIES

13-03-05 Northwest Native American Research Center for Health" renewal
Motion by Rhonda Metcalf, Sauk-Suaittle; seconded by Gerald Hill, Klamath: MOTION CARRIES

13-03-06 Approval and Adoption of Health Reimbursement Arrangement for Employees of NPAIHB
Motion by Cassie Sellards-Reck, Cowlitz; seconded by Rhonda Metcalf, Sauk-Suaittle: MOTION CARRIES

13-03-07 Opposition to FY 2018 Budget Cuts to U.S. Department of Health and Human Services
Motion by Andy Joseph, Jr, Colville; seconded by Rhonda Metcalf, Sauk-Suiattle: MOTION CARRIES

13-03-08 Support of Reauthorization of the Special Diabetes Program for Indians
Motion by Dan Gleason, Chehalis; seconded by Theresa Lehman, Jamestown: MOTION CARRIES

MINUTES
Motion by Dan Gleason, Chehalis, Tribe; 2nd by Cassie Sellars-Reck, Cowlitz Tribe, MOTION PASSES

FINANCE REPORT – Given by Eugene Motif, NPAIHB motion Cheryle Kennedy, Grand Ronde Tribe; 2nd by Ronda Metcalf, Sauk-Suiattle Tribe, MOTION PASSES

SDPI report: Cassie Sellars-Reck and Sharon Stanphill

Upcoming Board meetings:

- *July 2017 Joint Meeting w/ CRIHB – Canyonville, OR (Cow Creek)*
- *October2017 – Yakama Nation*
- *January 2018 – TBD*
- *April 2018 - Umatilla tentatively*

ADJOURN at 10:00 am

_____ _____

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

_____ _____

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

_____ _____

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

QUARTERLY BOARD MEETING

Quinault Beach Resort - Ocean Shores, WA

April 17-19, 2017

AGENDA

TUESDAY, APRIL 18, 2017

7:30 AM	**Executive Committee Meeting**	
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call	Andy Joseph, Chairman Hazel Rosander Tyson Johnson, Quinault Indian Nation, Vice President Quinault Veterans Shawna Gavin, Treasurer
9:15 AM	Area Director Report **(1)**	Dean Seyler, Portland Area IHS Director
10:00 AM	Psychotropic Medications and Youth Presentation **(2)** ***via teleconference***	Shawn S. Sidhu, M.D. Associate Training Director - Rural and Community Training, UNM , General Psychiatry Residency Program Assistant Medical Director, UNM-IHS Telebehavioral Health Center of Excellence Contract Assistant Professor, University of New Mexico Department of Psychiatry Division of Child and Adolescent Psychiatry, Division of Community Behavioral Health
11:00 AM	Executive Director Report **(3)**	Joe Finkbonner, NPAIHB Executive Director
11:15	Review of National Committee Representatives and Updates	Joe Finkbonner, NPAIHB Executive Director
11:45 AM	NW NARCH Update **(4)**	Dr. Tom Becker, NW NARCH & Cancer Project Director

12:00 PM	**LUNCH**	
	Committee Meetings *(working lunch)*	
	1. Elders	Staff: Clarice Charging
	2. Veterans	Staff: Don Head
	3. Public Health	Staff: Victoria Warren-Mears
	4. Behavioral Health	Staff: Jessica Leston
	5. Personnel	Staff: Andra Wagner
	6. Legislative/Resolution	Staff: Laura Platero
	7. Youth	Staff: Nanette Yandell
1:30 PM	Policy & Legislative Update **(5)**	Laura Platero, Government Affairs/Policy Director
2:15 PM	AIHC – Public Health Emergency Preparedness **(6)**	Lou Schmitz, AIHC Consultant
3:00 PM	**BREAK**	
3:15 PM	Hepatitis C **(7)**	Jessica Leston, HIV/STI/HCV Clinical Program Manager, CAPT Thomas Weiser, MD, MPH Medical Epidemiologist, and Sarah M. Hatcher, PhD, Epidemic Intelligence Service Officer, CDC
4:15 PM	Executive Session	

WEDNESDAY APRIL 19, 2017

9:00 AM	Call to Order Invocation	Cheryle Kennedy, Vice-Chairman
9:15 AM	WEAVE-NW **(8)**	Nanette Star Yandell, MPH, WEAVE-NW Project Director and Quinault Nation
9:45 AM	CARS **(9)**	Tam Lutz Tots2Tween & CARS Project Director and Jodi Lapidus, CARS Principle Investigator
10:00 AM	**BREAK**	
10:15 AM	Opportunities Presented by CMS Guidance Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility **(10)** ***via teleconference***	Bruce Goldberg, MD and Laura Platero, Government Affairs/Policy Director
11:00 AM	Medicaid Data **(11)**	Ed Fox, PhD
12:00 PM	**LUNCH**	On your own
	Roundtable - *Native Dental Therapy Initiative – Hosted luncheon -**Room 5***	*Washington Tribes discussion of new Washington State DHAT Bill*
1:30 PM	**Tribal Updates** 1. Makah 2. Nez Perce 3. Warm Springs Service Unit Update	
2:30 PM	Washington Medicaid Integration of Physical and Behavioral Health Services and Administration **(12)**	Jessie Dean, WA HCA, Administrator, Tribal Affairs & Analysis, Division of Policy, Planning & Performance
3:30 PM	**BREAK**	
6:00 PM	***Cultural Presentation and Salmon Dinner hosted by Quinault Nation honoring of Pearl Capoeman-Baller at Community Center in Taholah***	

THURSDAY, APRIL 20, 2017

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 –January 2017 2. Finance Report 3. Future Board Meeting Sites: • *July 2017 Joint Meeting w/ CRIHB – Canyonville, OR (Cow Creek)* • *October2017 – TBD* • *January 2018 – TBD* • *April 2018 - TBD*	
12:00 PM	Adjourn	

INDIAN HEALTH SERVICE PORTLAND AREA DIRECTOR'S UPDATE

Dean M Seyler - Area Director
April 18, 2017
Quinault Beach Resort
NPAIHB Quarterly Board Meeting

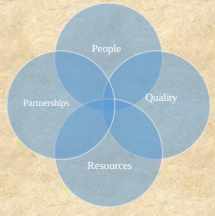
Indian Health Service Portland Area

- **Current IHS Headquarters Senior Leadership**
  - RADM Chris Buchanan – Acting Director
  - Elizabeth A. Fowler – Deputy Director for Management Operations
  - CAPT Michael Toedt, M.D. – Acting Chief Medical Officer
  - Jonathan Merrell – Acting Deputy Director for Quality Health Care
  - P. Benjamin Smith – Deputy Director for Intergovernmental Affairs
  - RADM Kevin Meeks – Acting Deputy Director of Field Operations
  - RADM Kelly M. Taylor – Acting Chief of Staff

  https://www.ihs.gov/aboutihs/keyleaders/
- **Current IHS Headquarters Senior Leadership**
  - Chief Contracting Officer - Elida Monroe
  - Contract Support Cost (CSC)/Indian Self Determination (ISDEAA) Specialist position

Indian Health Service Portland Area

- People
- Partnerships
- Quality
- Resources



Indian Health Service
Portland Area

- **Funds Distribution Workgroup**
  - Met March 14, 2017 at Portland Area Office
  - Discussed Area-wide CHSDA Proposal
  - A proposed CHSDA expansion pilot project for Tribes to opt into a secondary layer of coverage that would allow them to expand their individual CHSDA's throughout Portland Area (OR, WA & ID) in order to access Medicare Like and PRC Rates.
  - Under Review
- **FY17 CHEF**
  - **$115,904 submitted for Portland Area**
  - **100% reimbursement rate to date**
  - **Current balance: $46,801,410.**

Indian Health Service
Portland Area

- **2017 Tribal Self Governance Annual Conference**
  - Date: April 25 - 26
  - Location: Spokane, WA
- **Direct Service Tribe Advisory Committee Quarterly meeting**
  - May 3-4, 2017
  - Portland, OR
  - Location: Radisson Hotel – Portland Airport

Indian Health Service
Portland Area

- **2017 Portland Area Director's Recognition of Excellence**
  - Date: May 12, 2017
  - Location: Portland – Embassy Suites – downtown Portland, Oregon
  - Tribal Leaders, Recipients and Supervisors notified
- **2015 & 2016 IHS Directors Award Ceremony**
  - Date: July 28, 2017
  - Location: Rockville, MD
  - Both Fiscal Year Recipients will be recognized (FY15 & FY16)
- **IHS Direct Service Tribes National Meeting**
  - Date: July 26-27
  - Location: Boston, MA

Indian Health Service
Portland Area

- **P.L. 93-638 Orientation**
  - **When**: August 2-3, 2017
  - **Location:** Portland, OR – Embassy Suites Portland Airport
  - **Who Should Attend:**
    - Tribal Leaders
    - Tribal Administrators and staff
    - Area & Service Unit staff involved with P.L. 92-638 process

- **Oregon YRTC Contract With NARA Update**

Facilities update:
- Construction is on-going in all phases
- Building is projected to be complete and permit sign-off mid-May.
- Delay will be with electrical service to the building from PGE.
- Temporary Occupancy permit is being requested before power service.

Indian Health Service
Portland Area

- **Oregon YRTC Contract Update**
  - 16 bed facility at opening with an option to expand to 24 beds
  - Hired YRTC Manager and Youth Tribal Liaison
  - Interviews are in process for Milieu therapists, tutor, Youth A & D Counselors, cook, and others
- **Planning is on-going for:**
  - Medical services
  - School services
  - Treatment curriculum is developed – 2 months to 3 months anticipated treatment length of stay depending on the youth's progression through treatment

Indian Health Service
Portland Area

Indian Health Service Portland Area

Indian Health Service Portland Area

- September 2016 CMS Final Rule on Emergency Preparedness Requirements
  - Purpose: To establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems.
  - Four Major Points:
    - **Risk Assessment and Emergency Planning**- "All Hazards Approach"
    - **Policies and Procedures**
    - **Communication Plan**
    - **Training and Testing**- initial and annual refresher; drills
  - Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

Indian Health Service Portland Area

- September 2016 CMS Final Rule on Emergency Preparedness Requirements
  - Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid
  - Compliance:
    - AAAHC accredited clinics
    - Non-accredited Tribal health clinics
  - For assistance:
    - LCDR Matthew Ellis, MPH, REHS
      Institutional Environmental Health Officer/Emergency Management Coordinator
      Phone: 503-414-7788 or matthew.ellis@ihs.gov

Indian Health Service Portland Area

- **IHS Program Maximum Supportable Space (MSS) – Update from October 2016**
  - Approved IHS Program Space is Used to Determine Allocation of Maintenance & Improvement (M&I) and Equipment (EQ.) Funds.
  - Funds Are Not Allocated for Program Space Above the Maximum Supportable Space (MSS).
  - Health Facilities Engineering (DHFE) Analyzed all Tribal Programs with Retained Shares and Determined Six Tribal Programs Would Benefit From Recalculating MSS.
  - Area Director Notified These Tribes in November 2016.
  - Three Tribal Programs Responded and Worked With DHFE Resulting in Supported Program Space Increases of 41%, 21%, and 8%. The Increased Space Will be Considered in Future Year Allocations.
  - 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

- Grant Opportunity
- American Cancer Society/Walgreens
  - Will award five (5) grants in amounts up to $100,000 ($50,000/year for 2 years) to eligible tribal health organizations and organizations serving the health needs of AI/AN communities to support the implementation of colorectal cancer screening projects.
  - Information has been shared with all Portland Area I/T/U Clinical Directors. Contact Dr. Rudd for a copy of the grant announcement.
  - Deadline for grant applications: May 17, 2017.
  - Assistance:
    - Oregon- 503-295-6422
    - Washington- 206-283-1153
    - Idaho- 208-343-4609

American Cancer Society

Indian Health Service Portland Area

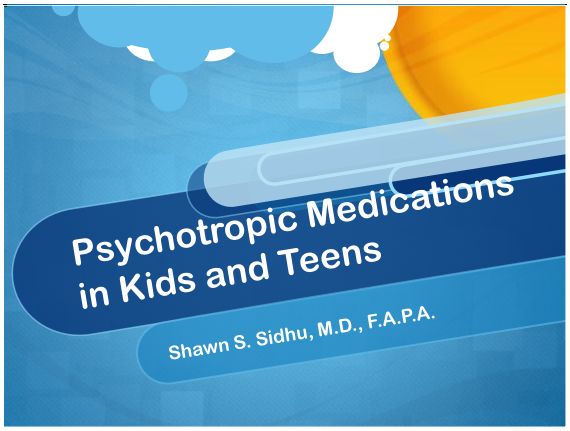
- **Federal Register Notice Published**
  - **Proposed re-designation of Service Delivery Area**
  - **Tolowa Dee-ni' Nation**
  - **Consultation with two Oregon Tribes**
  - **Open for comments until May 01, 2017**
  - https://www.federalregister.gov/documents/2017/03/31/2017-06383/proposed-re-designations-of-service-delivery-areas-tolowa-dee-ni-nation-smith-river-rancheria
- **Perception of Significant Amount of IHS Funds Returned**
  - IHS is not returning a significant amount of funds
  - Dear Tribal Leaders Letter dated March 28, 2017
  - https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2017_Letters/57343-1_DTLL_UIOLL_FundsReturnedTreasury_03282017.pdf

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.



Disclosures

- Dr. Sidhu receives royalties for writing continuing medical education questions for the American Psychiatric Association and *FOCUS*

Objectives

Upon completion of this session, participants will be able to better understand:

1) When medications are worth considering

2) Non-medical approaches worth trying

3) Risks and benefits of certain medication groups

When Might You Urgently Consult a Mental Health Provider?

- Acute/Precipitous Change in Functioning
- Concerns Over Safety of Home Life
- Suicidal/Homicidal Statements
- Concerns of Psychosis/Hallucinations
- Concern for Abuse

When Are Medications Generally Necessary?

When Are Medications Generally Necessary?

"Inability to function"

- Poor academic functioning (failure)
- Poor social functioning in the classroom
- Significant classroom disruption
- Concerns about emotional/mental wellbeing

Core Ethical Dilemma

Provider Beneficence versus Patient Autonomy (in the case of children Patient Autonomy is most often represented by the wishes of the parents)

State laws vary significantly

Discussion with Parents

First get the family's opinion on how the child is doing and what they think would make things better

Discussion with Parents

Next, discuss non-medical solutions to improve the child's level of functioning:

- Behavioral Classroom Interventions
- School/Individual/Family Counseling
- Speech & Language/OT/Academic Skills
- Social Skills Training
- 504/IEP interventions, possible 1:1 aides

Parent: "What Do You Think About Therapy?"

The potential reaches of therapy are even broader than medications

In non-emergent cases, and especially in children, often therapy is the best first approach

For most conditions, the best results are obtained when therapy is combined with medications

Sometimes medications allow the facilitation of therapy

Parent: "Do Medications Even Work?"

- Each medication class is given a grade of evidence for a particular condition
- More experimental medications will have a lower grade of evidence
- Each child is unique and not all individuals respond the same way to medications
- May need to try several medications before you find the right one for each child

Parent: "How Long Will My Child Need to Take Medications?"

- Depends on the condition and the student's progress
- ADHD course typically stabilizes by mid-20s
- Depression/Anxiety: risk of remission reduces greatly with approximately 1 year of treatment (some studies showing as little as six months)
- Cases of severe psychosis/Schizophrenia or Bipolar Disorder may require lifetime medications

Philosophical Approach

- Start Low, Go Slow (especially in kids)
- Find the lowest possible therapeutic dose
- Avoid polypharmacy whenever possible (maximize single agents before combining agents)
  - Difficult to assess effectiveness of any one agent
  - Drug-drug interactions increase the risk of side effects
  - Providers end up with laundry lists over years

Psychotropics and Street Drugs/Alcoholl

Some medications are more harmful to use with street drugs/alcohol than others. Similarly, some street drugs are more dangerous to use with psychotropic medications

Meth/Cocaine + stimulants: cardiac/stroke

Meth/Cocaine + anti-depressants: serotonin syndrome

Opiates (heroin) + anxiolytics: dangerous drops in blood pressure

Alcohol + Lithium: risk of kidney failure

Psychotropic Medications

- Diagnosis is INCREDIBLY important
  - Input from teachers is VERY valuable in diagnosing children (teachers see children more than parents)
- Wrong Diagnosis = Wrong Meds
  - Decreases trust with parents
  - Unnecessarily exposes children to unneeded meds

Common Psychotropic Medications

- Anti-Depressants
- Anxiolytics
- Stimulants/Non-Stimulants
- Mood Stabilizers
- Anti-Psychotics

*All of these groups have newer and older meds

Common Side Effects

- Headache, upset stomach, and sleep changes are common in most psych meds
- All psych meds can theoretically lower the seizure threshold
- Many psych meds can alter heart rhythms, especially mood stabilizers and antipsychotics
- Some psych meds interact with other meds
- Stimulants cause reduced appetite and insomnia

More Serious Side Effects

- Although rare, need to make sure the psych meds are not making depression/SI worse
- Anti-psychotics and mood stabilizers are known to cause significant weight gain, blood cell problems, endocrine problems, and even hormonal problems. These medications should only be used when absolutely necessary

SUMMARY

- In the end, if a child's level of function has deteriorated consider medications as a PART, but NOT the entire solution
- Ask the Psychiatrist if both medical and non-medical alternatives exist. Be sure to voice your opinion if you feel the plan revolves too much around medications rather than a comprehensive approach.

SUMMARY

- Many mental health diagnoses look similar, but have very different treatments. For example, Bipolar Disorder is traditionally over-diagnosed in children, and the medications have many side effects.
- Some culturally-appropriate beliefs may appear abnormal to a Psychiatrist who is unfamiliar
- Ask Psychiatrists for a detailed description of the child's diagnosis and choice of medications

SUMMARY

- Never underestimate the power of a child's environment on his/her mental and emotional well-being
- Often times helping families communicate in a healthier way can be incredibly helpful
- Cultural ceremonies/rituals and involvement can also be very helpful for children and families

Questions???

- ssidhu@salud.unm.edu

Northwest Portland Area Indian Health Board

Executive Director Report

Quinault Beach Resort
Ocean Shores, WA
April 18, 2017

Joe Finkbonner, RPh, MHA

Northwest Portland Area Indian Health Board

Personnel

- **New Hires:**
  - Rosetta Minthorn, On-Call Assistant
  - Elisabeth Stanphill, On-Call Assistant
- **Temps/Interns:**
  - Shalaya Williams, Temp BRFSS Interviewer
  - Rosamaria Frutos, Temp BRFSS Interviewer
- **Recognition:**
  - **Jenine Dankovchik, 10 Years of Service**

Northwest Portland Area Indian Health Board

Meetings

February

- NCAI, Washington, DC (Feb 13-16)
- Signing of Washington State DHAT Bill (Feb. 22nd)

March

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

Meetings

April

- Washington Dental Service Foundation Meeting (April 4)
- CMS I/T/U Training, Seattle, WA (April 4-5)
- Region 10 Consultation, Suquamish, WA (April 12th)

Upcoming Meetings

April

- 2017 Annual Tribal Self-Governance Conference, Spokane, WA (April 26-27)

May

- DSTAC Quarterly Meeting, Portland, OR (May 3-4)
- WDSF Strategic Planning Meeting (May 12th)
- ATNI Mid-Year, Portland, OR (May 23-26)

Upcoming Meetings

June

- DHAT Graduation, Anchorage, AK (June 2nd)
- NIHB PHS, Anchorage, AK (June 5-8)
- NCAI Executive Winter Session, Mohegan Sun, (June 12-14)
- NWIC Foundation Quarterly Board Meeting, Lummi (June 15th)
- PHAB Board meeting (June 21-22)

Business

- Review National Committee List

Questions…?

Northwest Tribal Epidemiology Center
(*The EpiCenter*)
January-March 2017 Quarterly Report

Northwest Tribal Epidemiology Center Projects' Reports Include:

- **Adolescent Health**
- **Clinical Programs-STI/HIV/HCV**
- **Epicenter Biostatistician**
- **Epicenter National Evaluation Project**
- **Immunization and IRB**
- **Injury Prevention Program (IPP)/Public Health Improvement & Training (PHIT)**
- **Medical Epidemiologist**
- **Native Children Always Ride Safe (Native CARS) Study/TOTS to Tweens Study**
- **Northwest Native American Research Center for Health (NARCH)**
- **Northwest Tribal Cancer Control Project**
- **Northwest Tribal Dental Support Center**
- **Northwest Tribal Registry Project-Improving Data and Enhancing Access (IDEA-NW)**
- **Tribal Health: Reaching out InVolves Everyone (THRIVE)**
- **Wellness for Every American Indian to View and Achieve Health Equity (WEAVE)**
- **Western Tribal Diabetes Project**

Adolescent Health

Stephanie Craig Rushing, Project Director
David Stephens, Multimedia Project Specialist
Tommy Ghost Dog, Project Red Talon Assistant

Contractor: Amanda Gaston, MAT, IYG Project
Students: Steven Hafner, Harvard PhD Student Intern

Technical Assistance and Training

NW Tribal Site Visits

- Chemawa Indian Boarding School's Wellness Day, January 20, 2017. Approximately 300 AI/AN high school students in attendance.
- Swinomish: OMH AI/AN Health Equity Grant RFP, January 18 and 30, 2017.
- Chemawa Indian Boarding School, Bootcamp Mtg. February 8, 2017.

Out of Area Tribal Site Visits

- None

January Technical Assistance Requests

- Tribal TA Requests = 5 (Stephanie), 3 (David), 1 (Tommy)
- Other Agency Requests = 5 (OHSU, SAMHSA, FYSB/ACF, WA DOH/Cardea, Ohio State University)

February Technical Assistance Requests

- Tribal TA Requests = 4 (Stephanie), 3 (David), 2 (Tommy)
- 8 (OMH, Focus on Youth, OHSU, UNITY/CNAY, Urban Clinic Utah, EngenderHealth, PSU, WA DOH)

March Technical Assistance Requests

- Tribal TA Requests = 3 (Stephanie), 1 (David)
- 6 (UNITY/CNAY, OHSU, IHS, ITCA, SAMHSA, OMH)

Project Red Talon / We R Native / Native VOICES

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

- Call and Meeting: Swinomish re: OMH AI/AN Health Equity Grant RFP, January 18 and 30, 2017.
- CDC site visit: Lisa Neel, March 23, 2017.
- Meeting: Native STAND Planning Team, January 9, 2017and March 6, 2017.
- Presentation: We R Native @ Chemawa Indian Boarding School's Wellness Day, January 20, 2017. Approximately 300 AI/AN high school students in attendance.
- Webinar: Native STAND cohort 3 recruitment, January 18, 2017.

Native It's Your Game and Healthy Native Youth

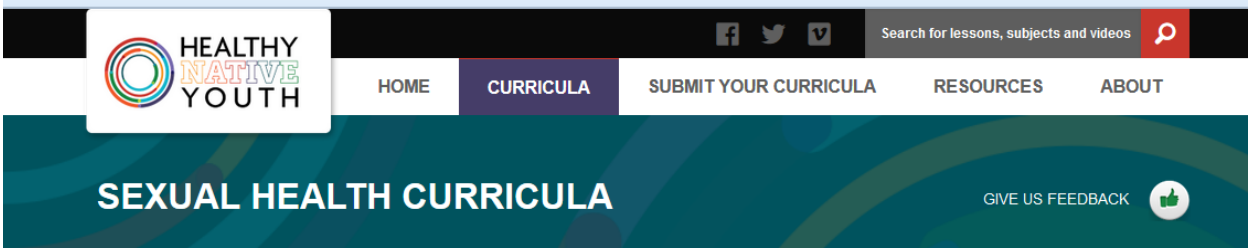
During the quarter, *Native It's Your Game* staff participated in eight planning calls with study partners, five site calls, and supported the following trainings and events:

- AdobeConnect: HNY Workgroup Conference Call, February 22, 2017.
- Native American Calling: February 13, 2017: http://www.nativeamericacalling.com/monday-february-13-2017-steering-teens-informed-decisions-sex/

- Webinar presentation: WRN and HNY, Supporting Native Youth Wellness Through HIV Strategies Webinar, March 16, 2017. With 47 adult attendees.

Health Promotion and Disease Prevention

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



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

The site contains 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.

This month, the site received:

Page views	876
Sessions	341
Percentage of new visitors	60%
Average visit duration	2:24
Pages per visit	2.57

Total **Healthy Native Youth Facebook** reach for the month: 1,980.

Facebook page "likes" = 349: https://www.facebook.com/HealthyNativeYouth

WE R NATIVE

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

This month, the site received:

Page views	9,649
Sessions	4,832
Percentage of new visitors	86.8%

Average visit duration	3:12
Pages per visit	2.00

- Over 360 health/wellness pages are included on the website.
- We continue to refine and improve the website, sitemap and wireframe.

Text Messages: *We R Native* has 4,491 active subscribers.

Twitter: Followers = 4,409

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

The project currently has 478 uploaded videos, has had 84,708 video views, with 150,570 estimated minutes watched.

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

By the end of the month, the page had 44,277 Likes.

Instagram: http://instagram.com/wernative

By the end of the month, the page had 4,562 followers.

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 3,080 times (16/17) on YouTube and reached 2,138,944 (2016/17) 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 are wrapping up TA to 3 tribal ACF sites implementing Native IYG + parent-child components.

Concerning Social Media: The NPAIHB has partnered with the Social Media Adolescent Health Research Team at Seattle Children's Hospital to design educational tools to address concerning posts on social media. We are evaluating the video intervention for adults who work with Native youth (March – December 2017).

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.

Other Administrative Responsibilities

Publications

- Published: Shegog, R., Craig Rushing, S., Gorman, G. et al. NATIVE-It's Your Game: Adapting a Technology-Based Sexual Health Curriculum for American Indian and Alaska Native youth. J Primary Prevent (2017) 38: 27. doi:10.1007/s10935-016-0440-9
- Working on Native VOICES Outcomes paper
- Working on *Texting 4 Sexual Health* papers (x3)
- Working on *IYG* papers (x2)

Reports/Grants Submitted

- Submitted Teen Preg Proposal, as a sub recipient to UTHealth
- Submitted CDC SIP grant application through OHSU
- Submitted OAH grant application: Expectant and Parenting Teen
- Working on OMH Health Equity Grant: w/ Swinomish

Clinical Programs-STI/HIV/HCV

Jessica Leston, Project Director
David Stephens, Project Manager

Contractor: Brigg Reilley, MPH, TA
Students: Melony Hart, OHSU PhD Student Intern

Technical Assistance and Training

NW Tribal Site Visits
- Swinomish: Hepatitis C Training – January 30-31st (25 attendees

Out of Area Tribal Site Visits
- None

January Technical Assistance Requests
- Tribal TA Requests = 6 (Jessica), 8 (David)
- Other Agency Requests = 2(OHSU, Cherokee Nation)

February Technical Assistance Requests
- Tribal TA Requests = 8 (Jessica), 10 (David)
- Other Agency Requests = 2 (OHSU, CDC, IHS)

March Technical Assistance Requests
- Tribal TA Requests = 7 (Jessica), 13 (David)
- Other Agency Requests = 2 (OHSU, CDC, IHS, NNAAPC, NIHB)

HIV/STI/HCV
During the quarter, HIV/STI/HCV clinical project staff participated in forty-one technical assistance calls, including:
- Zoom: HCV ECHO –January 4, 2017
- Adobe: Regional Great Plains ID Call – January 5, 2017
- Conference Call: UIHI and OMH PrEP call – January 9, 2017
- Conference Call: STI Monthly call with IHS – January 12, 2017
- Conference Call: IHS/ANTHC Liver Cancer Trends – January 12, 2017
- Conference Call: Tribal PrEP – January 18, 2017
- Zoom: HCV ECHO –January 18, 2017
- Adobe: Roundtable NAV-PIMC-OK- PrEP and HIV Screening – January 25, 2017
- Conference Call: IHS HIV Team Meeting – January 25, 2017
- Conference Call: PWID in NV Debrief and Follow-up – January 26, 2017
- Conference Call: CDC PrEP Curriculum – January 27, 2017
- Conference Call: Tribal PrEP – February 1, 2017
- Zoom: HCV ECHO –February 1, 2017
- Adobe: Regional Great Plains ID Call – February 2, 2017
- Conference Call: OHSU ECHO follow-up – February 2, 2017
- Adobe: CMOP HCV Medication for NW – February 6, 2017
- Meeting: NPAIHB/OHPRN ECHO discussion – February 6, 2017

- Conference Call: IHS HIV Team Meeting – February 7, 2017
- Conference Call: STI Monthly call with IHS – February 9, 2017
- Conference Call: Tribal PrEP – February 15, 2017
- Zoom: HCV ECHO –February 16, 2017
- Adobe: HCV, NAS Area/USET– February 22, 2017
- Zoom: NW HCV ECHO – February 22, 2017
- Conference Call: AI/AN PWID and HIV vulnerability project – February 23, 2017
- Conference Call: IHS HIV Team Meeting – February 28, 2017
- Conference Call: Evaluation Goals for ECHO with OHPRN – February 28. 2016
- Conference Call: Tribal PrEP – March 1, 2017
- Zoom: UNM HCV ECHO –March 1, 2017
- Adobe: Regional Great Plains ID Call – March 2, 2017
- Conference Call: STI Monthly call with IHS – March 9, 2017
- Conference Call: AI/AN PWID and HIV vulnerability project – March 9, 2017
- Zoom: Lummi ECHO – March 9, 2017
- Conference Call: IHS HIV Team Meeting – March 10, 2017
- Conference Call: NNAAPC/NIHB Mtg RE: IRB Process – March 10, 2017
- Conference Call: PrEP UIHI TA call – March 13, 2017
- Conference Call: Tribal PrEP – March 15, 2017
- Zoom: UNM HCV ECHO –March 15, 2017
- Call: Neah Bay HCV iCare Panel – March 15, 2017
- Adobe: Rosebud HCV iCare Panel – March 16, 2017
- Zoom: NPAIHB HCV ECHO – March 22, 2017
- Conference Call: Lummi Case Management – March 28, 2017

Health Promotion and Disease Prevention

Overview: Hepatitis C Virus (HCV) is a common infection, with an estimated 3.5 million persons chronically infected in the United States. According to the Centers for Disease Control and Prevention, American Indian and Alaska Native people have the highest mortality rate from hepatitis C of any race or ethnicity. But Hepatitis C can be cured and our Portland Area IHS, Tribal and Urban Indian primary care clinics have the capacity to provide this cure. Some of these clinics have already initiated HCV screening and treatment resulting in patients cured and earning greatly deserved gratitude from the communities they serve.

Goals: HCV has historically been difficult to treat, with highly toxic drug regimens and low cure rates. In recent years, however, medical options have vastly improved: current treatments have few side effects, are taken by mouth, and have cure rates of over 90%. Curing a patient of HCV greatly reduces their risk of developing liver cancer and liver failure. Early detection of HCV infection through routine and targeted screening is critical to the success of treating HCV with these new drug regimens.

It is estimated that as many as 120,000 AI/ANs are currently infected with HCV. Sadly, the vast majority of these people have not been treated. By treating at the primary care level, we can begin to eradicate this disease.
Our aim is to provide resources and expertise to make successful treatment and cure of HCV infection a reality in Northwest IHS, Tribal and Urban Indian primary care clinics. More at www.npaihb.org/hcv

Text Message service

Patient pamphlet: Based on Tribal feedback, a pamphlet was created for the Northwest, non-specific for Baby Boomers. www.npaihb.org/hcv

Surveillance and Research

STD/HIV/HCV Data Project: The project is monitoring STD/HIV GPRA measures for IHS sites throughout Indian Country. Infographics are 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.

PWID Study: To capture the heterogeneous experience of AI/AN PWID and PWHID, this project is being conducted in four geographically dispersed AI/AN communities in the United States using semi-structure interviews. The project is based on indigenous ways of knowing, community-based participatory research principles and implementation science.

HCV Paneling: American Indian/Alaska Natives have the highest rate of mortality from hepatitis C virus (HCV) of any race/ethnicity. New interferon-free antiviral drug regimens for chronic HCV infection have a sustained virologic response (cure) rate of over 90% with almost no clinical contraindications for

treatment. NPAIHB is helping local and national sites in ascertaining their current HCV burden and acuity.

HCV ECHO: Each month, the Northwest Portland Area Indian Health Board offers a TeleECHO clinic with Dr. Jorge Mera focusing on the management and treatment of patients with HCV. The 1 hour long clinic includes an opportunity to present cases, receive recommendations from a specialist, engage in a didactic session and become part of a learning community. Together, we will manage patient cases so that every patient gets the care they need. Thus far **30** cases have been presented to NPAIHB ECHO from **16** different sites.

Other Administrative Responsibilities

Publications

- Reilley B, Haberling D, Person M, Leston J, Iralu J, Haverekate R, Siddiqi A. (2017) HIV Trends in American Indian and Alaska Native Populations, 2005-2014. Submitted for publication
- Working on AI/AN HCV paper
- Working on AI/AN Opioid paper

Reports/Grants Submitted

- OMH Social Determinants Grant submitted with Swinomish

Epicenter Biostatitician

Nancy Bennett

Conference Calls:

- DAWG (Data Access Work Group) monthly call

NPAIHB Meetings:

- All staff meeting – monthly
- Onboarding work group, bi-weekly
- Art committee – choose remodeling colors
- TEC directors meeting
- Site visit from EPI HQ

Conferences/QBMs/Out of area Meetings

- QBM January, Grand Mound, WA
- SAS training, Raleigh, NC, Data repository data management software

Miscellaneous

- Data analysis, WeRNative social media survey
- Power analysis, Swinomish grant application

Reports:

Site Visits: None

Epicenter National Evaluation Project

Birdie Wermy, Project Specialist

Technical Assistance via telephone/email

January - March

- Ongoing communication with NPAIHB EpiCenter Director
- Ongoing communication with Tribal sites regarding project updates, information and technical assistance
- Email correspondence with the Puyallup Tribe on 3.31
- Email correspondence with UIHI regarding TIER 2 Evaluation Report on 3.31

Reporting

January

- GHWIC All Hands call on 1.05 @ 10am
- WEAVE NW Webinar on 1.12.17 @ 1pm
- GHWIC C2 call on 1.19 @ 11:30am
- GHWIC TEC Workgroup Call on 1.25 @ 10am

February

- GHWIC C2 call on 2.16 CANCELLED
- DVPI Call on 2.21 @ 11am

March

- Quarterly Evaluation call on 3.15 @ 10am
- GHWIC C2 call on 3.16 @ 11:30am CANCELLED
- DVPI call on 3.21 @ 11am

Updates

Birdie – continuing to provide evaluation TA to MSPI/DVPI service areas. Writing and reporting on NW WEAVE GHWIC project; sent request to CRIHB surrounding qualitative piece of TIER 2 work. Reached out to WAEVE PD Nanette Yandell and Francesca regarding performance measures, all questions were clarified and answered promptly. I will also be working with the Puyallup Tribe regarding their data needs and evaluation needs.

Challenges/Opportunities/Milestones

- I am continuing to reach out to the programs to provide technical assistance around their programs evaluation needs.
- I received the call notes from the 1.17 DVPI call and will be in touch with DVPI programs surrounding their evaluation TA
- I received an evaluation plan/logic model from the Puyallup Tribe on 3.31 asking for guidance
- Finalized TIER 2 Evaluation report for UIHI on NW WEAVE GHWIC project

Meetings/Trainings

- Quarterly Board Meeting @ Chehalish 1.17-1.19
    - Recognized for 10yrs of service
- Wellness Meeting on 1.26 @ 10am
- Public Health Seminar Series: Building Climate Resilience within Oregon's Public Health System presentation on 1.31 @ 12pm
- AI/AN Health Lecture Series 2017: Dr. Katrina Claw (Navajo) 2.13.17 @ 12pm

- Wellness Meeting 2.08.17 @ 10am
- Team HANDS meeting on 2.14 @ 1pm
- Joint PhD Seminar (PSU & OHSU) 2.24.17 @ 2:30pm.
- WAEVE GHWIC Overall Evaluation role on 3.09 @2pm
- Team HANDS meeting on 3.14 @ 1pm
- Wellness Meeting 3.16 @ 10am w/ Mike Severson from Providence
- Staff retreat meeting on 3.20 @ 1:30pm
- All TECC website survey on 3.22 @ 11:15am
- WEAVE GHWIC TIER 2 meeting on 3.22 @ 10:30am
- NW Tribal EpiCenter Site Visit on 3.23 @ 12pm w/ Lisa Neel from CDC
- WEAVE webinar on 3.28 @ 11:30am
- WEAVE GHWIC qualitative report meeting on 3.31 @ 10:30am

Site Visits

- NONE

Upcoming Calls/Meetings/Travel

- CDC GHWIC All Hands call on 4.06 @ 10:30am
- Team HANDS meeting on 4.11.17 @ 1pm
- Wellness Committee Meeting on 4.13.17 @ 10am
- DVPI call on 4.18.17 @ 11am
- Quarterly Board Meeting at Quinault on 4.18-4.20.17
- GHWIC C2 call on 4.20.17 @ 11:30am
- GHWIC TEC workgroup call on 4.26 @ 10am

Publications

- NONE

Immunization and IRB

Clarice Charging, Project Coordinator

Meetings:

NPAIHB all-staff, January 9, 2017
HPV Prevention Project, January 13, 2017
NPAIHB all-staff, February 7, 2017
Immunization Policy Advisory Team, March 2, 2017
NPAIHB all-staff meeting, March 6, 2017
Indian Day planning committee, March 14, 2017
HPV Prevention Project, March 15, 2017

Quarterly board meetings/conferences/site visits:

NPAIHB quarterly board meeting, Great Wolf Resort, Grand Mound, WA, January 17-19, 2017
Yakama Nation Women's Health Event, Toppenish, WA, March 9, 2017
Breast Cancer Issues Conference, Portland, OR, March 11, 2017
Northwest Tribal Epicenter site visit, March 23, 2017

Conference Calls:

Indian Health Service Immunization Coordinator's, January 5, 2017

IHS WIRB, January 20, 2017
Portland Area Immunization Coordinator's, January 23, 2017
IHS Influenza Prevention, January 31, 2017
Portland Area Immunization Coordinator's, February 7, 2017
Portland Area Immunization Coordinator's, March 23, 2017

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

PA IRB Meetings:
PA IHS IRB committee meeting, January 12, 2017
PRIMR webinar, September 2017

During the period of July 1 – September 30, Portland Area IRBNet program has 128 registered participants, received 2 new electronic submissions, processed 4 protocol revision approvals, 63 publications/presentations, and approved 3 annual renewals.

Provided IT and IRB regulation assistance to Primary Investigators from:

1) Cow Creek Band of Umpqua Tribe of Indians
2) Port Gamble S'Klallam Tribe
3) NPAIHB
4) Confederated Tribes of Warm Springs Tribe
5) Healing Lodge of the 7 Nations
6) Portland State University
7) Coquille Tribe

Injury Prevention Project/Public Health Improvement & Training

Bridget Canniff, Project Director
Luella Azule, Project Coordinator

Conference Calls

- 1/19 Conference call: Tribal Epidemiology Centers & CDC National Center for Injury Prevention and Control (Luella)
- 3/9 TIPCAP Admin conference call w/ IHS, all grantees (Bridget)
- 3/15 TIPCAP Project conference call w/ Project Officer & TA Provider (Bridget and Luella)
- 3/15 7 Directions Workgroup call (Bridget)
- 3/16 Call w/Delight Satter, CDC, to identify tribal rep for meeting on Medical Countermeasures (MCM) to be held in Atlanta in June (Bridget)
- 3/22 Tribal Public Health Accreditation Workgroup initial planning call (Bridget)

Meetings/Conferences/Presentations

- 2/8 Attended Tribal Government Day at Capitol (Luella)
- 2/7-9 Oregon Tribal Preparedness Meeting hosted by OHA, at Seven Feathers, Canyonville, OR (Bridget)
- 2/15 Meeting with Northwest Center for Public Health Practice Staff (Betty Bekemeier, Barbara Rose) and Sheryl Lowe, WA Department of Health Tribal Liaison, at WA DOH, Tumwater, WA (Bridget
- 3/6-9 NW Tribal Transportation (TTAP) Symposium, Spokane, WA (Bridget and Luella)
- 3/21-23 TEC Directors TEC-C Meeting (Bridget)
- 3/23 Tribal EpiCenter lunch/site visit w/ IHS (Bridget & Luella)

- 3/28-29 Northwest Center for Public Health Practice Regional Network Steering Committee Meeting, Seattle, WA (Bridget)

Trainings/Webinars

- 1/30 Webinar: Native Stand archive
- 2/10 Watched archived webinar: Understanding and Preventing Childhood Death and Injuries
- 2/23 Webinar: Learning Management System Discussion and TRAIN Q&A – hosted by Public Health Learning Network, National Network of Public Health Institutes (Bridget)
- Summer Institute 2017 registration information to tribal contacts
- 3/10 Webinar: WPIPN (Luella)

Funding

- 1/20 Application: CDC Public Health Associate Program (PHAP) host site application submitted for 2017-2019 (Bridget)
- 1/27 Supplemental request: IHS Injury Prevention supplemental funding request submitted for $5,000 (Bridget)
- 2/2 Letter of Support (approved/signed by Joe Finkbonner) to Seven Directions Center for Indigenous Public Health's application for membership to National Network for Public Health Institutes (Bridget)
- 2/28 Submitted Letter of Intent to WA DOH – Tribal Public Health Emergency Preparedness Conference RFA (Bridget)
- 2/2017 Emergency Preparedness 2017 Conference RFA submitted (Bridget)
- 3/31 TIPCAP Semi-Annual report submitted (Bridget, Luella, Tara, Eugene)

Technical Assistance – N/A

Core (Bridget)

Technical Assistance – Non-Tribal

- **March CDC:** Identify and confirm Steve Kutz as tribal rep for CDC MCM meeting in June

Technical Assistance – NW Tribal

- **March**
  - **Coquille:** Held preliminary call on new accreditation support workgroup on 3/22, at tribal request
  - **Umatilla:** Held preliminary call on new accreditation support workgroup on 3/22, at tribal request

Core Activities/Other (Luella)

- 2/16 Update NPIHB Injury Prevention and AI/AN contacts
- 3/23 Provide TEC Consortium website feedback (Luella)

Reviewed/Read:

January: WPIPN January newsletter, NIHB WA report 16-35, Health News & Notes, ZIKA powerpoint, Draft

February: Harborview Injury Prevention and Research Center (HIPRC) newsletter, 101 Revolutionary Ways Wellness newsletter, video: Using the WPIPN listserv for collaboration, subscribed to WPIPN, Oregon Safekids newsletter, Emergency Preparedness video, Build a kit on a budget video, NIHB Washington Report,

March: NAYA newsletter, CDC in review, CDC Vital Signs, Healthy Native Youth, TIPCAP newsletter, WeRNative, OPHI insights, Friday Mailouts re: grant opportunities

Forward e-mails to Tribal IP contacts, and/or CPS techs, coalition committee:
February: TIPCAP Funding Opportunity

March: Forward BIA Safety Program grant application information to CPS Techs, Tribal IP contacts, Tam Lutz, Kids in motion conference to CPS Techs and T Lutz; Fairfax VA suicide prevention to Colbie, BIA CSS and Law Enforcement grant opportunities for tribes

Travel/Site Visits

Tribe: Cow Creek **Date:** February 7-9, 2017 **Purpose:** OR Preparedness Tribal Meeting **Who:** Bridget	**Location:** WA State Department of Health **Date: 2/15** **Purpose:** Meeting w/ WA DOH & NWCPHP **Who:** Bridget
Location: Spokane, WA **Date:** March 6-9, 2017 **Purpose:** Attend NWTTAP Symposium **Who:** Bridget and Luella	**Location:** Seattle, WA **Date:** March 28-29, 2017 **Purpose**: Attend & Present at NWCPHP RNSC Mtg **Who:** Bridget

Medical Epidemiologist

Thomas Weiser, Epidemiologist (IHS)

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

Travel/Training:
1/24/17-Coquille; Outbreak investigation tabletop with Richard Lehman, Oregon DOH
1/29-2/1-Rockville, MD: Participate in IPC evaluation focus group.

Opportunities:
*IRB met in January and March. New proposal and continuing reviews were completed.
*Immunization Coordinator's Calls-January, February and March. Among the topics discussed were: Flu updates, data reporting, discussion of current mumps outbreak in WA, updates from the field.
*EIS Surveillance Project-EISO abstract #1 and oral presentation slides (HCV mortality) were submitted to the IRB and approved. Dr. Hatcher presented these at EIS Regional Conference in Tucson on March 27 and it was well received. Both abstracts were also accepted for oral presentation at the upcoming CSTE meeting in Boise in June. Dr. Hatcher will begin work on a manuscript for the HCV project after EIS conference in April.
*Completed initial analysis on Children with Disabilities project for poster presentation at ICHC. Planning to submit to the 2017 Southwest Conference on Disability in October 2017 which will have a special focus on the AI/AN and disability.
*Assisted with WSIRB submission for Communicable Disease linkage with WA DOH.
*Completed Winter quarter facilitation of Epidemiology medical student course (OHSU)

Publications:
*Final edits for Immunizations Policy paper completed, manuscript submitted to Annuals of Epidemiology

Clinic Duty:
Chemawa/March10, 2017

Native CARS & PTOTS

Tam Lutz, Co-Investigator/Project Director (Native CARS), Co-PI (TOTS to Tweens)
Nicole Smith, Biostatistician
Candice Jimenez, Research Coordinator
Jodi Lapidus, PI (Native CARS), Co-Investigator (TOTS to Tweens)
Thomas Becker, Co-PI (TOTS to Tweens)
Cathy Ballew, Lummi Site Coordinator

Native CARS Study

Background

In 2003, with funding from the Indian Health Service's Native American Research Centers for Health (NARCH, grant 1U269400013-01), six Northwest tribes conducted a child safety seat survey. We found that child safety seat use ranged from 25% to 55% by tribe. Forty percent of children were completely unrestrained in the vehicle, which was much higher than the 12% of unrestrained children in the general population in these same states. We concluded that culturally-appropriate efforts were needed to address child restraint use in the Northwest tribes. At the tribes' request, the EpiCenter pursued funding for child safety seat interventions.

The Native CARS study was funded in 2008 by the National Institute on Minority Health and Health Disparities (NIMHHD), and is a partnership with the NPAIHB, University of Washington, and the six Northwest tribes. This partnership aims to design and evaluate interventions to improve child safety seat use in tribal communities.

Between 2009 - 2013, during the intervention phase of this NIH-funded study, all six participating tribes received funding to implement community-based interventions.
All six tribes implemented intervention activities, but in a staggered design. Three tribes designed and implemented interventions from 2009-2011 and three tribes did so from 2011-2013. This gave us an evaluation time point in 2011 to compare child safety seat use in intervention tribes to tribes that had not yet implemented interventions. We evaluated child safety seat use again in 2013 to see if the interventions had a lasting impact in the first group and to see if child safety seat use increased in the second group of tribes.

Tribes planned their intervention efforts according to the data they collected from their community from surveys, interviews, and focus groups. Intervention activities included media campaigns, health education, car seat programs, getting child passenger safety technicians trained, community outreach, and even changing tribal policies or passing a tribal child passenger safety law.

By 2011, the percentage of kids riding in an age- and size-appropriate restraint increased by 50% in tribes that had implemented interventions, compared to an 11% increase in those that had not yet conducted child safety seat activities. In 2013, the increases we saw in the first group of intervention

tribes were mostly sustained, and the percentage of completely unrestrained children continued to decrease. Round 2 tribes also saw an increase in proper child restraint after their intervention activities.

The goal of the Native Children Always Ride Safe (Native CARS) project is 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.

Objective/Aims of Dissemination Phase

Because of the demonstrated success of the Native CARS Study, in 2014 the study was award additional funds for a dissemination phase of the study, where the protocols, tools and intervention materials were translated for use by other tribes both locally and nationally. These evidence-based tribal interventions were adapted and disseminated via plans guided by a dissemination framework that leveraged and expanded upon tribal capacity built during the previous Native CARS intervention phase, by engaging the tribal participants as experts throughout this dissemination 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 Native CARS kicked off the year, in January, with providing mini grant awards to six northwest Tribes to attend the first Native CARS Atlas training and return home with funds to support their local child passenger safety coalition, collect local data and implement two intervention activities. The Native CARS Atlas Native CARS Atlas is provided in an electronic platform, but it is more than just a website. In it provides everything we know about improving child passenger safety, along with tons of interactive tools that can be used to create change within one's own tribal community. It puts forth our best efforts to make sure **Native Children Always Ride Safe.**

While best efforts were made to get all six Tribe to Portland in January, mother nature had other plans, delivering a snow storm that shut down travel to Portland for two of the Tribes and shortening the available time to train. Thankfully, everyone returned home safely and we were able to add an additional training opportunity for the remaining two Tribes in March. Following receipt of their award and Native CARS Atlas training, all the Tribes have begun forming their child passenger safety coalitions, recruiting members, holding initial meeting and planning activies. Some have begun vehicle observation data collection other have begun recruiting for focus groups. Tribes have also finalized

budgets, timelines, evaluation measures and refining their interventions plans. Intervention activities selected by Tribes included creating Tribe specific media, providing passenger safety education, adopting the RPMS EHR Native CARS patch to link providers to Tribal car seat distribution, providing law enforcement education and training Child Passenger Safety Technicians to deliver car seat clinics. All Tribes have reported that they have begun planning these activities and some have begun to complete specific tasks on their timeline. Most notably are the following activities from Tribes: Yakama Indian Nation has collected planning to begin implementation of the Native CARS IHS EHR later in April. Confederated Tribes of Warm Springs also formed their coalition with members from six different programs who are already planning activities and participating in data collection. They have also implemented the Native CARS RPMS EHR patch and will be providing training to provider in April or May and have four individuals signed up for Child Passenger Safety Technician (CPS Tech) training this Spring. Lummi Nation has also identified 3-4 CPS Tech candidates, started recruiting members for their coalition and began recruiting focus group participants. Coeur d'Alene Tribe has also selected four candidate to send to CPS Tech training in April and has formed a coalition with four programs represented. They have distributed 35 cars seats while participating in a community baby fair and are making preparations for their focus groups.

Back at the office Native CARS staff have continued to worked with a our contracted web developer to complete or modify training modules for the Native CARS Atlas, provide technical assistance to mini grant awardees and present at regional venues to get the word out that the Native CARS Atlas is up and running at www.nativecars.org.

Specific activities of the Portland Native CARS team are as follow:

Native CARS Activities

Meetings - Conference Calls – Presentations – Trainings

- Staff Meetings – each Monday
- Site Coordinator Meetings – once per month
- Meetings with Mini Grant contractor Grazia Cunningham, January - March
- Meeting with Tribal Site Coordinator Kootsie Cunial via Phone, January
- Native CARS Atlas Training with 4 of 6 Mini Grant Communities on January 10-12, March

Program Support or Technical Assistance

- Atlas Module Revisions, January - March
- Drafted and dispersed Mini Grant Award Letters, Contracts and Correspondence, January
- Travel Preparation for Native CARS Mini Grant Training, January
- Communication with Jeff Nye/Julia Hammond regarding Atlas Revisions, January - March
- Native CARS Atlas meeting with Jeff Nye/Julia Hammond , January and March
- Meeting coordination, minutes and action item documentation, January - March
- Revised Native CARS Collection Instrument in Excel with Jenine's assistance, January
- Create Analysis File for Observations, January
- Mini-grant Training preparation, January and March
- Equipment Purchases/Invoice payments/Contract addendums to tribal sites and contractors, January
- Follow-up communication with mini grant sites, January - March
- Communication with potential replacement mini grant site, January
- Budget analysis, re-budget and identification of supplies, equipment, invoicing needed by end of fiscal year, January
- IRB renewal report submission, January
- Completed content for Atlas Module 2, February

- Creation of Stages of Readiness graphics for print/web use, February
- Native CARS Promotional item order completion for invoice payments, February
- Finished Version 1 of Observation Analysis in Excel and sent to Yakama for Testing/Implementation, February
- Wrote Tribal stories for Colville and Nez Perce for Atlas, February
- Preparation of Native CARS Atlas presentation of ATNI Tribal Transportation Summit, March
- Discussed and Facilitated Native CARS Atlas Speed Performance with Jeff Nye, March
- Reviewed CPS Tech Course Information for Lummi CPS Module, March
- Wrote and Posted Analysis Section for Data Module, March
- Reviewed Module 9 Distribution information for Warm Springs, March
- Reviewed Observation Analysis Excel Input for Nicole, March
- Revised/Updated FARS Section and Posted to Website, March
- Revised Distribution, RPMS and Coalition Modules, March
- Revised Qualitative Methods and Other Policy Modules, March
- Drafted and Sent Presentation for Yakama's Staff Training on Electronic Health Alerts for Car Seats, March
- Reviewed and Sent Feedback on Native CARS Atlas Homepage Re-design, March
- Revised Module 6 Data Driven Intervention Plans, March
- Constructed new continuation budget for Atlas, March
- Prepared for continuation meeting, March
- Created questionnaire for quarterly update phone calls, March
- Reviewed changes to home page, March

Number of requests responded to for technical assistance, including data requests, to Tribal and Urban organizations, communities, or AI/AN individuals.

How many requested: 36

How many responded to: 36

How many NW Tribe Specific:

Warm Springs (5), Yakama (15), Lummi (4), Swinomish (4), Coeur d'Alene (5), Northern Cheyenne (3)

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 did not hold a dental screening. Study team also began preparing for the next screenings to be held in Spring 2017.

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

Meetings - Conference Calls – Presentations – Trainings

- Project Meetings – Every Wednesday
- Site specific meeting, January
- Met with University of Wisconsin Intern, Ashley Swetzof (Tom, Tam, Nicole, Candice)

Program Support or Technical Assistance

- Meeting coordination, minutes and action item documentation, January - February
- Prepared internship preceptor paperwork for UW intern (Tam)

Project Contact Information

Jodi Lapidus, Principal Investigator
Lapidusj@ohsu.edu

Tam Lutz, Project Director, Co-Investigator, Co-PI
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Candice Jimenez, Graduate Research Assistant
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Cathy Ballew, Lummi Site Coordinator

Tom Becker, Co-PI
tbecker@npaihb.org

Northwest Native American Research Center for Health (NARCH)

Tom Becker, PI
Victoria Warren-Mears, Director
Tom Weiser, Medical Epidemiologist
Tanya Firemoon
Tasha Zaback

This report covers activities related to NARCH 7, which references the two training grants that the Board holds for provision of research training to American Indian and Alaska Native tribal members nationwide. The program is in the 4th year of funding in a five year cycle.

The Summer Research Training Institute planning is complete, and we are soon awaiting the arrival of over 100 tribal guests from around the country. Our last effort was the 13th such effort sponsored by the Board, with input from OHSU faculty and staff, as well as a host of consultants…so the upcoming event will be our 14th anniversary offering. We were successful in filling up our course instructors and our student enrollment in just a few days—Ms. Firemoon and Ms. Zaback did a masterful job at getting the advertisements around the country. As earlier reported, we will try a relatively new course again this year for the second round, in public health in Indian country and health priority decision making, under the guidance of Linda Frizzell, PhD. We will also have a lot of repeat classes that have been offered over the years. When possible, we have located tribal people to do the training for the summer students.

Ms. Firemoon has established hotel contracts for 2017, and we expect to award travel scholarships again this summer to around 60 trainees.

Also under NARCH funding, we recruited additional fellows who received small scholarships to help advance their careers in Indian health. Our scholarship program continues to graduate new researchers, and seems to be successful overall. We have added new fellows this last quarter who will receive partial scholarships. Ms. Firemoon has been extremely helpful in watching over this part of the NARCH, and her efforts to help the summer program have also been very valuable. The fellows whom we support consider her the 'NARCH mom'. She is a busy mom, she has a total of 17 fellows to watch after this year. Some have graduated already this academic year, others will soon do so in the spring.

Our success rate with the NARCH graduate students remains high, and we have several excellent candidates waiting in the wings for support if we can get some more of the currently funded students through their degree programs. We are told by federal officials that this program is one of the big success stories for the federal effort. As you are aware, the program requires input from a university, and OHSU and PSU have been very good partners to the Board and its NARCH efforts. The collaboration is real, and palpable. We will come to the delegates for a resolution to go after NARCH 10 funding at this QBM, seeking a resolution. We are worried, however, that the new federal administration may not support continued such efforts.

To date, the NARCH funding stream has brought in approximately $12 million to the Board to address health issues among tribal people in the Northwest and beyond. We are very pleased that the federal government continues to find funds to run this program. At the federal level, Mose Herne (Seneca), John Mosely Hayes, and Sheila Caldwell have been instrumental in finding federal funds to advance the health of tribal people in this national program. We are hopeful that we will be able to tap into additional NARCH resources to serve the regional tribes, as well as tribal people nationwide.

Northwest Tribal Comprehensive Cancer Control Project

Kerri Lopez, Director
Eric Vinson, Project Specialist

Training/Site Visits/ Yakima Women's Health Day Tea Party (100 tribal women and staff)

- Yakima
    - Women health risk factors, smoking and diabetes

- Smoking and pregnancy, ETS
- Present on E-cigarettes

- Umatilla Kick Butt's Day Awareness Walk & Tobacco 101 Presentation
  - Kick Butt's Day Awareness walk attendees: 15 adults and youth
  - Youth Tobacco 101 Presentation: 37 youth

Technical assistance (78 total calls this quarter)

- Share resources with Oregon Tribal TPEP coordinators; *all month ((tribes)*
- Disseminated NTCCP mini grant – local implementation funding to all 43 NW tribes
- Examples of technical assistance:to tribes
  - Four tribal Colorectal Cancer Events– Kiki Colon logistics
  - Information on tobacco cessation training
  - Sent smoke free events toolkit per request, housing, and youth
  - Quite line flow sheet and information
  - Resource information for colorectal cancer screening**;**
  - Appointment Companion information for diabetes and chronic care program
  - Information on cancer survivors
  - Tobacco cessation information; TA on getting No Smoking signs for Local Park
  - TA HPV and tobacco cessation information shared discussions, possible planning for BTIST training
  - Youth tobacco trainings and materials

Special projects

- Grant Application
  - NTCCP application submitted
- Tobacco cessation training June 20, 2017
  - Setup meeting space and hotel contracts
- Oregon Tribal Tobacco Coordinator meeting June 21, 2017
  - Setup meeting space and hotel contracts
  - Met with OHA staff to discuss agenda
- Continued Planning clinical update April 12, 2017 Northwest Tribal Cancer Coalition meeting
  - Topic survey returned from providers
  - Working with Dr. Becker and Legacy CME for presenters
  - Ongoing CME paperwork
  - Invitation to presenters sent
  - OHSU cardiologist unavailable
- Planning for women's health day April 11, 2017
  - Contact with Dr. DeRoin and Bruegl
  - Planning with NARA and SPIPA
- Oregon & Washington quit line research continues
  - Information on Oregon quit line from vendor and state employee

- Creating flow / algorithm on setting up a tribal tobacco cessation program
    - Curriculums,
    - Looking at what are tribes doing for cessation – community and clinic
    - Developing Tobacco Policy Flow Chart for Klamath Tribes & Coquille Tribe
- Follow up with CDC AI/AN inclusion in tobacco data
    - Emailed additional CDC article authors
- Follow-up with Oregon tribes on tobacco program characteristics
- Update Native Stand Curriculum
    - Waiting on feedback for updated material
- HPV Oregon roundtable conference
    - Presentation and break out workgroups
    - Established AI/AN workgroup
- HPV state round table strategy meeting – after roundtable
- HPV AI/AN workgroup - Oregon tribes (Kerri, Amanda, Clarice, Steph, Antoinette, Eric)
    - HPV Planning for tribal specific work group
    - Discussion of future activities – tribal site visit / provider training and parent information
    - OHSU, NPAIHB, OHA??
    - Invitation extended to CTGR OHSU pediatrician
    - Research and review HPV curriculums
- HPV AI/AN workgroup – Meeting scheduled for January
    - Create agenda for Januarys HPV workgroup meeting
    - Document notes from Novembers HPV workgroup meeting
- National Tobacco Conference
    - Plenary sessions – data, tobacco industry, 21
    - Data, cessation, quit line, industry tactics, smoke free tribal casinos
    - Tobacco Use Disparities to Improve Public Health, Youth Role in Impacting Population Health, Translating Data and Evidence to Action across Multiple Sectors, Advancing Cessation Strategies with Mental Health or Substance Use Disorders, Walk about Poster Session
- BRFSS –Tribe 5
    - 200 surveys complete
    - BRFSS records: document all completed or in-completed surveys
- BRFSS Tribe 6
    - Awaiting feedback on questions from tribal health committee
- BRFSS – Tribe 7
    - Survey development and
    - updates and input enrollment list into tracking sheet
    - Conference call updates with THD
- Policy Toolkit development and research
- Lung Cancer Screening Data – follow-up on race coding in screening registry
- Developing Nutritional Observation scan tool
- Developing Mental Health Observational scan tool
- Present in WeRNative Wellness Wednesday video

- Lead wellness exercises
- Tobacco cessation training for three staff –
    - Certified in RX change tobacco cessation 5a's

Meetings/Conferences

- Policy Toolkit meeting (NTCCP, WEAVE-NW, NICWA)
- Meeting with Oregon Komen to meet new staff and discuss collaboration
- OHA Meeting - Immunization QI with Tribal Clinics
- WeRNative Culture for Wellness workgroup meeting
- Quality Improvement at NPAIHB meeting
- Portland Area Cancer Survivorship Forum
    - Inaugural meeting with OHSU and Legacy Cancer Survivorship Programs
- Oregon Place Matters conference
    - Facilitated Oregon TPEP session
    - Attended 2 day conference and attended contractors meeting
- OPHA Annual Conference- Presented on Risky Business
    - Cultural competency
- OHSU PRC Tribal and Rural Advisory Board monthly meeting
- Policy Toolkit meeting (NTCCP, WEAVE-NW, NICWA)
- NW NARCH Luncheon Presentation: Erik Brodt
    - AI/AN Center for Excellence Grant meeting
- Kerry Kruehl OHSU (Sports Medicine Program) Carol, MI Esther, and
    - Discussion grant collaboration
    - Topics – fitness, nutrition, mi, youth curriculum (Athena) tobacco, cancer screening
- Preventing Harassment & Discrimination Training
- NPAIHB on boarding meeting for new staff orientation
- Portland Area Dental conference planning meeting – collaboration
    - Diabetes and tobacco
- All Staff meeting
- Project directors meeting
- Staff meetings – WTDP & NTCCP
- NPAIHB Quarterly Board Meeting
    - NTCCP project report, focus on tobacco rates
- **Conference / Webinar calls**
- Cancer Education meeting – planning committee conference call
- American Association for Cancer Education Board conference call

- Oregon quit line – focus CCO and tobacco metrics and loop for reimbursement
- Cancer Programs Tribal Call with CDC
- CDC program call with project officer
- CPCRN HPV Vaccination Workgroup Call
- PRC Tribal/Rural advisory call
- Webinar- New Technology to Improve Wellness in Indian Country
- Teleconference- CDC Vital Signs: Cancer and Tobacco use
- Webinar- NNN: Lung Cancer in Indian Country;
- Webinar- Nat'l Cancer Institute Research to Reality: Cancer Caregiving in the Community
- Webinar- How to support nationwide to encourage Walgreens to no longer sell tobacco
- Webinar- TRUTH: Smoking in video games;
- Webinar- Supporting cancer survivors through comprehensive control programs
- American Society of Radiation Oncology Health IT workgroup call – cancer survivorship plans
    - Addressing the Impact of Viruses and Related Cancers on Minority Populations

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 17th 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 Tulalip, Seattle Indian Health Board, and Muckleshoot. NTDSC is on track to meet the grant objective for this fiscal year.

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. Nine 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.

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

- 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 6-9 year olds this fall. Results will be available in 2017.

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

- NTDSC continues to provide 2 hours of CDE during site visits and recently provided CDE for the February BTM session. We are currently planning our yearly meeting in August 2017.

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 began work on updating the Northwest Tribal Registry with fresh data pulls from the Portland Area Indian Health Service and Seattle Indian Health Board. We began work on a data brief describing the burden of cardiovascular diseases among Washington AI/AN. We continued working with Dr. Amanda Bruegl (OHSU) on submitting data requests to the Idaho, Oregon, and Washington state cancer registries to obtain data needed for an analysis of gynecologic cancers among Northwest AI/AN women. We also worked in partnership with Washington's Office of Communicable Disease Epidemiology to update our protocols for conducting linkages with Washington's communicable disease systems. We began work on an Environmental Health project in partnership with the Oregon Environmental Public Health Tracking program and the Great Lakes Tribal Epidemiology Center. For this project, we will conduct a needs assessment to determine environmental health priorities and data needs for Oregon's 9 tribes. Finally, we completed a grant application to replace our project's current funding from the Office of Minority Health, which ends in August 2017.

Current status of data linkage, analysis, and partnership activities

Northwest Tribal Registry (NTR) data linkages

- Obtained data for annual NTR update, and began cleaning and preparing new NTR file
- Worked on project description for using IHS EpiDataMart data for creating the NTR file

Data Analysis Projects

- Tribal Health Profiles (THP) project

    - Developed template for Washington AI/AN cardiovascular disease data brief
    - Ran hospitalization rates for diabetes and cardiovascular diseases in Washington
    - Ran mortality indicators for Washington cardiovascular diseases
- Cancer Registry Data and Cancer Fact Sheets
    - Gynecological Cancers Analysis
        - Submitted application for exempt determination and variable request to Washington State IRB
        - Submitted research request form to Oregon State Cancer Registry
- Death certificate Data
    - Finished cleaning Washington 2015 death records, merged with multi-year Washington dataset, updated data dictionary and data notes
- Birth certificate data
    - No updates
- Substance Abuse Analysis
    - No updates
- Hospital discharge data
    - Completed merging Oregon 2014 data with Combined 2010-2013 data, updated data dictionary
    - Ran pre- and post-linkage age-adjusted rates for most recent Oregon and Washington data
- Oregon Tobacco Fact Sheet Development
    - Met with Oregon Health Authority staff to narrow down indicators and begin finalizing content for fact sheet
- Environmental Health Project
    - Had kickoff meeting with Oregon Environmental Public Health Tracking (EPHT) staff
    - Met with current and former IHS Environmental Health staff re: surveys, environmental health toolkit, and ideas for EPHT projects
    - Worked on reviewing Oregon Tribes' websites to identify environmental health projects and contacts
    - Met with Julie Sifuentes (Oregon EPH Program Manager) to discuss opportunities for collaboration outside of EPHT. Learned that there are some opportunities related to climate change work.
- Other
    - Created new population denominator file using National Center for Health Statistics' vintage 2015 bridged race data for Idaho, Oregon, and Washington

Data requests/Technical assistance

- Provided updated information to Tara Fox on Northwest AI/AN population and health disparities for grant/subcontract
- Sent Stephanie updated demographic and health information for grant application

Trainings Provided to Tribes/Tribal Programs

- Developed content and presented two sessions (data for Tribal Action Plans, NPAIHB's experience with developing Tribal Action Plans) at U.S. Department of Justice/Substance Abuse & Mental Health Services Administration's Tribal Action Plan workshop

Institutional Review Board (IRB) applications and approvals/Protocol development

- Washington communicable disease linkages
    - Updated and revised protocol for communicable disease linkages

- Completed forms for exempt determination request to Washington State IRB, sent to state partners for review

Grant Administration and Reporting

- Submitted application for new grant (Northwest Tribal Partnerships for Health Equity) to HHS Office of Minority Health (OMH)
- Submitted OMH progress report for Year 5 Quarter 2

Collaborations with other programs and other activities

- Monika began working with WeRNative to help produce informational "Wellness Wednesday" videos/blogs on nutrition, exercise and culture
- Sujata and Monika completed IHS Information Security Systems Awareness training to maintain access to the EDM
- We submitted forms and training documents for NWTEC's annual access renewal for the EpiDataMart
- Sujata applied for and was accepted to a MMWR writing course
- Monika assisted the BRFSS project with the Cow Creek and Coquille surveys
  - Helped make edits and changes to the 2017 Cow Creek BRFSS questionnaire
  - Worked on inputting the Cow Creek BRFSS questionnaire into CAPI
  - Ran frequencies and completed a spreadsheet of frequencies for all Coquille BRFSS questions

Data dissemination

- Presented about Tribal BRFSS and IDEA-NW Projects during IHS Project Officer's site visit

Travel

Linkages

- Picked up Seattle Indian Health Board Data (Seattle, WA) 1/19

Site visits

- None

Meetings, Trainings, and Conferences

- Presented at Tribal Action Plan Workshop (Columbia, SC) 1/24-1/26
- SAS Training : Macro Language Essentials, San Francisco, CA 3/16-3/17

Other Meetings, Calls and Trainings

- Call re: Suquamish Community Health Assessment 1/10
- Planning call with David Dickinson for TAP workshop 1/23
- Call with Washington State re: Informatics Field Assignee 1/20
- Discussion re: Washington communicable disease linkage 2/3
- Meeting with Oregon EPHT 2/16
- Attended GDM/EDM training (Monika) 2/22 – 2/24
- OMH Grant Conference Call 3/3
- Meeting with OHA re: Tobacco Fact Sheet Development 3/6
- Environmental Health Project Conference Call w/ GLITEC 3/9
- Quality Improvement Workgroup Meetings 3/9, 3/13
- Meeting with Suzanne Zane re: PRAMS/MCH 3/17

- MMWR Intensive Writing Training Session 1 3/20
- OMH Grants Program Closeout requirements webinar 3/29

Data reports, fact sheets, and presentations are posted to our project website as they are completed:
http://www.npaihb.org/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

Tribal Health: Reaching out InVolves Everyone (THRIVE)

Colbie Caughlan, Project Manager
Celena McCray, Project Coordinator

Site Visits

Tribal Site Visits

- Chehalis Tribe – January 17
- Coeur d'Alene Tribe – January 25
- Skokomish Tribe – February 3
- Suquamish Tribe – February 24
- Snoqualmie Tribe – February 24
- Stillaguamish, Samish, Swinomish, Nooksack, Lummi and Upper Skagit Tribes – March 17
- Sauk Suiattle – March 30-31

Out of Area Site Visits

- None during this reporting period.

Technical Assistance & Training

During the quarter, project staff:

- Participated in 62 meetings and conference calls with program partners.
- Disseminated 72 boxes of the two suicide prevention campaigns for AI/ANs.
- Confirmed the slogan and 2 looks for the Veteran campaign. The slogan will be: ***You Protected Us. Let Us Walk With You.*** (draft mock up to the right).

- The 13 videos for behavioral health professionals who work with Dialectical Behavior Therapy (DBT) were uploaded to the *Healthy Native Youth* webpage with an attached post-survey and will be re-disseminated to DBT professionals in mid-April.
- THRIVE partnered with the Social Media and Adolescent Health Research Team (SMAHRT) from Seattle Children's in the fall of 2016 to pilot, evaluate, and disseminate a webinar developed by Project Red Talon and SMAHRT in early 2016. This *Social Media Concerning Post Webinar* was launched as a randomized research project with 65+ adults working with Native teens enrolled in the evaluation.

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

- Presentations (4)– Chemawa Wellness Day THRIVE/WeRNative presentation, 350 participants, Salem, OR; NARA Veterans Monthly Meeting re: Veterans campaign call for lived experience video participants, Portland, OR; NIVA Veterans Monthly Meeting re: Mock up Veterans campaign posters,

Vancouver, WA and; Community of Learning (CoL) Webinar presentation led by SPRC re: ZS Tribal Academy and ZS implementation element "LEAD".

- Facilitation/Training (7) – Hosted a HOC refresher webinar via Adobe Connect, 10 participants; hosted ZS Introduction for the Coeur d'Alene Tribe, 17 attendees, Plummer, ID; hosted Screening training for the Coeur d'Alene Tribe, 17 attendees Plummer, ID; facilitated QPR workshop, 27 participants, Skokomish, WA; facilitated QPR workshop, 19 participants, Skokomish, WA; hosted an AMSR training, 20 participants, Arlington, WA and; facilitated ASIST workshop, 19 participants, Darrington, WA.

During the quarter, the THRIVE project responded to over 300 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. The Lived Experience videos for this new campaign will be recorded in May.

GLS Messages: Number/Reach of We R Native Facebook messages addressing…

- Suicide = 8 posts, 52,411 people reached
    - #WeNeedYouHere Campaign = 8 posts, 52,411

Other Administrative Responsibilities

Staff Meetings

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

Publications

- Staff submitted articles for the NPAIHB January Health News and Notes:
    - *Insights and Lessons Learned from Zero Suicide Implementation*
    - *What is Zero Suicide*
    - *Language Around Suicide Matters*

Reports/Grants

- Submitted quarterly to SAMHSA for year 3 quarter 1 of the GLS youth suicide grant.
- Submitted SAMHSA year 4 GLS continuation application.
- Submitted quarterly FFR's for both MSPI grants for year 2 quarter 1.

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
Jessica Marcinkevage, Epidemiologist
Jenine Dankovchik, Evaluation Coordinator
Nora Alexander, Health Educator/Communication Spec.
Birdie Wermy, National Evaluation Specialist

Meetings

External committee meetings

- 09-Feb-17 Wellness Committee Meeting
- 09-Mar-17 Training planning meeting w/ FGC

Internal Meetings

- 04-Jan-17 Collaboration tobacco projects follow up with Oregon tribes
- 05-Jan-17 #WellnessWednesday Content Creation
- 10-Jan-17 Wellness Wednesday Content Creation
- 26-Jan-17 Wellness committee
- 01-Feb-17 Art Committee
- 02-Feb-17 WEAVE Team Meeting
- 02-Feb-17 Onboarding Work Group
- 08-Feb-17 Nora's Annual Review
- 01-Mar-17 GHWIC Conference
- 06-Mar-17 All Staff Meeting
- 08-Mar-17 WEAVE TEAM meeting
- 10-Mar-17 WEAVE team sub-awardee check in
- 16-Mar-17 On boarding committee
- 16-Mar-17 Wellness Committee
- 29-Mar-17 Touch base & updates meeting

Meetings with Sub-Awardees

- 15-Mar-17 Phone call with Cow Creek to discuss Million Hearts project

Meetings with Funding Agency

- 07-Feb-17 Pick up tobacco sign
- 28-Feb-17 CDC Mid-Point Grantee Meeting
- 06-Mar-17 Oregon AI/AN Tobacco Fact Sheets
- 15-Mar-17 GHWIC quarterly evaluation call

Meetings with Tribal Communities

- 03-Feb-17 Youth Track July Planning Meeting

Other types of meetings

- 06-Feb-17 WRN #WellnessWednesday Monthly Planning
- 10-Feb-17 Introduction meeting with UIHI re: GHWIC
- 15-Feb-17 WRN #WellnessWednesday Resource Creation
- 24-Feb-17 Tribal Policy Toolkit Workgroup Meeting

Summary of Meetings by Type

Internal: 15
Conference/committee: 2
Tribal Community: 1

Funding Agency: 4
Sub-Awardee: 1
Community (non-tribal): 0
Government Partner: 0
Other: 4

Total Meetings: *27*

Site Visits

Date(s) WEAVE-NW Staff	Tribe	Short Summary
01/27/17	Klamath Tribe	Site Visit with Klamath Tribe
02/15/17	Grand Ronde Tribe	Site Visit with Grand Ronde
03/15/17	Umatilla Tribe	Site visit to Yellowhawk/wildhorse
03/21/17	Muckleshoot Tribe	Site visit with Muckleshoot to get an update on their progress

Total number of site visits this quarter: 4

Presentations

Date Given: 3/9/2017 **Type:** Women's Health Day
Title: You Take my Breath Away
Presented at: Pamper and Empower Women's Health Event
Location: Corvallis Oregon

Total number of presentations given this quarter: 1

Professional Development

Date	Title	WEAVE-NW Staff	Topics
01/19/17	Integrating Health Impact Assessments via Environmental Community Health Assessments		
01/17/17	Basic skills for working with smokers		Tobacco, Training Methods, Evaluation

Total number of professional development activities this quarter: 5

Technical Assistance Given

Guidance to analyze their own data

- 1/23/2017 NPAIHB program - EIS Assisted EIS Officer with analysis of mortality data Officer

Provided fact sheet

Sharing Resources

- 1/4/2017 C1 and C2 tribes Sent weekly WEAVE E-Newsletter with Tribal Digest, trainings, resources, and publications.
- 1/11/2017 C1 and C2 tribes Sent weekly WEAVE E-Newsletter with Tribal Digest, trainings, resources, and publications.
- 1/18/2017 C1 and C2 Tribes Sent weekly WEAVE E-Newsletter with Tribal Digest,

trainings, resources, and publications.

- 1/25/2017 C1 and C2 Tribes Sent weekly WEAVE E-Newsletter with Tribal Digest, trainings, resources, and publications.

- 2/1/2017 C1 & C2 Tribes WEAVE Weekly E-newsletter- Tribal Digest & Resources
- 2/1/2017 C1 and C2 tribes Sent weekly WEAVE E-Newsletter with Tribal Digest, trainings, resources, and publications.

- 2/8/2017 C1 & C2 Tribes WEAVE Weekly E-newsletter- Tribal Digest & Resources
- 2/15/2017 C1 & C2 Tribes WEAVE Weekly E-newsletter- Tribal Digest & Resources
- 2/22/2017 C1 & C2 Tribes WEAVE Weekly E-newsletter- Tribal Digest & Resources

Survey design & implementation

- 1/10/2017 Lummi Assisted Lummi Tobacco Coordinator with design of youth tobacco survey
- 1/26/2017 Coquille
- 1/26/2017 Warm Springs Assisted Warm Springs in developing a community readiness survey

Western Tribal Diabetes Project

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

Trainings

- Diabetes Management Systems Training (DMS)
  - 14 participants
  - 7 Portland area
  - 6 other IHS areas
- Diabetes Management Systems Training (DMS)
  - 15 participants
  - 3 Portland area – Cowlitz and area office
  - 6 other IHS areas
- Diabetes Management Systems Training (DMS)
  - Aberdeen, SD 35 attendees
- Assistance with SOS report for documenting required key measures for IHS best practice
- Technical assistance to tribal programs for Audit and SOS
  - Worked with Albuquerque are tribes Audit and SOS

Site Visits (10)

- Cowlitz (2)
- Lower Elwha
- Neah Bay (Makah)
- Nisqually
- Port Gamble
- Quileute
- Quinault
- Skokomish
- Squaxin Island

- Yakima Women's Health Day 100 tribal community and staff attended
    - Take care of yourself
    - Smoking and diabetes, E-cigarettes and pregnancy and tobacco presentation

Technical Assistance (60 technical assistance calls)

- Portland Area Office, ADC request for a contact list for Portland Area SDPI grantees work with ADC on updating SOS and audit
- .Albuquerque Area; ta with patient education taxonomies. And DM Audit edu topics
- Examples of technical assistance calls
    - ta Audit forms to us. and entered forms into WebAudit
    - SOS target population
    - Taxonomy clean up. Tobacco screenings are not getting captured. Nor is LDL and Diet Education
    - ta to upload Audit file; FTP upload via area office
    - SOS baseline data
    - TA to run GPRA indicators
    - TA with RPMS. Taxonomy issues with pre-diabetes package
    - TA create a search template in QMAN, based on the provider
    - pulled the Audit from previous years, and the A1cs not being reported were significantly higher than the Area average.

Special projects

- Submitted call for proposals for Native wellness conference – diabetes data, improvement and wellness
- Working with N7 staff – NF
    - New staff person to complete internal request for training at TWC
    - Still waiting -
- Compiled Best Practice information about SDPI programs here in the Portland Area
- Assisted with slides for TLDC representatives presentation
- Reached out to Portland Area ADC, to offer assistance with the SDPI Outcomes System (SOS) submissions in the Portland Area – She responded with a spreadsheet of programs' status
- Article for Health News & Notes: Audit and SDPI Outcomes System
- Registered students for the Feb DMS training
- Updated the Shortcut & Reference Manual
- Printed and bound 55 Shortcut & Reference Manuals for Feb-Mar trainings
- Travel project collaboration
    - Transported Suicide prevention signs for PRT to various clinics (Makah, Lower Elwha, & Jamestown)
    - Transported Kiki the inflatable colon back to NPAIHB

Meetings/Conferences

- NPAIHB All Meeting
- Project Directors Meeting
- Diabetes in Indian Country planning committee conference call
- HPV/Dental toolkit – conference call for resources for dental conference
- Onboarding workgroup
- Staff meeting WTDP NTCCP

Conference Calls:

- OHA DPP Quarterly Call Oregon DPP Program Providers
- DDTP & SDPI Website Update Webinar
- Webinar on Baseline SOS RKM Data
- DDTP & SDPI Website Update Webinar

NARCH and PRC program updates

Tom Becker and colleagues

Recognition

- I would like to recognize and thank the Quinault Nation and their elders…past and present…for hosting me at this gathering.
- I would also like to thank the delegates for allowing me to present to you today.

Main components of NARCH

(Native American Research Centers for Health)

- **Narch 3**: scholarship program
- **Narch 4**: Summer Institute
- **Narch 5**: Monitoring Abuse of Drugs
- **Narch 5 supplement**: HIV prevention
- **Narch 6, 7**: Continues scholarships and Summer Institute
- **Narch 8**: Dental follow up study of 'tweens'

Accomplishments in past year

- Continued support of prior year's fellows
- Identified several new fellows (150 total)
- Added Board-based scholars
- Identified and hired an intern to help with tribal BRFSS projects
- Hosted summer institute with 84 participants (1085 total)
- Wrote Narch 9 grant
- Now writing Narch 10 grant

Coming up this year

- Continue fellow/scholar support
- Next summer institute June, 2017 (classes full)
- Submit new NARCH grant for round 10
- Attend and present at conferences on Indian health and on public health nationwide and worldwide

Prevention Research Center Update

Funding from CDC to OHSU, to partner with the Board and member tribes in health projects

Main Topics:
- preservation of sight and hearing via community-based research projects
- avoidance of risky decisions by tribal youth

PRC Prevention Research Centers

Additional Activities:
- regular seminar series on Indian health
- classes in epidemiology of health conditions in tribal people
- assisting with Board projects
- provided funding for expansion of HPV vaccine

We seek your support

- For the Narch 10 application, including three components…two that extend the fellowships and Summer Institute, one on use of texting to avoid alcohol-related violence among tribal young people
- Draft resolution is in your hands
- Thanks much

Policy & Legislative Update

NW Portland Area Indian Health Board
Quarterly Board Meeting
Hosted by the Quinault Indian Nation

April 18, 2017

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Report Overview

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

Status of IHS Budgets

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FY 2017 IHS Budget

- Congress enacted a second continuing resolution (CR) for FY 2017 for the period of December 10, 2016 to April 28, 2017.
  - Based on FY 2016 levels and under the authority and conditions of the FY 2016 appropriations.
- Congress is working on a FY 2017 Omnibus Appropriations Bill for last five months.
- On March 27, 2017, Administration proposed cuts to domestic discretionary spending which included IHS prevention programs (*submitted late, likely not considered*).
- Another CR is possible if Omnibus Appropriations Bill is not enacted.

FY 2018 IHS Budget

- President's FY 2018 "Skinny Budget" was released on 3/16/17
  - Proposes a 17.9% decrease to HHS
  - Mentions that budget supports services delivered by IHS because services provided to "low-income and vulnerable populations."
- Detailed budget anticipated in May, 2017.
  - Based on FY 2016 enacted levels.

FY 2019 IHS Budget

- National Tribal Budget Formulation Workgroup's Recommendations to IHS for FY 2019
  - Available at: http://www.nihb.org/legislative/budget_formulation.php
  - Fully fund IHS at $32 billion phased in over 12 years
  - HHS/IHS Budget Tribal Consultation in DC March 30, 2017 in DC
- FY 2019 Evaluation/FY 2020 Planning meeting
  - April 24-25, 2017 in Spokane, WA

New Administration

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Presidential Actions

- Memorandum for the Heads of Executive Departments and Agencies – Hiring Freeze, 1/23/17
- Executive Order (E.O.) No. 13765: Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, 1/24/17
- E.O. No. 13771: Reducing Regulation and Controlling Regulatory Costs, 1/30/17
- E.O. No. 13777: Enforcing the Regulatory Reform Agenda, 2/24/17
- Executive Order No. 13781: Comprehensive Plan for Reorganizing Executive Branch, 3/13/17
- E.O. No. 13784: Establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis , 4/30/17

Letter from HHS Secretary & CMS Administrator to Governors

- Letter (dated 3/14/17) focused on improving collaboration with states for more effective program management in these areas:
  - Improve Federal and State program management
  - Support Innovative Approaches to Increase Employment and Community Engagement
    - See Judicial Review of Medicaid Work Requirements under Section 1115 Demonstrations, dated 3/28/17
  - Align Medicaid and Private Insurance Policies for Non-Disabled Adults
  - Provide Reasonable Timelines and Processes for Home and Community-Based Services Transformation
  - Provide States with More Tools to Address Opioid Epidemic

Current & Pending Policy Issues

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CMS 4 Walls Limitation

- CMS determined that If a Tribal facility is enrolled in the state Medicaid program as a provider of clinical services under 42 CFR 440.90, the Tribal facility may not bill for services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility.
- Per CMS, under FQHC designation there is no requirement that the services be provided within the 4 walls.
- Section 1905 of the SSA recognizes outpatient Tribal clinics as FQHCs.
- In order to not have any revenue losses, Tribal health programs have to work with their respective Medicaid agencies to change their designation to an FQHC.
- CMS FAQ released January 18, 2017.
- *Deadlines*:
  - January 18, 2018: Notify state of intent to change provider status
  - January 30, 2021: Effective date

CMS Market Stabilization Proposed Rule (CMS-9929-P)

- Proposed rule proposes changes designed to help stabilize the individual and small group health insurance markets.
- Specifically, it proposes to amend:
  - Standards relating to special enrollment periods, guaranteed availability, and timing of annual enrollment period in 2018 plan year;
  - Standards related to network adequacy and essential community providers for QHPs; and
  - Rules on actuarial value requirements.
- Interim final rule or final rule forthcoming.

Indian Health Service

- IHS Notice to Propose the Re-Designation of the Service Delivery Area for the Tolowa Dee-ni' Nation (Smith River Rancheria), dated March 31, 2017
  - Comments due May 1, 2017
- IHS Dear Tribal Leader Letter on Return of Funds to Treasury, dated March 28, 2017

Other Brief Updates

- **IHS Contract Support Costs**
  - New CSC Policy approved in October, 2016
  - IHS has resumed settling past-year CSC claims
- **IHS Catastrophic Health Emergency Fund (CHEF)**
  - Final regulation not issued
  - Update on *Redding Rancheria v. Price*
- **IHS Tribal Premium Sponsorship Program**
  - No update on circular

Other Brief Updates-Cont'd

- **IHS Community Health Aide Program**
  - Work group being convened.
- **IHS Lease Proposals Under 105(l) of ISDEAA**
  - Two USDC-DC decisions state that 105(l) of ISDEAA and implementing regulations require IHS to fully-compensate lease with tribe or tribal organization.

Legislation in 115th Congress

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Legislation in 115th Congress

- Repeal and Replace of Affordable Care Act
- Reauthorization of the Special Diabetes Program for Indians (S. 747)
- Independent Outside Audit of the Indian Health Service Act of 2017 (S. 465)
- Tribal Veterans Health Care Enhancement Act (S. 304)
- Trauma-Informed Care for Children and Families Act of 2017 (H.R. 1757)
- **Other**:
  - Access to Insurance for All Americans Act (H.R. 1408)
  - Indian Health Service Hiring Freeze Exemption Act (H.R. 981)
  - IHS Advanced Appropriations Act of 2017 (H.R. 235)

Indian Legislative Bills in 115th Congress

- Repeal and Replace of Patient Protection and Affordable Care Act (ACA)
  - American Health Care Act (pulled 3/24/17)
  - The fight is not over!
  - Tribes must continue to let their representatives know priorities in any health care reform: benefits of Medicaid expansion, no block granting, 100% FMAP, Indian Health Care Improvement Act, Indian provisions in ACA and AI/AN cost sharing protections in Marketplace, etc.
  - ACA can also be undermined through administrative and regulatory process.

Indian Legislative Bills in 115th Congress

- S. 747 – Special Diabetes Program for Indians Reauthorization Act of 2017
  - Introduced by Sen. Tom Udall (D-NM) on 3/28/17.
  - $150 million for FY 2018
  - Reauthorizes the Special Diabetes Program for Indians (SDPI) from FY 2019-FY 2024 with medical inflation rate increase.
  - 3/28/17: Referred to Committee on Health, Education, Labor and Pensions.

Indian Legislative Bills in 115th Congress

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

Indian Legislative Bills in 115th Congress

- S. 304 – Tribal Veterans Health Care Enhancement Act
  - Introduced by Sen. John Thune (R-SD) and Sen. Mike Rounds (R-SD) on 2/3/17.
  - Amends the Indian Health Care Improvement Act to allow the Indian Health Service to cover the cost of a copayment of an Indian or Alaska Native veteran receiving medical care or services from the Department of Veterans Affairs, and for other purposes.
  - 3/29/17: Referred to Committee on Indian Affairs.

Indian Legislative Bills in 115th Congress

- S. 774 & H.R. 1757 – Trauma Informed Care for Children and Families Act of 2017
  - Introduced by Sen. Heitkamp (D-ND) on 3/29/17 and Rep. Davis (D-IL) on 3/28/17.
  - Addresses the psychological, developmental, social and emotional needs of children, youth, and families who have experienced trauma, and for other purposes.
  - Establishes task force to develop best practices, training, Native American Technical Assistance Resource Center and grant funding.
  - *Actions*:
    - S. 774: 3/29/17- Referred to HELP Committee
    - H.R. 1757: 4/12/17- Referred to Subcommittee on Crime, Terrorism, Homeland Security, and Investigations

National & Regional Meetings

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HHS Tribal Consultations

- National HHS Budget Tribal Consultation- March 30, 2017 in DC
- Region 10 Tribal Consultation- April 10, 2017 in Suquamish

HHS STAC Meeting Update

- Last meeting was March 7-8, 2017
- Tribal leaders met with HHS Secretary Tom Price.
  - "Patients, people and partnerships"
- Tribal Leaders made several requests, including:
  - Honor Tribal Consultation and Government-to-Government Relationship
  - More federal funding beyond IHS
  - Expand ISDEAA Self-Determination and PL 477
  - Assist in Treating Opioid Abuse and Addiction
  - Provide Continued Support for Special Diabetes Program for Indians
  - Maintain Medicaid expansion for AI/AN and 100% FMAP

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) – face-to-face meeting February 28th; last conference call was on April 5th
  - Face-to-face strategy session is May 16-17, 2017.
- CMS TTAG – face-to-face meeting March 1st - 2nd; last conference call was on April 12th
  - Next conference call June 14, 2017.
  - Face-to-face meeting is June 12-14, 2017 in DC.

Discussion?

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Dear Governor:

We write to you to affirm our partnership in improving Medicaid and the lives of those it serves. Medicaid is a safety net program that provides life-saving medical care to millions of Americans facing some of the most challenging health circumstances. In addressing the diversity and complexity of Medicaid recipients, we have a duty to ensure the highest level of quality, accessibility, and choices for Americans who rely on the program. We also have an obligation to taxpayers to make sure Medicaid operates in a way that best serves the most vulnerable populations.

Today, there are significant impediments that stand in the way of achieving these goals. Rigid and outdated implementation and interpretation of federal rules and requirements hinder states from focusing on their most important job: ensuring Medicaid achieves positive health outcomes for vulnerable individuals and families. The federal framework for Medicaid has not kept pace with emerging evidence around the factors that drive improvements in health outcomes. It often fails to properly account for demographic and geographic considerations, as well as health system variables, which vary in degree from one state to the next. Despite the significant investment by states and the federal government, the results should be better.

The expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program. Moreover, by providing a much higher federal reimbursement rate for the expansion population, the ACA provided states with an incentive to deprioritize the most vulnerable populations. The enhanced rate also puts upward pressure on both state and federal spending. We are going to work with both expansion and non-expansion states on a solution that best uses taxpayer dollars to serve the truly vulnerable.

Today, we commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population. We wish to empower all states to advance the next wave of innovative solutions to Medicaid's challenges—solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.

As we break down the barriers to support state initiatives aimed at continuously improving the health outcomes for their Medicaid population, we remain committed to certain mechanisms, which ensure state accountability for the outcomes produced by the Medicaid program. For example, budget neutrality for waivers and demonstration projects remains an important policy for protecting the long-term sustainability of the program for states and the federal government,

and state waiver and demonstration requests will continue to be reviewed on a case-by-case basis. Similarly, reasonable public input processes and transparency guidelines provide states an opportunity to consider the views of Medicaid enrollees and stakeholders and gather input that may support continuous improvement of the program.

Some of the key areas where we will improve collaboration with states and move towards more effective program management are described below.

Improve Federal and State Program Management
The Centers for Medicare & Medicaid Services (CMS) is committed to engaging with states in a bilateral process to make the State Plan Amendment approval process more transparent, efficient, and less burdensome. Additionally, we aim to improve the process and speed to facilitate expedited—or "fast-track"—approval of waiver and demonstration project extensions. We also endeavor to be more consistent in evaluating and incorporating state requests for specific waivers and demonstration project approaches that have already received approval in another state. Finally, we plan to conduct a full review of managed care regulations in order to prioritize beneficiary outcomes and state priorities.

Support Innovative Approaches to Increase Employment and Community Engagement
Today, we reaffirm the agency's commitment to support and complement the various federal, state, and local programs that have demonstrated success in assisting eligible low-income adult beneficiaries to improve their economic standing and materially advance in an effort to rise out of poverty. The best way to improve the long-term health of low-income Americans is to empower them with skills and employment. It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.

Align Medicaid and Private Insurance Policies for Non-Disabled Adults
States may also consider creating greater alignment between Medicaid's design and benefit structure with common features of commercial health insurance, to help working age, non-pregnant, non-disabled adults prepare for private coverage. These state-led reforms could include, as allowed by law:

- Alternative benefit plan designs and cost-sharing models, including consumer-directed health care with Health Savings Account-like features, for individuals at all income levels;
- Facilitating enrollment in affordable employer-sponsored health insurance options;
- Reasonable, enforceable premium or contribution requirements, with appropriate protections for high-risk populations;
- Initiatives designed to break down the barriers that prevent families from being together on the same plan;
- Waivers of non-emergency transportation benefit requirements;
- Expanded options to design emergency room copayments to encourage the use of primary and other non-emergency providers for non-emergency medical care; and
- Waivers of enrollment and eligibility procedures that do not promote continuous coverage, such as presumptive eligibility and retroactive coverage.

Provide Reasonable Timelines and Processes for Home and Community-Based Services Transformation

CMS has worked with our state partners and other stakeholders to implement provisions of the final regulation defining a home and community-based setting. In recognition of the significance of the reform efforts underway, CMS will work toward providing additional time for states to comply with the January 16, 2014, Home and Community-Based Services (HCBS) rule. Additionally, we will be examining ways in which we can improve our engagement with states on the implementation of the HCBS rule, including greater state involvement in the process of assessing compliance of specific settings.

Provide States with More Tools to Address the Opioid Epidemic

We are committed to ensuring that states have the tools they need to combat the growing opioid epidemic that is devastating families and communities. In recognition of the urgent need to improve access to comprehensive substance abuse treatment, we will continue to work with states to improve care for individuals struggling with addiction under their Medicaid state plans and through the Medicaid Innovation Accelerator Program to improve their substance abuse treatment delivery systems. In addition, under recent regulatory changes, states may now make managed care capitation payments for individuals with Institutions for Mental Disease stays of 15 days or less within a month. We will continue to explore additional opportunities for states to provide a full continuum of care for people struggling with addiction and develop a more streamlined approach for Section 1115 substance abuse treatment demonstration opportunities. We look forward to building upon initial efforts, including previous collaborations amongst the states.

We intend for this to be the beginning of a discussion on how we can revamp the federal and state Medicaid partnership to effectively and efficiently improve health outcomes. We look forward to partnering with you in the years ahead to deliver on our shared goals of providing high quality, sustainable, health care to those who need it most.

Yours truly,

/Thomas E. Price, M.D./

Thomas E. Price, M.D.
Secretary

/Seema Verma, MPH/

Seema Verma, MPH
CMS Administrator

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Congressional Research Service

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Judicial Review of Medicaid Work Requirements Under Section 1115 Demonstrations

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CRS REPORT
Prepared for Members and Committees of Congress

Summary

Proposals have been introduced in the 115th Congress to reform the Medicaid program, which provides medical assistance to low-income and needy individuals. At least one of these legislative proposals would allow states to impose work requirements on certain categories of individuals as a condition of coverage under the Medicaid program. While such proposals have been included as legislative amendments to the Medicaid statute (such as the American Health Care Act, H.R. 1628), work requirements have also been discussed in the context of waivers granted to states under the existing demonstration authority provided in Section 1115 of the Social Security Act (SSA). Section 1115 authorizes the Secretary of Health and Human Services (HHS) to waive a number of Medicaid requirements to the extent necessary to allow a state to undertake an "experimental, pilot, or demonstration project" that is likely to assist in promoting the objectives of Medicaid. This report examines the scope of authority to grant such waivers under Section 1115, including the degree to which such waivers may be judicially reviewable and the level of scrutiny courts would apply in such cases.

Numerous federal courts have held that the Secretary's decision to grant a waiver under Section 1115 is reviewable under the Administrative Procedure Act (APA). Such review uses the deferential "arbitrary and capricious" standard to evaluate the permissibility of agency action. In cases where Section 1115 waivers have been challenged, courts have held that the APA does not empower judges to substitute their judgment for that of the agency, but only to consider whether the Secretary's decision was based on consideration of relevant factors and whether there has been a clear error of judgment. Therefore, a court's evaluation of a particular Section 1115 waiver will likely turn upon the sufficiency of the actual administrative record relied upon by the HHS Secretary when deciding to grant a waiver.

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Reforms to the Medicaid program, which provides medical assistance for low-income and medically needy individuals,[1] have been proposed during the 115th Congress. At least one of these proposals includes allowing some form of "work requirements" to be imposed on certain categories of individuals as a condition of coverage under the program.[2] While such proposals have been included as legislative amendments to the Medicaid statute, work requirements have also been discussed in the context of waivers granted to states under the existing demonstration authority provided in Section 1115 of the Social Security Act (SSA).[3] Pursuant to this authority, the Secretary of Health and Human Services (HHS) may waive a number of Medicaid requirements to the extent necessary to allow a state to undertake an "experimental, pilot, or demonstration project" that is likely to assist in promoting the objectives of Medicaid.[4] This report examines the scope of authority to grant such waivers under that provision, including the degree to which such waivers may be judicially reviewable and the level of scrutiny courts would apply in such cases.

Background

The Medicaid program, established under Title XIX of the SSA, is a cooperative effort by the federal government and the states to provide medical assistance for low-income and medically needy individuals. To participate in the Medicaid program, a state must have a plan for medical assistance approved by the HHS Secretary and must comply with all applicable conditions.[5]

In general, the Medicaid statute identifies specific categories of individuals, known as "mandatory eligibility groups," that must be covered under a state plan.[6] The statute also requires that an individual in a mandatory eligibility group be offered medical assistance that is the same in amount, duration, or scope as assistance made available to any other persons considered to be "categorically needy" under the state plan.[7] The costs of medical services provided pursuant to a state plan are shared by the state and federal governments. The share of costs paid by the federal government varies for each state and is referred to as the federal medical assistance percentage (FMAP).[8] Failure to cover a "mandatory eligibility group" under a state plan places all federal Medicaid funds received by the state in jeopardy of being withheld.[9]

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[1] For more information on Medicaid, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[2] *See* CRS Report R44785, *H.R. 1628: The American Health Care Act (AHCA)*, coordinated by Annie L. Mach, at Table 2.

[3] SSA § 1115; 42 U.S.C. § 1315.

[4] SSA § 1115(a); 42 U.S.C. § 1315(a).

[5] "A state is not required to participate in Medicaid, but once it chooses to do so, it must create a plan that conforms to the requirements of the Medicaid statute and the federal Medicaid regulations." Cal. Dep't of Health Servs. v. Sec'y of Health & Human Servs., 823 F.2d 323, 325 (9th Cir. 1987). *See also* Pharm. Research and Mfrs. of Am. v. Walsh, 538 U.S. 644, 650 (2003) (noting that a state Medicaid plan must be approved by the HHS Secretary).

[6] SSA § 1902(a)(10)(A)(i); 42 U.S.C. § 1396a(a)(10)(A)(i) (including, among others, families receiving Aid to Families with Dependent Children (AFDC), pregnant women and children meeting certain income requirements, and blind or disabled individuals receiving Supplemental Security Income (SSI)).

[7] SSA § 1902(a)(10)(B); 42 U.S.C. § 1396a(a)(10)(B). The "categorically needy" include both mandatory and optional coverage groups. SSA § 1902(a)(10)(A); 42 U.S.C. § 1396a(a)(10)(A).

[8] SSA § 1905(b); 42 U.S.C. § 1396d(b). For more information on the FMAP formula see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell.

[9] SSA § 1904; 42 U.S.C. § 1396c.

Some of the proposals to impose work requirements in Medicaid have focused on a newer category of individuals for whom coverage under Medicaid was added in the ACA. Specifically, Section 2001 of the Affordable Care Act (ACA) amended the Medicaid statute to add a new mandatory eligibility group, effective beginning in 2014.[10] This "ACA Medicaid expansion group" was defined to cover those individuals who were under 65 years of age, not pregnant, not Medicare-eligible, and not otherwise eligible for Medicaid, who also fell below a certain income threshold.[11]

This ACA Medicaid expansion group is notable for at least two reasons. First, the federal government's share of the costs of medical services provided to this group is more than the normally applicable FMAP, which ranged between 50% and 74.63% in FY2017.[12] In contrast, the "enhanced FMAP" for the ACA Medicaid expansion group started at 100% through 2016 and will gradually decline until it reaches 90% for 2020 and years thereafter.[13] Second, although the ACA Medicaid expansion group was designated as a mandatory coverage group by the ACA, the Supreme Court in *National Federation of Independent Businesses (NFIB) v. Sebelius* held that Congress could not constitutionally "withdraw existing Medicaid funds for failure to comply with [the requirement to provide coverage for the ACA Medicaid expansion group]."[14] The "existing Medicaid funds" referred to by the Court are that portion of federal financial assistance provided to states that are attributable to the mandatory eligibility groups that were in existence prior to the ACA and governed by the traditional FMAP. For purposes of this report, this portion of federal assistance is referred to as "pre-ACA dollars." The holding in *NFIB v. Sebelius* effectively allows states to decline to cover the new ACA Medicaid expansion group without jeopardizing pre-ACA dollars. However, it would appear that *NFIB v. Sebelius* does not preclude the disapproval by CMS of that portion of the hypothetical state plan which provides only partial coverage of the ACA Medicaid expansion group. Assuming that partial coverage of the ACA Medicaid expansion group is not permitted, the Secretary could potentially deny a state any federal assistance under the enhanced FMAP with respect to the costs of medical services provided to those beneficiaries in the partially covered ACA Medicaid expansion group.[15]

The Medicaid statute does not appear to expressly address whether a state plan may permissibly impose work requirements as a condition of receiving benefits for most beneficiaries. However, Section 1931 of the SSA authorizes states to terminate Temporary Assistance for Needy Families (TANF) recipients' eligibility for medical assistance under Medicaid if the individuals' TANF benefits are denied for failing to comply with work requirements imposed under the TANF program.[16]

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[10] Patient Protection and Affordable Care Act, P.L. 111-148, § 2001 (2010).

[11] SSA § 1902(a)(10)(A)(i)(VIII); 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). For more information on the expansion of the Medicaid program under the ACA, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*, by Alison Mitchell.

[12] See CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell.

[13] SSA § 1905(y); 42 U.S.C. § 1396d(y).

[14] This holding was reached by seven of the Supreme Court Justices. *See* Nat'l Fed'n Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012) (Roberts, C.J., joined by Breyer and Kagan, JJ.) and *id.* at 2666 (Scalia, Kennedy, Thomas, Alito, JJ. dissenting).

[15] *NFIB*, 132 S. Ct.at 2607 (Roberts, C.J.) ("Today's holding does not affect ... the Secretary's ability to withdraw funds provided under the Affordable Care Act if a State that has chosen to participate in the expansion fails to comply with the requirements of that Act.").

[16] SSA § 1931(b)(3)(A); 42 U.S.C. § 1396u-1(b)(3)(A).

Outside of this specific authority, imposing a work requirement on Medicaid beneficiaries could arguably violate the Medicaid program requirement to cover all individuals in an eligibility group.[17] For example, if a state elects to cover the ACA Medicaid expansion, SSA Section 1902(a)(10)(A)(i)(VIII) requires a state plan to provide medical assistance to "all individuals" in the ACA Medicaid expansion (i.e., non-elderly, not pregnant, and non-Medicare eligible).[18] Excluding individuals in this group based on employment status would arguably not cover "all individuals" in the group, assuming some individuals who sought coverage could not satisfy the work requirements.

H.R. 1628, the American Health Care Act (AHCA), would include significant changes to the Medicaid program.[19] As introduced, the bill would phase out the enhanced matching for the ACA Medicaid expansion and convert Medicaid financing for most groups to a per capita cap model, which would subject federal payments to states to aggregate limits measured by the number of enrollees in the states' plans.[20] On March 21, 2017, a manager's amendment to the AHCA was released which would additionally allow states to impose work requirements on non-disabled, non-elderly, non-pregnant individuals.[21] Under this proposal, states could elect to require those beneficiaries to engage in work activities as a condition of continued eligibility under Medicaid. Work activities would be defined to be the same as those employment-related requirements imposed on TANF recipients.[22] A rule providing for consideration of H.R. 1628 was passed by the House of Representatives on March 24, 2017, but a final vote on passage was postponed.[23]

Allowing Work Requirements in Medicaid Under a Section 1115 Waiver

In general, SSA Section 1115 permits states to examine potential innovations in certain state-administered public programs, including Medicaid.[24] On March 14, 2017, HHS Secretary Tom Price and CMS Administrator Seema Verma cosigned a letter to state governors affirming the federal and state "partnership in improving Medicaid."[25] Among other things, the letter announced the Administration's intent to use Section 1115 demonstration authority to "approve

[17] *See* T H v. Jones, 425 F. Supp. 873, 877 (D. Utah 1975), *aff'd sub nom.* Jones v. H., 425 U.S. 986 (1976) (holding that parental consent requirements imposed on Medicaid family planning services by Utah were incompatible with SSA, because states may not add a condition of eligibility not authorized by Congress). *See also* Comacho v. Tex. Workforce Comm'n, 408 F.3d 229, 235 (5th Cir. 2005) ("Texas cannot add additional requirements for Medicaid eligibility.").

[18] SSA § 1902(a)(10)(A)(i)(VIII); 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

[19] CRS Report R44785, *H.R. 1628: The American Health Care Act (AHCA)*, coordinated by Annie L. Mach.

[20] *Id.*

[21] *Id.*

[22] For more information on TANF work requirements, see CRS Report R43400, *Work Requirements, Time Limits, and Work Incentives in TANF, SNAP, and Housing Assistance*, by Gene Falk, Maggie McCarty, and Randy Alison Aussenberg.

[23] Office of the Clerk of the House of Representatives, *Final Vote Results for Roll Call 192* (Mar. 24, 2017) *available at* http://clerk.house.gov/evs/2017/roll192.xml.

[24] *See* Sara Rosenbaum, Sara Schmucker, Sara Rothenberg, and Rachel Gunsalus, *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?*, COMMONWEALTH FUND ISSUE BRIEF (May 2016), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/may/1877_rosenbaum_section_1115_medicaid_expansions_fed_policy.pdf.

[25] Letter from HHS Secretary Tom Price and CMS Administrator Seema Verma to State Governors, (Mar. 14, 2017), *available at* https://www.hhs.gov/sites/default/files/sec-price-cms-admin-verma-ltr.pdf.

meritorious innovations that build on the human dignity that comes with training, employment and independence."[26] Several states, such as Kentucky,[27] Pennsylvania,[28] and Indiana,[29] have also recently sought waivers to impose some type of Medicaid work incentives under Section 1115.

Section 1115 authorizes the HHS Secretary to waive a number of requirements imposed by the SSA, including Medicaid requirements contained in Section 1902, to the extent necessary to allow a state to undertake an "experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [Medicaid and other programs authorized by the SSA]."[30] Thus, the central limitation provided in the text of this provision is whether, "in the judgment of the Secretary," the project is "likely to assist in promoting the objectives of [Medicaid and other covered programs]"; namely the provision of medical assistance to those whose income and resources are inadequate to meet the costs of such care.[31] In the words of one federal court, SSA Section 1115 "vests in the Secretary broad power to authorize projects which do not fit within the permissible statutory guidelines of the standard public assistance programs."[32]

Judicial Review of Section 1115 Waivers

In the event that the Secretary approves a waiver, it is possible that injured parties may sue to enjoin the waiver's operation. Numerous federal courts have held that the Secretary's decision to grant a waiver is reviewable under the Administrative Procedure Act (APA).[33] When reviewing the Secretary's issuance of a waiver, courts are likely to review the Secretary's action under the deferential standard set forth in APA Section 706(2)(A).[34] Under this standard, a reviewing court "shall ... hold unlawful and set aside agency action, findings, and conclusions found to be ... arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[35] Case law

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[26] *Id.* at 2.

[27] KY. DEP'T OF MEDICAID SERVICES, at 16 (Aug. 24, 2016), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf (proposing requirement for able-bodied working age adult enrollees participate in community engagement and employment initiative to maintain enrollment).

[28] PA. DEP'T OF PUBLIC WELFARE, *HEALTHY PENNSYLVANIA 1115 APPLICATION*, at 12-13 (Feb. 2014), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-demonstration-app-022014.pdf (seeking a waiver to "require adults working less than 20 hours a week to participate in the Encouraging Employment program as a condition of eligibility").

[29] IND. FAMILY AND SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN (HIP) SECTION 1115 WAIVER EXTENSION APPLICATION, at 25-26 (Jan. 31, 2017), *available at* https://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf (requiring managed care entities to develop "member incentive programs specific to promoting employment, including but not limited to rewarding members for successful participation in the HIP Gateway to Work program through the completion of available job training, work search, or educational activities that will assist members in securing gainful employment").

[30] SSA § 1115(a); 42 U.S.C. § 1315(a).

[31] SSA § 1901; 42 U.S.C. § 1396-1. *See also* Cal. Welfare Rights Org. v. Richardson, 348 F. Supp. 491, 496 (N.D. Cal. 1972).

[32] Crane v. Mathews, 417 F. Supp. 532, 539 (N.D. Ga. 1976).

[33] *See, e.g.*, Beno v. Shalala, 30 F.3d 1057, 1066 (9th Cir. 1994); Aguayo v. Richardson, 473 F.2d 1090 (2d Cir. 1973); Wood v. Betlach, No. CV-12-08098, 2013 U.S. Dist. LEXIS 105027 (D. Ariz. July 26, 2013); *Crane*, 417 F. Supp. at 539; *Cal. Welfare Rights Org.*, 348 F. Supp. at 494 (noting that SSA § 1902, 42 U.S.C. § 1396-1, provides the "law to apply" in evaluating grant of waiver).

[34] 5 U.S.C. § 706(2)(A) .

[35] *Id.* It should be noted that it may not be possible to bring a suit under the APA to *compel* the HHS Secretary to grant a waiver, as suits to compel agency action must assert a failure by an agency to take an action that it was *required* to (continued...)

interpreting this language has developed what is known as the "arbitrary and capricious" standard which allows reversal of agency action if

> the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.[36]

As such, the ultimate conclusion reached by a reviewing court assessing whether the HHS Secretary's grant of a waiver under Section 1115 was arbitrary and capricious will likely depend upon the actual administrative record upon which the Secretary made his decision.[37] Further, in examining whether there has been an abuse of agency discretion, courts have held that "[t]he APA does not give the court power 'to substitute its judgment for that of the agency,' but only to 'consider whether the decision was based on consideration of the relevant factors and whether there has been a clear error of judgment.'"[38]

Standard of Review for Section 1115 Waivers

Courts have applied the arbitrary and capricious stand of review in APA-related challenges to cases involving the Secretary's waiver authority under Section 1115 to permit state plans imposing work requirements on categories of individuals as a condition to their receipt of certain benefits, though not in the context of the Medicaid program. In the case of *Aguayo v. Richardson*, New York had sought a waiver to allow the imposition of work requirements in its Aid to Families with Dependent Children (AFDC) program.[39] AFDC recipients contended, among other things, that Section 1115 did not permit the Secretary to waive a requirement that would curtail or deny program assistance.[40] The U.S. Court of Appeals for the Second Circuit (Second Circuit) examined the administrative record, which, in the court's view, showed that the Secretary of Health, Education, and Welfare[41] had considered objections to the waiver and attempted to answer those objections.[42] In its decision, the appeals court examined, among other things, a federal agency memorandum outlining the goals of the waiver program, including "[i]ncreased

(...continued)

take. *See* Norton v. S. Utah Wilderness Alliance, 542 U.S. 55, 64 (2004) (holding that a claim under § 706(1) of the APA, which authorizes a court to compel agency action under certain circumstances, "can proceed only where a plaintiff asserts that an agency failed to take a discrete agency action that it is *required to take*"). The language of § 1115 provides only that the Secretary "*may* waive compliance," but does not state that she is required to do so under any circumstances. SSA § 1115(a)(1); 42 U.S.C. § 1315(a)(1).

[36] *Beno*, 30 F.3d at 1073 (citing Motor Vehicle Mfr. Ass'n v. State Farm Ins., 463 U.S. 29, 44 (1983)).

[37] *See also* C.K. v. N.J. Dep't of Health & Human Servs., 92 F.3d 171, 182 (3d Cir. 1996) (observing that when examining whether an agency's finding is arbitrary or capricious, a court must "confine its review to the full administrative record that was before the Secretary at the time he made his decision, and consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment") (citations and internal quotation marks omitted).

[38] *See*, *e.g.*, *Beno*, 30 F.3d at 1073 (quoting Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 416 (1971)).

[39] *Aguayo*, 473 F.2d at 1093-95. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced the AFDC program with the Temporary Assistance for Needy Families (TANF) block grant demonstration project, changing the federal welfare program from an open-ended entitlement program to a capped block grant program. *See* 42 U.S.C. §§ 601 *et seq*. For more information on the TANF program, see CRS In Focus IF10036, *The Temporary Assistance for Needy Families (TANF) Block Grant*, by Gene Falk.

[40] *Aguayo*, 473 F.2d at 1105.

[41] The Department of Health, Education, and Welfare is the previous name for the Department of HHS.

[42] *Aguayo*, 473 F.2d at 1105-06.

self-support or self-care of recipients" and "[i]ncreased community participation."[43] Based on these parts of the administrative record, the Second Circuit concluded that it was "impossible to deny that attainment of these goals, or even of some of them, would meet the test of [Section 1115]."[44] On these facts, the court held that the Section 1115 waiver decision by the Secretary was valid, and that the decision to grant a waiver to that state was supported by the administrative record before him.[45]

The imposition of "work incentives" in the AFDC program pursuant to a Section 1115 waiver were also discussed by the U.S. Court of Appeals for the Ninth Circuit (Ninth Circuit) in *Beno v. Shalala*.[46] In that case, beneficiary groups had raised objections alleging deficiencies in the design of the project during the HHS Secretary's consideration of a waiver sought by California. Among other things, the plaintiffs had argued that the waiver would have cut benefits to almost all AFDC recipients, even though data from the project was only being collected on a fraction of beneficiaries.[47] The plaintiffs also objected that the proposal included the imposition of a "work-incentive" cut on individuals whose disabilities preclude work.[48] In its decision, the Ninth Circuit addressed what determinations the Secretary must make before approving a waiver under Section 1115. The court noted that pursuant to the language of this section, the Secretary is compelled to determine, among other things, that a state's project was "an experimental, demonstration, or pilot" project, and thus, such a project must have research or demonstration value.[49] The court stated that "[a] simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy this requirement."[50]

The court in *Beno* further noted that Section 1115 directs the Secretary to ascertain whether a proposed project is "likely to further the objectives" of the program.[51] As part of this inquiry, the court stated that the Secretary must examine the impact that the project would have on program beneficiaries and the scope of the project.[52] This inquiry should also include the potential to harm incurred by individuals and the plaintiff's objections to the project.[53] Taking these and other considerations into account, the court reviewed the administrative record before the Secretary and found that it "contain[ed] a rather stunning lack of evidence that the Secretary gave plaintiffs' objections any such consideration."[54] The court further observed that the record contained no indication that the Secretary considered factors such as the risk that the benefits cut would have on program recipients; the need for cutting benefits for work-incentive purposes; or the merits of

[43] *Id*. at 1106.

[44] *Id.*

[45] *Id.*

[46] *Beno*, 30 F.3d at 1062. The state's waiver application in *Beno* aimed to encourage program recipients to find work by decreasing benefits. *Id.* at 1061. The state alleged that any application benefits cut would promote the objectives of the program through the creation of a "work-incentive" experiment to "encourage able-bodied adults" to find work, and that the project would assist in evaluating whether such incentives could be effective in other states. *Id*. at 1062.

[47] *Id.* at 1072-73.

[48] *Id.*

[49] *Id.* at 1069 (quoting SSA § 1115(a); 42 U.S.C. § 1315(a)).

[50] *Id.*

[51] *Id*. at 1069-71.

[52] *Id.* at 1070 (citing *Cal. Welfare Rights Org.*, 348 F. Supp. at 498, where the district court stated that "it is clear that the Secretary would abuse his discretion if he were to approve a project which went beyond that point by either subjecting an unreasonably large population to the experiment or continuing it for an unreasonably long period").

[53] *Id.*

[54] *Id.* at 1074.

imposing such a cut on vulnerable individuals.[55] Consequently, the court held that the Secretary's decision in this case could not be sustained, even under the deferential review of the APA.[56]

While these cases demonstrate the extent that judicial review may rely upon an examination of the administrative record when assessing the legality of a waiver under Section 1115, both *Beno* and *Aguayo* dealt with work incentives in the context of AFDC, which is a distinct program from Medicaid, and one which was created to achieve different ends. While Medicaid was created for the provision of medical assistance to individuals whose income and resources are inadequate to meet the costs of such care,[57] the stated purposes of AFDC are

> Encouraging the care of dependent children in their own homes or in the homes of relatives by enabling each State to furnish financial assistance and rehabilitation and other services ... to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and [helping] such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection.[58]

While Medicaid and AFDC both focus on recipients' financial need, the AFDC language also references the attainment of self-support and personal independence for beneficiaries as important goals of the program.[59] To the extent that similar language describing Medicaid's purpose is lacking, the AFDC cases supporting work incentives above may not necessarily be dispositive of whether work incentives are consistent with the objectives of Medicaid. Similarly, as the Supreme Court has noted the difference in character between the objectives of the pre-ACA Medicaid program and the ACA Medicaid expansion, it is possible that a court may find this disparity to be relevant in evaluating a Section 1115 waiver imposing work requirements in either category.[60]

Other courts have used similar principles to review Section 1115 waivers specifically for the Medicaid program, but not in the context of work requirements. For example, in *Newton-Nations v. Betlach*, the Ninth Circuit reviewed a waiver authorizing Arizona to impose increased co-payments on Medicaid beneficiaries.[61] Similarly to the situation in *Beno*, the court examined the administrative record and found that it lacked the requisite findings regarding the waiver's research value and potential harm to beneficiaries to support the Secretary's decision approving the waiver.[62] In particular, the court suggested that justifying the waiver's "research or demonstration value" would require more than a cursory discussion, as the plaintiffs' public health expert had testified that co-payments had already been heavily studied over the past 35

[55] *Id.*

[56] *Id.* at 1076. *Cf.* C.K. v. N.J. Dep't of Health & Human Servs., 92 F.3d 171 (3d Cir. 1996) (relying upon reasoning in *Beno* but finding that the administrative record supported the Secretary's decision to grant a §1115 waiver request and concluding that the arbitrary and capricious standard did not require a specific refutation or discussion of every objection raised by private groups).

[57] *Cal. Welfare Rights Org.*, 348 F. Supp. at 496.

[58] SSA § 401; 42 U.S.C. § 601 (1994).

[59] *Id.*

[60] *See NFIB*, 132 S. Ct. at 2606 (Roberts, C.J.) ("[Post-ACA Medicaid] is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.")

[61] Newton-Nations v. Betlach, 660 F.3d 370, 381 (9th Cir. 2011).

[62] *Id.*

years.[63] Citing *Beno*, the court concluded that the waiver could not be justified on the basis of cost-savings without an identifiable research or demonstration value.[64]

Potential Use of Section 1115 Waivers to Allow Work Requirements in Medicaid

Assuming, for purposes of this discussion, that implementation of a work requirement on Medicaid recipients would otherwise violate the provisions of SSA Section 1902, the Secretary's authority to waive those provisions as part of an "experimental, pilot, or demonstration project" under Section 1115 may be examined. As discussed above, SSA Section 1115 explicitly authorizes the Secretary to "waive compliance with any of the requirements of § 1902," upon a determination that it "is likely to assist in promoting the objectives of [Medicaid]."[65] While most states implementing the ACA Medicaid expansion have done so through an expansion of their existing Medicaid programs, six states operate their expansions through Section 1115 waivers, in some cases using plans purchased through the private health insurance market rather than providing coverage under Medicaid for certain individuals.[66] While the Secretary has rejected waiver proposals to link Medicaid benefits to certain work requirements for the ACA expansion group,[67] Pennsylvania requested a waiver to conduct a demonstration project that involved *voluntary* work incentives, and a waiver for that plan was granted in August 2014.[68]

Whether a reviewing court would conclude that the HHS Secretary could permissibly issue a Section 1115 waiver to allow a state to impose a work requirement on beneficiaries in the ACA Medicaid expansion group may depend on the specifics regarding a particular proposal. For example, the precise parameters of the work requirement, and their relationship to the hypotheses to be tested by the project, would likely be relevant.[69] Additionally, the particular administrative record, which could include objections raised by commenters in opposition to the project, may inform a reviewing court's evaluation of whether the Secretary had considered all relevant factors.

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[63] *Id.*

[64] *Id.*

[65] SSA § 1115(a); 42 U.S.C. § 1315(a).

[66] MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, EXPANDING MEDICAID TO THE NEW ADULT GROUP THROUGH SECTION 1115 WAIVERS 4-5 (Jan. 2017), https://www.macpac.gov/publication/expanding-medicaid-to-the-new-adult-group-through-section-1115-waivers/. Arizona, Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire are currently providing Medicaid benefits to the ACA expansion population through § 1115 waivers. *Id.* at 4. Pennsylvania also provided Medicaid benefits to these individuals through a § 1115 waiver from January 1, 2015, through August 31, 2015, but then transitioned to a traditional expansion effective September 1, 2015. *Id*. at n.2.

[67] *See* ROBERT WOOD JOHNSON FOUNDATION, MEDICAID EXPANSION, THE PRIVATE OPTION, AND PERSONAL RESPONSIBILITY REQUIREMENTS: THE USE OF SECTION 1115 WAIVERS TO IMPLEMENT MEDICAID EXPANSION UNDER THE ACA 5 (May 2015), http://www.rwjf.org/en/library/research/2015/05/medicaid-expansion—the-private-option—and-personal-responsibil.html (discussing proposals from Pennsylvania and Indiana).

[68] Letter from CMS Administrator Marilyn Tavenner to Pennsylvania Public Welfare Secretary Beverly Mackereth (Aug. 28, 2014), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf. Pennsylvania subsequently transitioned to a traditional expansion that does not require a waiver, and the voluntary work incentives are no longer in effect. *See* MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, *supra* note 65, at 1.

[69] For example, the approved waiver from Pennsylvania permitting voluntary work incentives was intended to test the hypotheses that "being employed results in improved physical and mental health," and that the program would "help individuals move out of poverty." PA. DEPT. OF PUBLIC WELFARE, *supra* note 28, at 13-14.

Nevertheless, it is possible to describe a general framework under which a legal analysis would likely follow once all the facts had been established. A central aspect of this framework is the Secretary's determination concerning whether a proposed demonstration project promotes the objectives of Medicaid.[70] As discussed above, courts evaluating whether the Secretary properly approved a Section 1115 waiver have focused on the Secretary's consideration of a waiver. In particular, courts have looked at whether the Secretary evaluated factors such as the waiver's research or experimental goals, the potential impact on program beneficiaries, and objections raised concerning the proposal.[71]

Thus, a reviewing court would likely evaluate a hypothetical Section 1115 waiver related to work requirements similarly, basing its analysis on the Secretary's determination that the waiver promotes the objectives of the Medicaid program (e.g., the provision of medical care for low-income individuals), and the sufficiency of the evidence in the administrative record supporting such a determination. If the Secretary's approval of a Section 1115 waiver is later subject to a legal challenge, a reviewing court would likely examine whether his determination was arbitrary or capricious in light of the administrative record, and the Secretary's decision will likely be afforded deference, to the extent it is not a clear error of judgment.[72]

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[70] It was stated by the dissenting justices in *NFIB v. Sebelius* that "[t]he purpose of Medicaid is to enable States to furnish ... medical assistance on behalf of [certain persons] whose income and resources are insufficient to meet the costs of necessary medical services ... By bringing health care within the reach of a larger population of Americans unable to afford it, the Medicaid expansion is an extension of that basic aim." 132 S. Ct. 2566, 2635 (2010) (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) (citations and internal quotation marks omitted).

[71] It may be noted that § 10201(i) of ACA amended § 1115 of the SSA to require the Secretary to issue regulations that are generally intended to ensure that interested parties have opportunity to provide input into the development of state demonstration projects, as well as to provide transparency in the review and approval of state demonstration applications and renewals. *See* 42 U.S.C. § 1315(d). The Secretary issued a final rule regarding § 1115 waivers in 2012. *See* 77 Fed. Reg. 11678 (Feb. 27, 2012); 42 C.F.R. §§ 431.400 *et seq*. It would seem that information provided pursuant to the regulations would be considered by a reviewing court as part of the administrative record. A CRS search of the LEXIS database for instances in which these regulations were addressed in a case involving a § 1115 waiver yielded no results.

[72] *See, e.g.*, Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 416 (1971).

5C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Frequently-Asked Questions (FAQs)
Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002)
January 18, 2017

On February 26, 2016, the Center for Medicaid and CHIP Services (CMCS) issued a State Health Official letter (SHO) to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. Under the updated policy, IHS/Tribal facilities may enter into written care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries. Amounts paid by the state Medicaid program for services requested by facility practitioners in accordance with those agreements are eligible for federal matching funds at the enhanced federal matching rate (FMAP) of 100 percent.

This FAQ document addresses common questions related to the provisions at pages 5-6 of the SHO letter relating to Medicaid billing and payments to non-IHS/Tribal providers. Questions related to other provisions of the SHO letter will be addressed in subsequent FAQs.

Q1. When services are furnished to an AI/AN Medicaid beneficiary by a non-IHS/Tribal provider under the terms of a written care coordination agreement with an IHS/Tribal facility that meets the requirements of the SHO letter, what are the options for billing for the services?

A1. There are two options for billing the state Medicaid program. The first is for the non-IHS/Tribal provider to bill the state Medicaid program directly. In this case, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and the service rendered, not at the facility rate that the IHS/Tribal facility would receive. The second option is for the IHS/Tribal facility to enter into an arrangement with the non-IHS provider, under which the provider assigns its claim for payment to the facility in return for payment from the facility, and the facility bills the state Medicaid program for the service. In that case, the IHS/Tribal facility would have to identify services provided by non-IHS/Tribal providers under the care coordination agreement that are within the scope of covered services of the IHS/Tribal facility and separate them from those services are not. The facility can claim and receive reimbursement from the state for services that can properly be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") at the facility rate authorized under the Medicaid state plan. The facility would be directly responsible to the extent of any overpayments resulting from such services that were not, in fact, covered under the state plan. The facility can claim and receive reimbursement from the state for those services that do not qualify as IHS/Tribal facility services at the rate under the Medicaid state plan applicable to the provider type and service rendered. The circumstances under which off-site services may be considered facility services are described in the response to question number four.

Q2. If the non-IHS/Tribal provider is willing to accept the Medicaid program payment rate for his or her service, is there any reason for the IHS/Tribal facility to bill the state Medicaid program for the service at the facility rate?

A2. No. In this circumstance, the first option above could apply. The non-IHS/Tribal provider could bill the state directly at his or her provider rate, the IHS/Tribal facility would not have to bill the state at the facility rate on the non-IHS/Tribal provider's behalf and the remaining FAQs would not be relevant.

Q3. Does the availability of 100 percent FMAP depend on whether the service furnished by the non-IHS/Tribal provider is billed directly by the non-IHS/Tribal provider or by the IHS/Tribal facility?

A3. No. If all of the requirements of the SHO letter are met, then federal matching funds are available to the state at the 100 percent rate for the amount paid by the state Medicaid program, regardless of whether the service is billed directly by the non-IHS/Tribal provider or by the IHS/Tribal facility. This is a separate issue than the amount paid by the state for the service, which will depend on the provider type and service rendered.

Q4. When may IHS/Tribal facilities claim services furnished by non-IHS/Tribal providers delivering services offsite under written care coordination agreements as IHS/Tribal facility services at the facility rate?

A4. As stated in the SHO letter, the circumstances under which IHS/Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, clinics, Federally Qualified Health Centers, etc.). For IHS facilities, services furnished by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. For Tribal facilities, whether services furnished by non-Tribal providers can be billed as facility services depends on whether the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services" or as a Federally Qualified Health Center (FQHC). If the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services", the Tribal facility may not bill for the services furnished outside the facility by a non-Tribal provider at the facility rate for clinic services even if a written care coordination agreement is in place. The reason is that, as CMS has interpreted section 1905(a)(9) of the Social Security Act in its regulation at 42 CFR 440.90, "clinic services" do not include services furnished outside of the "four walls" of the clinic, except if the services are furnished by clinic personnel to a homeless individual. If, on the other hand, the Tribal facility is enrolled in the state Medicaid program as an FQHC, and if the Tribal facility has a contract in effect with the non-Tribal provider, the Tribal facility may properly claim payment for services furnished outside of the facility by the non-Tribal provider at the facility rate. For example, if a Tribal FQHC contracts with a cardiologist whose practice is offsite, and if the cardiologist treats an AI/AN Medicaid beneficiary as a patient of the FQHC, the Tribal facility may bill the Medicaid program for the cardiologist's service at the facility rate, not at the Medicaid rate for that cardiologist's service, and 100 percent FMAP would apply to the state's payment for the service. A Tribal facility that is enrolled as a "clinic services" provider may enter into a written care coordination agreement with an off-site non-Tribal provider and bill the state Medicaid program for the services furnished as an assigned claim by that provider, but the payment rate for the service would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan Tribal facility rate.

Q5. Does the contract between a Tribal FQHC and an offsite non-Tribal provider need to meet the requirements of the written care coordination agreement under the SHO letter in order for the Tribal FQHC to bill the state for the services furnished to Medicaid beneficiaries at its facility rate?

A5. No. The contract between the Tribal FQHC and the offsite non-Tribal provider for this kind of arrangement is different than a written care coordination agreement; it must establish that the non-Tribal provider is a Tribal facility contractor furnishing services of the facility offsite. Since the services would be services of the Tribal facility for purposes of this Medicaid billing policy, we would expect that the Tribal facility would coordinate and monitor such services in the same manner as it does any other facility services. The amount paid by the state for these Tribal FQHC services to an AI/AN Medicaid beneficiary would qualify for 100 percent FMAP.

Q 6. For what services may a Tribal FQHC contract? If the contracting offsite non-Tribal provider is a specialist, may the services qualify as FQHC services?

A6. Yes. FQHC services are defined in section 1905(l)(2)(A) of the Social Security Act as "services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as a patient of a Federally-qualified health center…." Section 1861(aa)(1)(A) describes "physicians services", which include services furnished by specialists as well as those furnished by primary care physicians. As discussed in FAQ #4, above, **t**he Tribal FQHC may bill for the services furnished by the contracting non-Tribal specialist at the Tribal FQHC's facility rate, and the amount paid by the state for the FQHC service would qualify for 100 percent FMAP. For example, a Tribal FQHC could contract with a neurologist or orthopedist or dentist and bill for the services provided by those specialists at their offsite practice locations at the Tribal FQHC's facility rate.

Q7. Most Tribal facilities are now enrolled in state Medicaid programs as "clinic services" providers. As explained in A4, if these Tribal facilities seek to bill for services furnished by off-site non-Tribal providers at the facility rate, they will have to bill for those services as FQHCs, not as "clinic services" providers. How does a Tribal facility change its provider enrollment designation to FQHC?

A7. Under section 1905(l)(2)(B) of the Social Security Act, outpatient health programs or facilities operated by a Tribe or Tribal organization under the Indian Self-Determination Act (Public Law 93-638) are by definition FQHCs. Tribal facilities may enroll in state Medicaid programs as FQHCs, but they are not required to do so. A Tribal facility that elects to enroll in a state Medicaid program as an FQHC bills Medicaid for covered services on a per-visit basis at a rate determined by the state Medicaid program using the Prospective Payment System (PPS) methodology, whether those services are furnished at the facility or by off-site providers under contract to the FQHC. The decision as to whether to enroll in the Medicaid program as a "clinic services" provider (to the extent that the state plan covers the optional clinic services benefit) or as an FQHC is solely that of the Tribal facility. Tribal facilities that wish to bill for services furnished to their AI/AN patients outside of their "four walls" will need to change their provider enrollment designation from "clinic" to FQHC by notifying their state Medicaid agency. The state will then need to determine the applicable FQHC payment rate under its state plan. The treatment of tribal clinics as FQHCs without any change in actual provider enrollment for purposes of the eligibility of physicians for Electronic Health Record (EHR) Incentive Payments, as indicated in a June 17, 2011 CMCS Information Bulletin, is not applicable for purposes of determining facility payment under the state plan.

Q8. Does a Tribal facility that wishes to change its provider enrollment designation to FQHC need to enroll in Medicare as an FQHC?

A8. No. An outpatient health program or facility operated by a Tribe or Tribal organization under P.L. 93-638 is qualified under the Medicaid statute to participate as an FQHC. There is no requirement that the facility enroll as an FQHC under the Medicare program. For purposes of being recognized as an FQHC by Medicaid, Tribal facilities need not meet any requirement other than being operated by a Tribe or Tribal organization under P.L. 93-638.

Q9. Does a Tribal facility that wishes to change its provider enrollment designation to FQHC need to meet the requirements for receipt of grant funds under section 330 of the Public Health Service Act or for designation as a "look alike" by the Health Resources and Services Administration (HRSA)?

A9. No. The Medicaid FQHC status of an outpatient health program of facility operated by a Tribe or Tribal organization under P.L. 93-638 is specified in the Medicaid statute. HRSA rules for receipt of section 330 grant funding or "look alike" status do not apply. A Tribal facility may in addition choose to apply for section 330 grant funding or for designation as a "look alike;" in this case, it must meet the relevant HRSA requirements. For purposes of being recognized as an FQHC by Medicaid, however, Tribal facilities need not meet any requirement other than being operated by a Tribe or Tribal organization under P.L. 93-638.

Q10. If a Tribal facility elects to enroll in the Medicaid program as an FQHC, what is its facility rate?

A10. In general, FQHCs are paid at rates that are based on the Prospective Payment System (PPS) methodology. However, under the authority of section 1902(bb)(6) of the Social Security Act, state Medicaid agencies and FQHCs have the ability to agree to use an Alternative Payment Methodology to determine rates. Under this authority, Tribal facilities and the state Medicaid agency may agree that the Tribal provider's facility rate is the IHS All-Inclusive Rate (AIR) rather than the Tribal provider's PPS rate. The AIR rate would apply to all of the Tribal facility's Medicaid visits, not just those by AI/AN Medicaid beneficiaries; the 100 percent FMAP would apply only to the costs of facility visits by AI/AN beneficiaries.

Q11. May a State pay a Tribal facility at the AIR rate for services furnished to AI/AN beneficiaries and at the FQHC PPS rate for non-AI/AN beneficiaries?

A11. No. A Tribal facility may be only one type of provider (either a "clinic services" provider or an FQHC) and receive only one reimbursement rate that applies to all Medicaid beneficiaries. Whatever rate a Tribal FQHC facility and the state Medicaid agency agree upon, whether PPS or AIR, that same rate must be applied to all Medicaid beneficiaries who receive services through the facility.

Q12. What must the state Medicaid agency do to operationalize this change in provider enrollment designation?

A12. If a Tribal facility is enrolled in the state Medicaid program as a "clinic services" provider, and notifies the state agency that it wishes to change its designation to an FQHC, the state Medicaid agency must simply change the designation of the facility in its Medicaid Management Information System (MMIS) from clinic services provider to FQHC. The Tribal facility is not required to re-enroll in the program, and the state Medicaid agency is not required to process a new enrollment or re-screen the

facility. If the state Medicaid agency and one or more Tribal FQHCs agree to use the IHS AIR rate as the facility rate, the state agency will have to submit a state plan amendment (SPA) to designate payment for Tribal FQHC services at the IHS AIR as an Alternative Payment Methodology. The Medicaid agency will also be required to assign a PPS rate to the Tribal facility so that the agency can demonstrate on an annual basis that the APM is higher than the PPS rate. The Tribal facility would not be required to report its costs for purposes of establishing a PPS rate. Under 42 CFR 430.20(b)(2) and 42 CFR 447.256(c), an approved SPA will be effective not earlier than the first day of the calendar quarter in which an approvable amendment is submitted.

Q13. Some Tribal facilities enrolled in state Medicaid programs as "clinic services" providers have been billing at facility rates for services that are furnished by facility employees or non-Tribal providers outside the "four walls" of the facility (for example, behavioral health services provided to children in schools). Will CMS seek to recover overpayments from state Medicaid programs that pay for such "clinic services" at facility rates or from the Tribal facilities that bill for such "clinic services" at facility rates?

A13. As noted in Q4 above, the Medicaid statute and regulations require that "clinic services" be provided at the clinic – i.e., within the "four walls" of the facility – unless the beneficiary is homeless. Services furnished outside of the "four walls," even services furnished by an off-site non-Tribal practitioner under a written care coordination agreement that meets the requirements of the SHO letter, may not be billed as "clinic services" or reimbursed at the facility rate (unless the beneficiary receiving the service is homeless). CMS recognizes that it has not given tribal-specific guidance on this issue or outreach, and that as a result policies and practices vary. CMS further recognizes that some states and tribes will need to make legislative or regulatory policy changes, provide public notice, define services, make systems changes, and potentially make programmatic and staffing changes. For this reason, CMS has no present intention to review claims by Tribal "clinic services" providers for services furnished outside of the "four walls" before January 30, 2021 unless there is clear evidence of bad faith efforts to engage in improper claiming procedures in violation of this guidance. Tribal facilities that are enrolled in Medicaid as "clinic services" providers and bill for services furnished outside the "four walls," whether by facility employees or by non-Tribal providers under contract, will either need to discontinue billing for those services or change their enrollment status to FQHC before that date. If a Tribal facility wishes to change its enrollment status to FQHC, it should notify the state Medicaid agency of its intent to change its status no later than one year from the date of this letter. Tribal facilities that are enrolled in Medicaid as "clinic services" providers that do not bill for services furnished outside the "four walls" will not need to change their provider enrollment status.

Q14. In many IHS areas, the IHS or Tribes operate a hospital that has remote health centers or health stations on the reservation affiliated with it that bill for their services to AI/AN Medicaid beneficiaries through the hospital. Do the rules described above relating to "clinic services" apply to these health centers or clinics?

A14. In most cases, these health centers or health stations participate and are enrolled in Medicaid as outpatient departments of the hospital, not "clinic services" providers. The hospital, and not the health center or health station, would bill for the services furnished at the remote site as a hospital outpatient service. Hospital services are not affected by the "four walls" limitation on the "clinic services" benefit.

Q15. What billing and payment rules apply if the AI/AN Medicaid beneficiary is enrolled in a Medicaid managed care plan?

A15. The previous FAQs assume that the AI/AN Medicaid beneficiary is receiving services on a fee-for-service basis. In the case of beneficiaries that are enrolled in a Medicaid managed care organization (MCO), a prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), the following rules apply. As set forth in the SHO letter on page 6, the non-IHS Tribal provider with a care coordination agreement would have to participate in the MCO's or PIHP's or PAHP's provider network and would have to be paid at a rate consistent with the provider's contractual agreement with the managed care plan. However, if the Tribal facility elects to enroll in the state Medicaid program as an FQHC, the Tribal FQHC may properly bill the MCO for services furnished by a non-Tribal provider with which it contracts as a facility service. The rate of payment to the Tribal FQHC by the managed care plan would be the amount the plan pays an FQHC that is a network provider. The FQHC may also be entitled to a supplemental payment from the State Medicaid agency as required under sections 1902(bb) and 1932(h)(2)(C)(i) of the Social Security Act. This payment rule applies whether or not the Tribal facility participates in the provider network of the MCO, PIHP, or PAHP.

5E

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20857

MAR 2 8 2017

Dear Tribal and Urban Indian Organization Leader:

I am committed to ensuring transparency and accountability at the Indian Health Service (IHS). To that end, I want to address a subject I've received many questions about: the perception that the IHS is returning a significant amount of unused money to the United States Treasury each year.

Let me say clearly: the IHS is not returning a significant amount of money to the Treasury. Furthermore, the IHS remains committed to continually improving Agency financial management to ensure that we are good stewards of Federal resources and funds are being used efficiently to carry out our mission, which is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

To clarify this issue, it is important to first understand the source of the IHS's funds. The IHS receives two types of money that finance our operations:

- Third-Party Collections – funds we collect from Medicare, Medicaid, the Veterans Administration, and other responsible or liable third parties for care and services furnished to our patients; and

- Federal Appropriations – funds provided by the Congress to fund our services and facilities.

Collections are straight forward – they are available until they are spent, must be spent at the Service Unit/facility where they were earned, and are never returned to Treasury. Any unused balances remaining at the end of one fiscal year (FY) are carried over to the next FY to continue funding hospital and clinic operations and may also fund facility repairs or renovations that could not be purchased in the prior FY (although Medicare and Medicaid collections must first be used to achieve compliance with such programs in accordance with appropriations acts). We monitor these funds regularly to ensure balances are not excessive.

Federal appropriations are more complex. We receive two types of appropriated funds: 1) funds that are available for use for only a single FY; and 2) funds that are available until expended. Funds that are available until expended are never returned to the U.S. Treasury, with balances carrying over year-to-year similar to our collections. Funds that are appropriated and available until expended provide resources for the following: health care facility construction; sanitation facility construction; environmental health; equipment; maintenance and improvement; Purchased/Referred Care (PRC); the Methamphetamine and Suicide Prevention Initiative; the Domestic Violence Prevention Initiative; scholarship and loan repayment programs; and the Special Diabetes Program for Indians. The balances carried over year-to-year are driven by business necessity.

Here are two examples:

- Service Units are encouraged to administer their PRC funds with a 10-12 percent carryover each FY, which provides stable funding for this activity year round.
- Facility fund balances may temporarily build up as projects proceed through the planning process – these are purposefully increased unobligated balances that are part of the multi-year facility planning process. Facility fund balances will be drawn down as we initiate new facility construction, renovation, or expansion.

While balances in these funds may fluctuate year to year, the IHS does not bank increasing amounts of funding year to year, nor are we maintaining balances in these accounts beyond what we can use within a reasonable period of time.

The other type of federally appropriated funds we receive are annual, or single-year, appropriations. These provide the bulk of our appropriated funding for health services, such as clinical services, preventive health care, contracts and grants to Urban Indian Organizations, as well as contract support costs (CSC)[1] for Tribes conducting their own health care programs under Indian Self-Determination and Education Assistance Act (ISDEAA) authorities.

Annual appropriations are the most typical type of funding provided by Congress and are available for new spending only for a particular FY (October 1 through September 30), meaning that at the close of each FY, on September 30, the IHS loses the use of a particular FY's funding for making new obligations. However, by law, after a FY's funding expires, it remains in an agency's accounts for 5 years to be expended, essentially remaining to cash the "checks" the agency wrote during that FY. During this period of time, balances will typically increase as small sums of money are returned from purchases and contracts we made where the amount utilized or the ultimate cost was less than estimated when we originally purchased the item or service. This is a routine process throughout the Federal Government. When this 5-year period closes, the IHS is required to return any remaining annual funds to the U.S. Treasury. As previously stated, the IHS cannot legally use these funds for new obligations at any time during this 5-year period.

For example, at the end of FY 2016, the annual funds appropriated for FY 2011 reached the end of their 5-year adjustment period, officially expired, and remaining balances were returned to the U.S. Treasury. Congress originally appropriated $2,818,256,892 for FY 2011, and as of September 30, 2011, the close of FY 2011, the IHS had just $58,684[2] not yet obligated, or spent.

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[1] Starting in FY 2016, the IHS received a separate, indefinite annual appropriation for CSC. This type of appropriation includes an unspecified amount to cover the full CSC need of all ISDEAA agreements for the single FY. At the end of the FY for which funds were appropriated, the amount spent on CSC becomes the appropriated amount. In other words, Congress and the U.S. Treasury provide exactly the amount needed for CSC, so there are no unused balances.

[2] IHS records include a $5,660,256 accounting transaction to reconcile Agency accounting books with those of the U.S. Treasury. This transaction was reversed in subsequent accounting activity and is not reflected in the amount returned to the U.S. Treasury.

This figure represents 0.002 percent of the total funds provided by Congress. After 5 years of close out work, on September 30, 2016, the IHS returned to the U.S. Treasury $3,818,000, about 0.14 percent of the total annual appropriations funding provided for FY 2011 activities.

Total annual appropriations returned by the IHS to the U.S. Treasury at the close of each expenditure period from FY 2006 through FY 2011 include the following:

FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
$1,620,000	$787,000	$2,920,000	$1,562,000	$2,289,000	$3,818,000

These returns represent just a fraction of a percent of the IHS's total appropriated funding, and the IHS generally spent its appropriations during the period of time for which Congress allowed the IHS to enter into obligations and make expenditures with the funding.

The Federal funding process can be very complex and technical, and is easily misunderstood. I can assure you, however, that the IHS is doing our best to make full use of the funds provided by Congress.

We are working hard to continue improving our financial planning processes and systems, to ensure our finances are transparent and accountable. This FY, we began implementation of a standardized and more automated process for financial planning, which builds on existing planning activities to strengthen accountability within all levels of the Agency and promote a more coordinated approach.

Thank you for your continued partnership and support in improving the quality of care provided to American Indians and Alaska Natives.

Sincerely,

RADM Chris Buchanan, R.E.H.S., M.P.H.
Assistant Surgeon General, USPHS
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECRETARY'S TRIBAL ADVISORY COMMITTEE

March 21, 2017

The Honorable Tom Price
Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Secretary's Tribal Advisory Committee Follow up items from March meeting

Dear Secretary Price,

On behalf of the Secretary's Tribal Advisory Committee (STAC), we thank you and your staff for the productive meeting that was held from March 7-8, 2017. We appreciate your commitment to Indian Country and recognition of the value of partnership with the Tribes as the Department of Health and Human Services (HHS) moves forward under this new administration. We look forward to continuing to meet with you and agency leadership to hear our concerns and address key issues in a responsive and transparent manner.

The following letter presents the STAC's key priorities for this year and provides more information on some of the topics we discussed in March. We hope to work with you to advance these issues in a collaborative and meaningful way.

Continued Commitment to Tribal Consultation and Nation-to-Nation relationship between Tribes and the United States.

The principles that shape American Indian law are sovereignty, the Federal-to-Tribe (government-to-government) relationship, and the "Trust Responsibility" of the U.S. Government to Indian Tribes. Indian Tribal governments are indigenous governments that possess a unique government-to-government relationship with the United States. Indian Tribes are part of the constitutional structure of government. Tribal authority was not created by the Constitution—Tribal sovereignty predated the formation of the United States and continued after it (Article 1, Section 8, Clause 3 of the U.S. Constitution). "*Indian relations are … the exclusive province of Federal law*." (County of Oneida v. Oneida Indian Nation, 470 U.S. 226, 234 (1989), making the unique status of Indian Tribes and the government-to-government relationship with the Federal Government clear.

The U.S. Supreme Court has repeatedly recognized Tribal sovereignty in court decisions for more than 150 years. In 1831, the Supreme Court agreed, in Cherokee Nation v. Georgia, that Indian nations had the full legal right to manage their own affairs, govern themselves internally, and engage in legal and political relationships with the federal government and its subdivisions. In 1942 Supreme Court Justice Felix Cohen wrote, "*Indian sovereignty is the principle that those powers which are lawfully vested in an Indian tribe, are not delegated powers granted by express acts of Congress, but rather inherent powers of a limited sovereignty which can never be extinguished*."

Tribal governments' special political status is not that of a racial or ethnic group, nor are they associations or affiliations. Accordingly, the federal government has a duty to consult with Indian Tribes on federal policies with implications for the Indian health care delivery system. This consultation requirement, rooted in Tribal sovereignty, treaty rights, the government-to-government relationship, and the Trust responsibility, is reflected in federal policy and is confirmed in the HHS Tribal Consultation Policy.

- Tribes must have timely written notice before the federal government can move forward with new policies that have Tribal implications. Tribal implications refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effect on one or more Tribes, on the relationship between the federal government and Tribes, or on the distribution of power and responsibilities between the federal government and Tribes.
- Consultation must take place prior to the rulemaking process.
- Continue to meet with the STAC and other Tribal advisory committees within HHS to gather feedback and input on the development of policies that impact Tribal communities.
- The White House Council on Native American Affairs should continue to work on Health and Human Service issues and we welcome your support in working with other departments across the federal government to address American Indian and Alaska Native health challenges.

Challenges for Federal Funding for Indian Health Beyond IHS including Administration for Children and Families (ACF)

Tribes and Tribal organizations receive a disproportionately low number of Department of Health and Human Services (HHS) grant awards. For instance, while Tribal children make up 2% of the United States population, Tribes receive less than 0.5% of federal child welfare funds. Several significant obstacles impair Tribes' ability to receive adequate funds for these programs.

First, program funding awards are predominately made by competitive grants, which prejudices against Tribes with less capacity to compete for funds, and requires finite terms in the award of funds that interrupts the delivery of program services and discontinuity in program effectiveness.

Second, programs predominately require large matching contributions of non-federal shares by Tribal governments, ranging from 20% to 50% of the funding award. Many Tribes have limited or no discretionary, unencumbered Tribal funds sufficient to provide the required contribution. Tribes should not be required to contribute such a large amount of its own funds to operate federal programs that are a duty of the federal trust responsibility. For example, the Child Support Enforcement program requires Tribes to contribute up to 20% of the program award.

Third, certain federal programs limit the recovery of indirect costs against program funds to a small percentage that in almost all instances is much less than the Tribes' indirect cost rate percentage that requires full recovery at the federally approved rate or else Tribes must reconcile the shortfalls of recoveries from their own funds. For example, the TANF program "caps" indirect rate recoveries at 20%, when Tribal indirect cost rates are mostly well above this percentage.

Fourth, block grant funds typically flow directly to states who then must pass funding on to Tribes. Sadly, these funds often do not make it to the Tribal level. According to a report issued by the Congressional Research Service (CRS) in June 2013, there are 22 funded block grants. HHS administers 10 of these

programs, but where states must "pass through" funds Tribes are often left out, despite eligibility. For example, Tribes are eligible to receive the Preventative Health and Health Services Block Grant, Administered by the Centers for Disease Control and Prevention (CDC). It funds all 50 states, eight U.S. territories, but only two Indian Tribes. In several block grants, Tribes are not eligible to receive any federal funds, such as the Social Services Block Grant and Community Mental Health Services Block Grant, and few, if any, states actually pass through any funds to Tribes while using their numbers to establish their federal allocation. Without having a state intermediary, Tribes would not only receive more adequate funding but could more easily tailor program needs to their people. Therefore, we request that HHS:

- Provide an administrative waiver of support legislation to remove statutory requirements for competitive grants, Tribal non-federal contributions to program awards, and limits on Tribal direct cost rate percentages against program funds.
- Work with Congress to ensure that health and human services programs throughout HHS have set-asides for Tribes and Tribal organizations, and increase the Tribal set-aside for Child Care.
- Facilitate and require that states receiving federal funds engage in Tribal consultation prior to the submission of state grant proposals to the federal government.
- Despite having some of the worst health disparities in the country, many Tribes are under-resourced to search for and apply for federal grants, whereas states and local governments often employ hundreds of staff to seek funding opportunities. We ask that you take the limited capacity of Tribes into consideration when reviewing grant applications across all agencies at HHS.

Expansion of ISDEAA Self-Determination Agreements and PL 477

The Indian Self-Determination and Education Assistance Act (ISDEAA) of 1974, and 1995 amendments, is the basis for the most successful federal Indian policy of modern times by authorizing Tribal governments' self-governance compacts and 638 contracts of federal programs. While ISDEAA compacts and contracts are mandatory within the Bureau of Indian Affairs (ISDEAA Title IV) and Indian Health Service (ISDEAA Title V), it is discretionary for the Department of Health and Human Services outside of IHS. Similarly, PUBLIC LAW 102-477 allows Federally Recognized Tribes and Alaska Native entities to combine Federal employment and training formula-funded grant funds. Tribes and the STAC have long advocated for HHS interpretations that would add programs to the PL 477 program, such as Low Income Heating Energy Assistance Program (LIHEAP). Therefore, we request that HHS:

- Add ACF programs to ISDEAA compact or 638 contract agreements.
- Add LIHEAP, Head Start and other related programs to the PL 477 program.

Assistance in Treating Opioid Abuse and Addiction

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.

- Does HHS have a plan to address the opioid epidemic in Tribal communities? If not, STAC would like to work with HHS to develop one.
- How will HHS ensure that funding and resources meant to address the national opioid epidemic 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?
- We suggest that HHS lead an effort with IHS, CDC, SAMHSA, NIH, and Tribes to develop a demonstration project targeted for Tribal communities and addressing opioid abuse and addiction in particular using the consolidation of funding tools established as successful with the 477 program.

Quality Care Challenges at IHS

Several Indian Health Service (IHS) operated hospitals continue to experience serious violations of patient welfare and safety which not only endangers lives of patients but also results in but diminished care and loss of critical third party revenues. In fact, some of these deficiencies have been identified for years, but the situation in certain IHS-operated facilities has not improved. This situation is unacceptable to the STAC and we urge you to do all in your power to see these situations rectified immediately. Recently, Senator Rounds introduced legislation to provide for a comprehensive audit of the Indian Health Service. In addition, the GAO recently released a report adding IHS to the list of high-risk agencies. While we appreciate the federal government's interest in addressing some of the challenges at IHS, we urge strong caution and request that Tribes be consulted in these efforts moving forward so that effective and lasting change occurs.

- What is the plan for HHS to provide leadership to address some of the quality care issues happening at IHS?
- How is IHS working to directly answer questions posed by Tribes and Congress concerning its efforts in the Great Plains Area?
- 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 immediately
- 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 executive and service unit level?
- While the STAC appreciates the exemptions for some IHS positions from the federal hiring freeze, we request that exemptions also be provided for some of the high level administrative positions including the Area Directors in order to provide stable leadership during this time of reform at the agency. Further the resources required for the Area Directors to conduct Tribal consultation is an important and relevant requirement and should not be diminished.

Continued Support for SDPI

The Special Diabetes Program for Indians (SDPI) was started in 1997 to provide funding to IHS, Tribal health programs, and Urban Indian Programs to implement interventions which reduce risk factors for

diabetes and its complications, including End-Stage Renal Disease. The program has proven a success and today this comprehensive public health-oriented national program has shown great strides in treating the diabetes epidemic and reducing complications from End-Stage Renal Diseases. In January, the CDC released its Vital Signs Monthly report where they found that between 1996 and 2013, among AI/AN adults with diabetes, End-Stage Renal Disease incidence decreased by 54%, which is the biggest driver of Medicare costs. SDPI is a model program that demonstrates the effectiveness of collaboration between Tribes and IHS by being community-driven and culturally appropriate. Its success cannot be denied and its operation should be continued and modeled by other programs.

- SDPI is set to expire on September 30, 2017. We request that HHS work with Congress to ensure that this legislation is renewed.
- SDPI is an example of true Tribal consultation and collaboration and we request that HHS use it as a model for other programs to address the extreme health disparities suffered by AI/ANs.

Maintain Medicaid Payments and Protections for Tribes and American Indians and Alaska Natives

In 1976, Congress amended the Social Security Act to authorize Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated health care facilities, recognizing that the trust responsibility for health was not limited to just the Indian Health Service but extended to the entire federal government. Medicaid reimbursements are critically important in filling the gap created by chronic underfunding of IHS, and are a critical source of funding for IHS, Tribal health programs and Urban Indian health programs. While we understand that any changes to the laws authorizing these health insurance programs are done through Congress, we appreciate the federal government's commitment to honoring its trust responsibility in advocating for American Indian and Alaska Native protections and trust that HHS, as well as CMS, will consult with Tribes on any changes in regulations and policies.

- Retain eligibility under Medicaid to all American Indians and Alaska Natives up to 138% of the Federal Poverty level (FPL).
- Maintain or strengthen affordability of individual market (e.g. Marketplace) coverage for American Indians and Alaska Natives.
- Ensure the trust responsibility for Indian health care remains a federal responsibility and is not shifted to the states.
- Maintain 100% Federal Medical Assistance Percentage (FMAP), plus the reimbursement rates for services at the OMB rates published annually in the Federal Register for inpatient and outpatient facilities and give full effect to CMS's recent State Health Official Letter
- Ensure Medicaid payments to the Indian health care system are not subject to a block grant or per capita cap.
- Preserve American Indian and Alaska Native specific provisions in Medicaid, including protections from premiums and cost sharing, prohibition of classifying trust lands and cultural and religious items as resources for eligibility purposes, and other protections.
- Extend and apply these provisions to urban Indian health care programs (UHPs) whenever permissible under federal law.

Conclusion

In conclusion, we would like to reiterate our appreciation for your willingness to work with us and for your prioritization of issues in Indian Country. We look forward to continuing a strong relationship with you and to hearing your response to these requests.

Sincerely,

Chester Antone
Chairperson
Secretary's Tribal Advisory Committee

Community Emergency Preparedness Assessment Project

April 18, 2017

NPAIHB Quarterly Board Meeting

Goals of Today's Presentation

Provide an overview of the AIHC's Community Emergency Preparedness Assessment Project

Invite delegates to share information and encourage Washington state tribes to participate in the project

BACKGROUND

AIHC's Tribal Community Emergency Preparedness Toolbox

Background

- In 2014, AIHC hosted a series of 8 regional meetings with tribes
  - 59 representatives from 24 tribes participated
- Tribal representatives identified the need for technical assistance to better understand what components are needed to prepare their communities for public health emergencies and other disasters (for example, plans training, equipment, etc.)

- In 2016, the AIHC developed a toolbox designed specifically for tribal communities to:
  - Assess their preparedness status
  - Document assets and identify gaps
  - Plan strategies to strengthen community preparedness

Emergency Preparedness

What is in the Toolbox?

- AIHC Tribal Community Emergency Preparedness Self-Assessment
- AIHC Asset Map and Gap Analysis Workbook
- Resources
  - Models and Examples
  - Tools
  - Training

- http://www.aihc-wa.com/aihc-health-projects/community-preparedness-toolkit/

AIHC Community Emergency Preparedness Assessment Project

Project Goal:

The project's goal is to assist 2 Washington state tribes in strengthening their preparedness status, by facilitating a process to document community assets, identify gaps, and develop plans to strengthen capabilities.

Approach

1. Announce the opportunity to tribes
2. Request statements of interest from tribes
3. Select 2 tribes

Approach (continued)

4. Facilitate a series of meetings with each tribe's community preparedness leadership group, using the AIHC Tribal Community Preparedness Toolbox to complete:

    - AIHC Tribal Community Emergency Preparedness Self-Assessment, and
    - AIHC Asset Map and Gap Analysis Planning Workbook

To Participate

Step 1:

- Establish Tribal Government's support for engaging in the project

Step 2:

- Identify the members of your Community Preparedness Leadership Group

Step 3:

- Complete the Statement of Interest

Step 4:

Submit the Statement of Interest

STATEMENT OF INTEREST TO PARTICIPATE IN AIHC's COMMUNITY EMERGENCY PREPAREDNESS SELF-ASSESSMENT PROJECT
Tribe:
Primary Project Contact Name and Title:
Primary Project Contact Email and Phone Number:
Tribal Council Authorized Approval Signature:
Tribal Council Approving Official's Name and Title:
Names and Titles of Tribal Leadership Group Members:

The “Asks”

1. Please share materials with others at your tribe (Tribal Council, Medical Directors, Clinic Managers, Emergency Managers, Planning Directors, etc.)

2. Please complete the “Statement of Interest”

QUESTIONS?

AMERICAN INDIAN HEALTH COMMISSION
MUTUAL AID AGREEMENT PROJECT

2017

AIHC Mutual Aid Project

The American Indian Health Commission (AIHC) will facilitate a collaborative process to develop Mutual Aid Agreements (MAAs) between interested tribes and local health jurisdictions in Washington's Public Health Emergency Planning Regions 1 and 3. The project will also facilitate a process to revise the operational plan for Region 2's existing Tribal-Public Health Mutual Aid Agreement. Funding for the project comes from Tribal Reinvestment Funds from the Washington State Department of Health (DOH) and is set for completion by June 2017.

Project Objectives

- 22 tribes will have had the opportunity to participate in a regional MAA
- Agreements and operational plans that reflect lessons learned by 7 tribes and 3 LHJs (in Region 2) will be in place in 3 Regions
- Training materials will be available online

Region 1

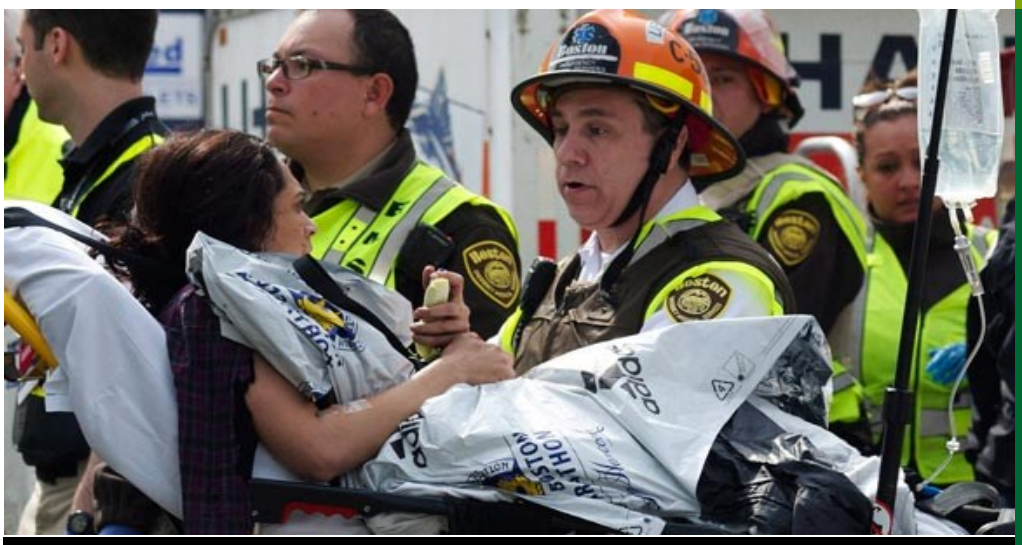
Lummi Nation
Nooksack Tribe
Samish Tribe
Sauk-Suiattle Tribe
Stillaguamish Tribe
Swinomish Tribe
Upper Skagit Tribe
Tulalip Tribe

Region 2

Hoh Tribe
Jamestown S'Klallam Tribe
Lower Elwha Klallam Tribe
Makah Nation
Port Gamble S'Klallam Tribe
Quileute Nation
Suquamish Tribe

Region 3

Chehalis Tribe
Cowlitz Tribe
Nisqually Tribe
Quinault Nation
Shoalwater Bay Tribe
Skokomish Tribe
Squaxin Island Tribe



Planned Coordination Saves Lives

MUTUAL AID AGREEMENTS SAVE LIVES AND PROPERTY

CONTACT: Lou Schmitz, lou.schmitz.aihc@outlook.com

The MAA Project Will

- **Facilitate a process with tribes and local health jurisdictions (LHJs) in Region 2 to revise their operational plan and develop training materials**
- **Facilitate a process with tribes and LHJs in Region 1 and Region 3 to develop MAAs, operational plans, and training materials**

Background

Mutual aid agreements (MAAs) facilitate rapid and effective processes for requesting and offering help, and play a key role in a government's legal preparedness. Since Local Health Officers have no jurisdiction on tribal lands, MAAs establish mechanisms for tribes to delegate or share authority—*if they choose*—during public health emergencies. MAAs are an important tool for tribal governments to maintain maximum control over who provides assistance and what assistance is provided, during community emergencies.

In 2010, the tribes and local health jurisdictions in Region 2 executed a MAA. Since then, the partners have exercised the agreement with test scenarios and activated it in response to real public health incidents. Through these experiences, the tribes and LHJs identified the need to revise the agreement's operational plan. They found the current plan needs to be simplified and made more "user friendly." This project will facilitate a process to revise the plan.

This project will also provide tribes in other regions the opportunity to participate in a regional MAA. The AIHC will facilitate a process in Regions 1 and 3 for interested partners to develop MAAs. Future projects will support the remaining regions in the state, with the goal that all tribes and LHJs have the opportunity to develop regional MAAs.

"I have seen that in any great undertaking it is not enough for a man to depend simply upon himself."

- Lone Man (Isna-la-wica)

Teton Sioux

Project Activities

1. Conduct outreach and site visits to tribes to obtain tribal input
2. Facilitate in-person kick-off meetings with representatives from tribes and LHJs at each region
3. Facilitate ongoing webinar meetings with Region 2 to collaboratively revise operational plan
4. Facilitate ongoing webinar meetings with Regions 1 and 3 to collaboratively develop MAAs and operational plans
5. Develop, distribute, and post training materials for each MAA

CONTACT: Lou Schmitz, lou.schmitz.aihc@outlook.com

AMERICAN INDIAN HEALTH COMMISSION

MUTUAL AID AGREEMENT PROJECT

UPDATE—APRIL 14, 2017

PARTNERS BY REGION

Region 1

TRIBES

Lummi Nation
Nooksack Tribe
Samish Tribe
Sauk-Suiattle Tribe
Stillaguamish Tribe
Swinomish Tribe
Upper Skagit Tribe
Tulalip Tribe

LOCAL HEALTH

Island County
San Juan County
Skagit County
Snohomish County
Whatcom County

Region 2

TRIBES

Hoh Tribe
Jamestown S'Klallam Tribe
Lower Elwha Klallam Tribe
Makah Nation
Port Gamble S'Klallam Tribe
Quileute Nation
Quinault Nation
Suquamish Tribe

LOCAL HEALTH

Clallam County

Kitsap County
Jefferson County

Region 3

TRIBES

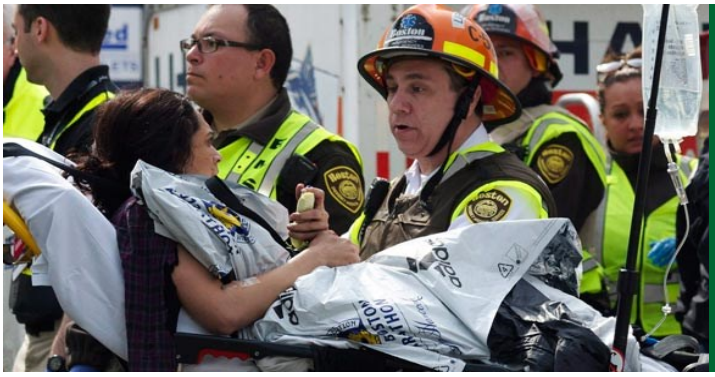
Chehalis Tribe
Cowlitz Tribe
Nisqually Tribe
Quinault Nation
Shoalwater Bay Tribe
Skokomish Tribe
Squaxin Island Tribe

LOCAL HEALTH

Grays Harbor County
Lewis County
Mason County
Pacific County
Thurston County

Project Objectives

- Provide the opportunity for 22 tribes to participate in a regional MAA with tribes and LHJs in their region
- Develop mutual aid agreements and operational plans that reflect lessons learned by the 7 tribes and 3 LHJs in Region 2 and region-specific requirements
- Develop training materials and make available online



MUTUAL AID AGREEMENTS

SAVE LIVES AND PROPERTY

ACTIVITIES COMPLETED

Region 1

MEETINGS

February 22

March 16

PARTICIPATION

Every tribe in the region has participated

Every LHJ in the region has participated

DOCUMENTS

Process review of Operational Plan—on Version 3

Agreement distributed to all partners' legal counsel

In-person tribal legal counsel review

Region 2

MEETINGS

February 15

March 22

PARTICIPATION

6 of 7 tribes in the region have participated

Every LHJ in the region has participated

DOCUMENTS

Process review of Operational Plan—on Version 3

Agreement distributed to all partners' legal counsel

Region 3

MEETINGS

February 28

March 28

PARTICIPATION

Every tribe in the region has participated

Every LHJ in the region has participated

DOCUMENTS

Process review of Operational Plan—on Version 3

Agreement distributed to all partners' legal counsel

NEXT STEPS

MEETING

April 20
Skagit Valley Casino
Concurrent Sessions:
- Tabletop Exercise of Mutual Aid Plan
- Legal Counsel Breakout

LEGAL REVIEW

RESOLUTIONS

MEETING

April 26
Jamestown Red Cedar Hall
Finalize Mutual aid Plan

Revisions

ADOPTION

MEETING

April 27
Chehalis Lucky Eagle Hotel
Finalize Mutual aid Plan
Revisions

LEGAL REVIEW

RESOLUTIONS

TENTATIVE SIGNING CEREMONY WITH DOH SECRETARY, EARLY JUNE

AMERICAN INDIAN HEALTH COMMISSION

COMMUNITY EMERGENCY PREPAREDNESS ASSESSMENT PROJECT

2017

AIHC Community Emergency Preparedness Assessment Project

The AIHC's Community Preparedness Toolbox was designed specifically for tribes, to be used by a Tribal Leadership Group approved by Tribal government. The Leadership Group should have broad representation, from every area of the Tribe's government: Accounting, Early Childhood, Natural Resources, Economic Development, Health, Law Enforcement, Emergency Management, Cultural Resources, and others.

Project Goal

The project's goal is to assist 2 tribes in strengthening their preparedness status, by facilitating a process to document community assets, identify gaps, and develop plans to strengthen capabilities.

Toolbox

The AIHC Tribal Community Preparedness Toolbox is available on the AIHC website at: http://www.aihc-wa.com/aihc-health-projects/community-preparedness-toolkit/

Approach

- Announce the opportunity to tribes
- Request statements of interest from tribes
- Select 2 tribes
- Facilitate a series of meetings with each tribe's community preparedness leadership group, using the AIHC Tribal Community Preparedness Toolbox to complete the AIHC Tribal Community Emergency Preparedness Self-Assessment and AIHC Asset Map and Gap Analysis Planning Workbook

TO PARTICIPATE, COMPLETE THE STATEMENT OF INTEREST ON THE BACK PAGE (TRIBAL RESOLUTION IS OPTIONAL)

CONTACT: Lou Schmitz, lou.schmitz.aihc@outlook.com

STATEMENT OF INTEREST

TO PARTICIPATE IN AIHC's COMMUNITY EMERGENCY PREPAREDNESS SELF-ASSESSMENT PROJECT

Tribe:
Primary Project Contact Name and Title:
Primary Project Contact Email and Phone Number:
Tribal Council Authorized Approval Signature:
Tribal Council Approving Official's Name and Title:
Names and Titles of Tribal Leadership Group Members:

Step 1: Establish Tribal Government's Support for Engaging in the Project

Step 2: Identify the Members of Your Community Preparedness Leadership Group

Step 3: Complete the Statement of Interest

Step 4: Submit the Statement of Interest to:

Lou Schmitz at lou.schmitz.aihc@outlook.com

ATTACH ADDITIONAL PAGES AS NEEDED

Protecting Tribal Communities During and After Disasters through Mutual Aid

April 18, 2017

NPAIHB Quarterly Board Meeting

Goals of Today's Presentation

Provide an overview and update of the AIHC's Tribal-Public Health Mutual Aid Agreement (MAA) Project in Washington State

INTRODUCTION

Mutual Aid Agreements and Tribal Communities

Disasters and Public Health Emergencies are a Fact of Life

1. **Wildfires**, 2015 - burned nearly 250,000 acres of Colville Reservation
2. **OSO Mudslide**, 2014 - Sauk-Suiattle, Stillaguamish, and Tulalip Tribes affected
3. **Measles Outbreak,** 2015 – Clallam County, Lower Elwha Klallam Tribe

"When (Hurricane) Andrew hit (1992), there was no standardized way for states to share resources…It ended up being a midnight phone call between governors. …A lot of legal things had to be done in the middle of the night."

-Amy Hughes

Policy Analyst

National Emergency Association

"Mutual Aid Agreements: Essential Legal Tools for Public Health Preparedness and Response," Daniel D. Stier, JD, and Richard A. Goodman, MD, JD, MPH, *Am J Public Health*; 97: S62.

Preparing for Disasters through Partnerships

What is Mutual Aid?

"the sharing of supplies, equipment, personnel, and information across political boundaries"

"Mutual Aid Agreements: Essential Legal Tools for Public Health Preparedness and Response," Daniel D. Stier, JD, and Richard A. Goodman, MD, JD, MPH, *Am J Public Health*; 97: S62.

Preparing for Disasters through Partnerships

Mutual aid is accomplished by entering into agreements with other jurisdictions.

Why Tribes Need Strong Multi-Jurisdictional Partnerships

- Public health issues, emergencies and disasters know no boundaries
- Public health emergencies and natural disasters can quickly overwhelm the resources of any tribal, local or state jurisdiction

Why Tribes Need Strong Multi-Jurisdictional Partnerships

- Local Health Officers do not have jurisdiction on tribal land
- Federal funding for emergency preparedness and response has steadily declined
- Although some tribes have been developing and adopting public health codes, most tribes have gaps

How a Mutual Aid Agreement Can Benefit Your Tribe

- Supports relationships and systems to quickly and effectively request and receive assistance

- Supports your tribal government in maintaining maximum control over who provides assistance and what type of assistance is provided, during a community emergency

How a Mutual Aid Agreement Can Benefit Your Tribe

- Plays an important role in tribal legal preparedness

- Establishes structured mechanisms for your tribe to delegate or share authority – if you choose - during public health emergencies

EXAMPLE OF A TRIBAL-COUNTY MUTUAL AID AGREEMENT

Olympic Regional Tribal-Public Health MAA

Background
Olympic Tribal-Public Health MAA

WA State's Public Health Emergency Planning Region 2

TRIBES	LOCAL HEALTH DISTRICTS
Hoh Tribe	Kitsap County Health District
Jamestown S'Klallam Tribe	Clallam County Health Dept.
Lower Elwha Klallam Tribe	Jefferson County Health Dept.
Makah Nation	
Port Gamble S'Klallam Tribe	
Quileute Nation	
Suquamish Tribe	

Background
Olympic Tribal-Public Health MAA

- In 2008, Jefferson/Clallam Local Health Officer (LHO), Dr. Tom Locke, and Kitsap LHO, Dr. Scott Lindquist, proposed and supported a project to develop a MAA
- Tribes expressed an interest in exploring the possibility of a MAA
- DOH agreed to support the work

Background
Olympic Tribal-Public Health MAA

- 2008 - Workgroup convened to write the agreement
- 2009 - 7 Tribes in the Kitsap and Olympic Peninsulas and the three Local Health Jurisdictions signed the agreement
- 2010 - Workgroup completed the Operational Plan
- 1st agreement of its kind in United States

OVERVIEW

AIHC MAA PROJECT 2017

Overview of AIHC's MAA Project

AIHC submitted an application for Washington State DOH's Tribal Reinvestment Funds and was approved

Overview of AIHC's MAA Project

OBJECTIVE 1: Revise the existing Operational Plan for Region 2.

Tribes in Region 2:

Hoh
Jamestown S'Klallam
Lower Elwha Klallam
Makah Nation
Port Gamble S'Klallam
Quileute Tribe
Quinault
Suquamish Tribe

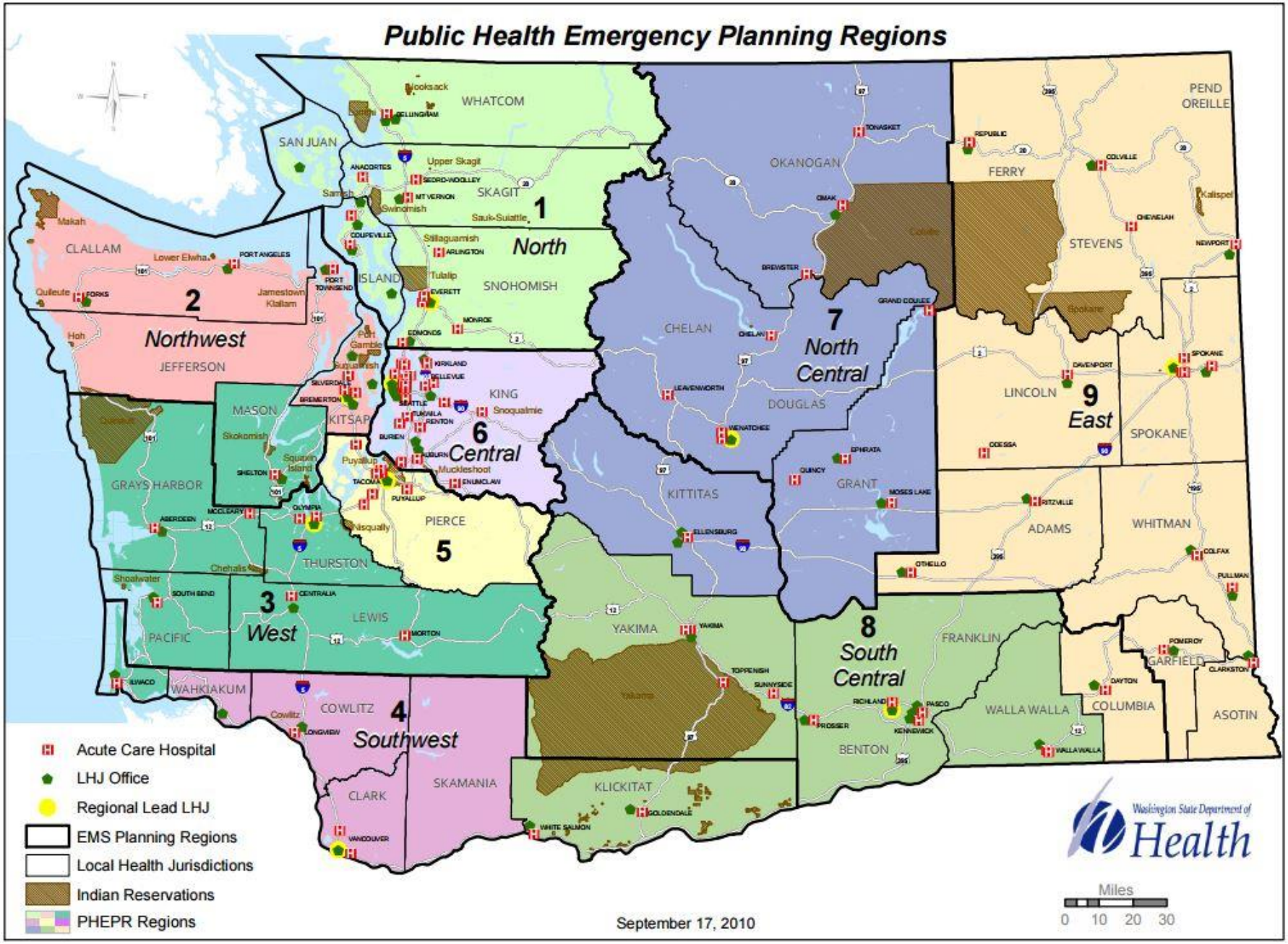
Overview of AIHC's MAA Project

OBJECTIVE 2: Facilitate a collaborative process for tribes and local health jurisdictions in Regions 1 and 3 to develop mutual aid agreements and operational plans.

Tribes in Region 1:	**Tribes in Region 3:**
Lummi Nation **Nooksack Tribe** **Samish Tribe** **Sauk-Suiattle Tribe,** **Stillaguamish Tribe** **Swinomish Tribe** **Tulalip Tribes** **Upper Skagit Tribe**	**Chehalis Tribe** **Cowlitz Tribe** **Nisqually Tribe** **Quinault Nation** **Shoalwater Bay Tribe** **Skokomish Tribe** **Squaxin Island Tribe**

Partners by Region

Region 2	Region 1	Region 3
Hoh Tribe	Lummi Nation	Chehalis Tribe
Jamestown S'Klallam Tribe	Nooksack Tribe	(Cowlitz Tribe)
Lower Elwha Klallam Tribe	Samish Tribe	Nisqually Tribe
Makah Nation	Sauk-Suiattle Tribe	Quinault Nation
Port Gamble S'Klallam Tribe	Stillaguamish Tribe	Shoalwater Bay Tribe
Quileute Nation	Swinomish Tribe	Skokomish Tribe
Suquamish Tribe	Tulalip Tribes	Squaxin Island Tribe
Clallam County LHJ	Upper Skagit Tribe	Grays Harbor LHJ
Jefferson County LHJ	Island County LHJ	Lewis County LHJ
Kitsap County LHJ	San Juan County LHJ	Pacific County LHJ
	Skagit County LHJ	Thurston County LHJ
	Snohomish County LHJ	
	Whatcom County LHJ	


Public Health Emergency Planning Regions
WHATCOM
SAN JUAN
SKAGIT
1
North
CLALLAM
2
Northwest
JEFFERSON
ISLAND
SNOHOMISH
KING
6
Central
MASON
KITSAP
GRAYS HARBOR
PIERCE
5
THURSTON
3
West
LEWIS
PACIFIC
WAHKIAKUM
COWLITZ
4
Southwest
CLARK
SKAMANIA
OKANOGAN
7
North Central
CHELAN
DOUGLAS
KITTITAS
GRANT
PEND OREILLE
FERRY
STEVENS
LINCOLN
9
East
SPOKANE
ADAMS
WHITMAN
YAKIMA
8
South Central
FRANKLIN
BENTON
KLICKITAT
WALLA WALLA
COLUMBIA
GARFIELD
ASOTIN
Acute Care Hospital
LHJ Office
Regional Lead LHJ
EMS Planning Regions
Local Health Jurisdictions
Indian Reservations
PHEPR Regions
September 17, 2010
Washington State Department of Health
Miles
0 10 20 30

Project Activities

- Facilitate in-person meetings at each region with representatives from tribes and LHJs
- Facilitate tabletop exercises to test the Mutual Aid Plans
- Facilitate legal counsel reviews
- Facilitate approval of Mutual Aid Agreements
- Develop, distribute, publish and post training materials for each MAA

Upon completion of the project, AIHC will seek funding to provide the same opportunity to tribes and LHJs in the remaining regions of Washington state

Additional information on the AIHC website under:

- Public Health
  - Emergency Preparedness
    - Mutual Aid Project

Questions?

Hepatitis C Mortality Among American Indians and Alaska Natives in the Northwest, 2006–2012

Sarah Hatcher, PhD
Epidemic Intelligence Service Officer
Northwest Portland Area Indian Health Board

NPAIHB QBM Meeting
April 18, 2017

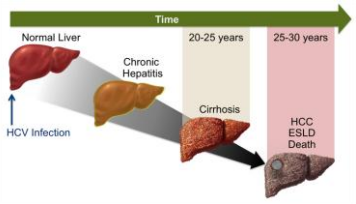
NPAIHB
Indian Leadership for Indian Health

Hepatitis C Virus (HCV) Infection

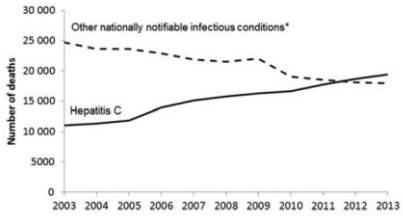
Acute or chronic

75-85% of acute infections become chronic

Increased risk of all-cause and non-liver disease related mortality

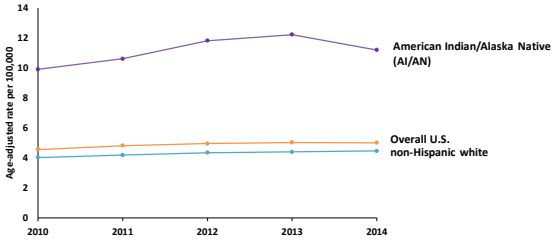


Hepatitis C Mortality is Increasing in the United States

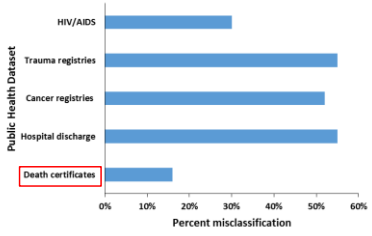


Ly, et al. *CID* 2016

Disparity in Hepatitis C Mortality—United States, 2010–2014



Racial misclassification



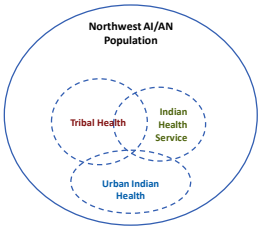
Assess the health disparity in AI/AN hepatitis C-related mortality in the Northwest

Methods

- Idaho, Oregon, and Washington death certificates, 2006–2012
- Corrected for racial misclassification using the Northwest Tribal Registry

Northwest Tribal Registry

A list of AI/AN patients in the Northwest



Methods

- Idaho, Oregon, and Washington death certificates, 2006–2012
- Corrected for racial misclassification using the Northwest Tribal Registry
  - LinkPlus software

Definition of AI/AN Race

A death certificate record listed as AI/AN alone or in combination in death certificate

OR

A death certificate record matched with a patient in the Northwest Tribal Registry

Photo credit: Erik Kakuska

AI/AN Race

Death certificate race/ethnicity	Northwest Tribal Registry Match?	Final Dataset Race/Ethnicity
AI/AN	No	AI/AN
Non-AI/AN	Yes	AI/AN
Missing	Yes	AI/AN

Hepatitis C-Related Death

International Classification of Diseases, 10th Revision codes

Underlying or contributing cause of death	ICD-10 code
Acute Hepatitis C	B17.1
Chronic viral Hepatitis C	B18.2

Mortality Rate and Rate Ratio

- Age-adjusted mortality rate for AI/AN and non-Hispanic whites (NHW) separately
- Rate ratio comparing AI/AN mortality rate with NHW mortality rate

Mortality Rate and Rate Ratio

- Age-adjusted mortality rate for AI/AN and non-Hispanic whites (NHW) separately
- Rate ratio comparing AI/AN mortality rate with NHW mortality rate

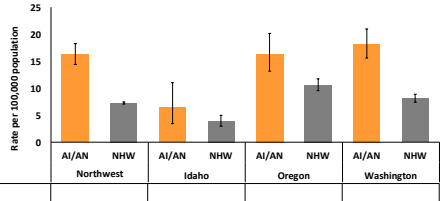
$$\text{Rate Ratio (RR)} = \frac{\text{AI/AN age-adjusted mortality rate}}{\text{NHW age-adjusted mortality rate}}$$

RR > 1 → Mortality rate greater among AI/AN

RR < 1 → Mortality rate greater among NHW

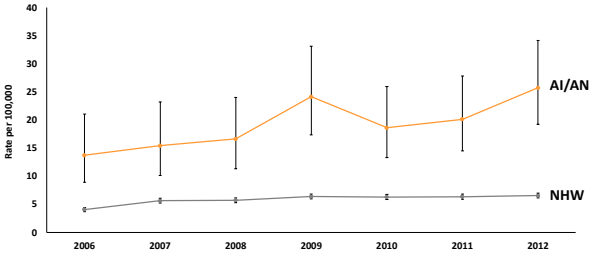
RR = 1 → No difference

Age-adjusted Hepatitis C-related Mortality – Northwest, 2006–2012

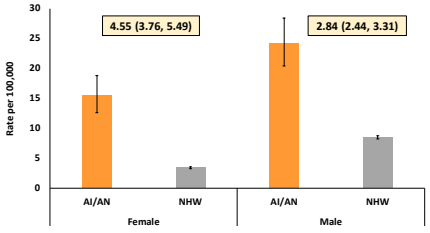


	Northwest	Idaho	Oregon	Washington
Rate Ratio (95% Confidence Interval) AI/AN : NHW	3.33 (2.96, 3.75)	3.22 (1.85, 5.62)	2.52 (2.04, 3.11)	3.88 (3.34, 4.50)

Age-Adjusted HCV-Related Mortality, 2006–2012



Age-Adjusted HCV Mortality Rate, Stratified by Sex



Age-Specific Rates

	AI/AN			NHW			AI/AN:NHW
	n	Rate (95% CI)	Rate Ratios (95% CI)	n	Rate (95% CI)	Rate Ratios (95% CI)	Rate Ratios (95% CI)
Northwest							
≤44	29	2.25 (1.51, 3.23)	Ref	216	0.50 (0.43, 0.57)	Ref	4.50 (3.05, 6.63)
45-54	107	48.6 (39.9, 58.8)	21.6 (14.3, 32.6)	1604	14.9 (14.1, 15.6)	29.8 (25.9, 34.4)	3.26 (2.68, 3.97)
55-64	108	72.1 (59.2, 87.1)	32.0 (21.3, 48.3)	2675	28.3 (27.2, 29.4)	56.6 (49.3, 65.0)	2.55 (2.10, 3.09)
≥65	42	41.7 (30.0, 56.4)	18.5 (11.6, 29.8)	863	8.63 (8.06, 9.22)	17.3 (14.9, 20.0)	2.25 (1.65, 3.07)

HCV Outcomes

Cause	AI/AN		NHW		AI/AN:NHW	
	Count (%)	Rate	Count (%)	Rate	Rate Ratio	95% CI
All HCV-related mortality	286 (100)	19.6 (17.3, 22.2)	5358 (100)	5.88 (5.73,6.05)	3.33	(2.96, 3.75)
Liver failure	69 (24.1)	4.53 (3.48, 5.87)	1086 (20.3)	1.18 (1.11, 1.26)	3.83	(3.00, 4.88)
Cirrhosis	96 (33.6)	6.52 (5.31, 8.11)	1622 (30.3)	1.76 (1.68, 1.85)	3.7	(3.01, 4.54)
Other liver disease	23 (8.04)	1.63 (1.00, 2.58)	333 (6.21)	0.37 (0.33, 0.41)	4.4	(2.88, 6.72)
Hepatitis B	10 (3.5)	0.72 (0.32, 1.46)	140 (2.62)	0.16 (0.13, 0.19)	4.55	(2.39, 8.63)
Primary Liver Cancer	35 (12.2)	2.40 (1.63, 3.47)	936 (17.5)	1.00 (0.93, 1.06)	2.41	(1.72, 3.38)
Other liver cancer	2 (0.7)	0.19 (0.02, 0.77)	79 (1.47)	0.09 (0.07, 0.11)	2.17	(0.53, 8.85)
Alcoholic Liver Disease	81 (28.3)	5.29 (4.15, 6.72)	1297 (24.2)	1.43 (1.35, 1.51)	3.7	(2.96, 4.64)

HCV Outcomes

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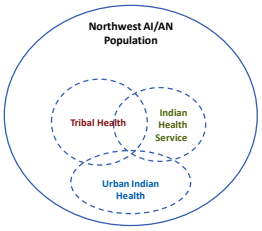
Limitations

Death certificates may underestimate HCV mortality

20%

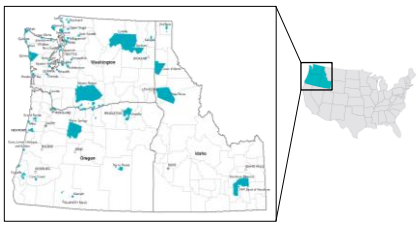
Limitations

Representativeness of Northwest Tribal Registry



Strengths

- Regional analysis
- Data source



Conclusion

- HCV-related mortality is greater among AI/AN compared to NHW
- Health disparity persists over time

Recommendations

Expand access to HCV treatment for American Indians and Alaska Natives

Support providers in the Northwest treating HCV

Photo credit: Erik Kakuska

National Viral Hepatitis Action Plan 2017-2020

GOAL 1 PREVENT NEW VIRAL HEPATITIS INFECTIONS

GOAL 2 REDUCE DEATHS AND IMPROVE THE HEALTH OF PEOPLE LIVING WITH VIRAL HEPATITIS

GOAL 3 REDUCE VIRAL HEPATITIS HEALTH DISPARITIES

GOAL 4 COORDINATE, MONITOR, AND REPORT ON IMPLEMENTATION OF VIRAL HEPATITIS ACTIVITIES

"Expanded access to diagnosis, treatment, and cure"

Acknowledgments

IHS
CAPT Tom Weiser, MD, MPH*

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David Stephens, BSN, RN

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Photo credits:
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NPAIHB

Contact:
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shatcher@npaihb.org

NPAIHB
Indian Leadership for Indian Health

Image sources

- University of Washington, Hepatitis C Online
- Department of Health and Human Services: https://www.hhs.gov/about/budget/fy2017/budget-in-brief/ihs/index.html

HOW to expand HCV treatment for American Indian and Alaska Natives in the Northwest

Jessica Leston, MPH and David Stephens, RN
Northwest Portland Area Indian Health Board
NPAIHB QBM Meeting - April 18, 2017

NPAIHB
Indian Leadership for Indian Health

Recommendations -

- Expand access
- Support providers
- Themes from last CD call

Expand Access

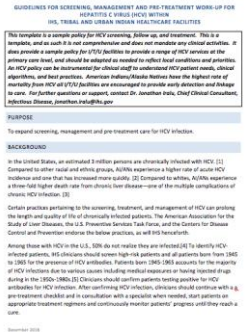
"We are responsible for each other and ourselves" – Alutiiq Cultural Value, Kodiak, AK, United States.

CMOP

Provider Support

- I/T/U screening, treatment and management guidelines
- Flow sheets
- Decision trees
- Treatment Checklists
- Paneling
- ECHO

www.npaihb.org/hcv



GUIDELINES FOR SCREENING, MANAGEMENT AND PRE-TREATMENT WORK-UP FOR HEPATITIS C VIRUS (HCV) WITHIN IHS, TRIBAL AND URBAN INDIAN HEALTHCARE FACILITIES

This template is a sample policy for HCV screening, follow up, and treatment. This is a template, and as such it is not comprehensive and does not mandate any clinical activities. It does provide a sample policy for I/T/U facilities to provide a range of HCV services at the primary care level, and should be adapted as needed to reflect local conditions and priorities. An HCV policy can be instrumental for clinical staff to understand HCV patient needs, clinical algorithms, and best practices. American Indians/Alaska Natives have the highest rate of mortality from HCV all I/T/U facilities are encouraged to provide early detection and linkage to care. For further questions or support, contact Dr. Jonathan Iralu, Chief Clinical Consultant, Infectious Disease, jonathan.iralu@ihs.gov

PURPOSE

To expand screening, management and pre-treatment care for HCV infection.

BACKGROUND

In the United States, an estimated 3 million persons are chronically infected with HCV. [1] Compared to other racial and ethnic groups, AI/ANs experience a higher rate of acute HCV incidence and one that has increased more quickly. [2] Compared to whites, AI/ANs experience a three-fold higher death rate from chronic liver disease—one of the multiple complications of chronic HCV infection. [3]

Certain practices pertaining to the screening, treatment, and management of HCV can prolong the length and quality of life of chronically infected patients. The American Association for the Study of Liver Diseases, the U.S. Preventive Services Task Force, and the Centers for Disease Control and Prevention endorse the below practices, as will IHS henceforth.

Among those with HCV in the U.S., 50% do not realize they are infected.[4] To identify HCV-infected patients, IHS clinicians should screen high-risk patients and all patients born from 1945 to 1965 for the presence of HCV antibodies. Patients born 1945-1965 accounts for the majority of HCV infections due to various causes including medical exposures or having injected drugs during in the 1950s-1980s.[5] Clinicians should confirm patients testing positive for HCV antibodies for HCV infection. After confirming HCV infection, clinicians should continue with a pre-treatment checklist and in consultation with a specialist when needed, start patients on appropriate treatment regimens and continuously monitor patients' progress until they reach a cure.

Hepatitis C Evaluation for Treatment: **Patient Checklist**

Patient Name or MRN:_____

Treatment Evaluation

✓	To Do	Description
	Confirm Chronic HCV Infection	___ Confirm Hepatitis C Virus antibody reflex testing for quantitative HCV is positive. Establish the patient is *HCV antibody* **AND** *HCV RNA positive* ___ Discuss test results with the patient and provide him/her with handout *Hepatitis C: Treat, Cure* ___ Encourage patient to text CURE to 97779 for Hepatitis C education, tips and tx options
	Obtain Baseline Labs	___ HCV Genotype ___ HIV Screen ___ Hepatitis B Serology (HBsAG, hepatitis B surface antibody (anti-HBs),and hepatitis B core antibody (anti-HBc)) ___ Hepatitis A (HAV antibody total or IgG) ___ CBC (WBC, ANC, HGB, HCT, PLT) *(drawn on the same day as CMP)*

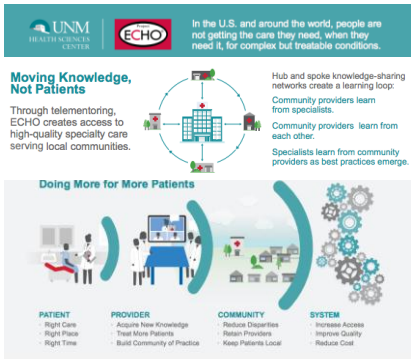
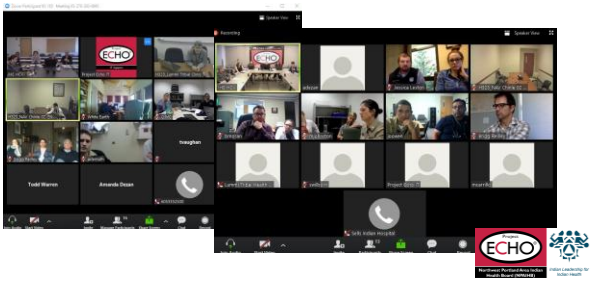
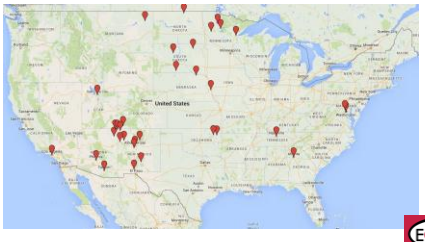


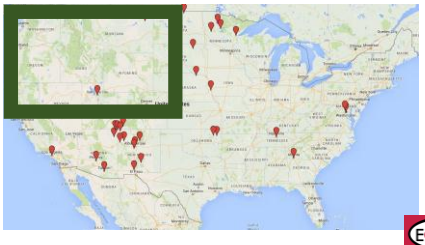
Image IHS HCV ECHO session (PIC)



IHS HCV TeleECHO Clinic Sites



IHS HCV TeleECHO Clinic Sites



NPAIHB – Northwest HCV teleECHO

- Held the 4th Wednesday of the month from 12pm-1pm PST
- 16 different sites have participated
- 30 case presentations

HCV Clinician Training-Fall

- Free clinical training for I/T/U facilities to provide a range of HCV services at the primary care level with Dr. Jorge Mera
- Host?

Where: *Swinomish Casino & Lodge*-12885 Casino Drive, Anacortes, Washington 98221
When: *January 30-31*
Who: *Physicians, midlevels, pharmacists, nurses, and other clinicians from I/T/U sites*

Monday, January 30

8:30-9	Continental Breakfast Provided
9-9:30	Introductions and welcome from Chairman Cladoosby - invited
9:30-10:45	"HCV Screening, Management, & Treatment Guidelines" (PowerPoint) – Dr. Mera
10:45-11	Break
11:00-noon	"Cont. HCV Screening , Management, &Treatment Guidelines "(PowerPoint) – Dr. Mera
noon-1:00pm	Lunch provided
1:00-2:15pm	HCV at your location: An Overview (Discussion) *Attendees are invited to give an overview of HCV caseload at their site, and share what would be most helpful in their efforts to treat HCV*
2:15-2:45pm	Accessing HCV Medications @ Lummi (Discussion) – Jessica Riemstra, LPN
2:45-3:30pm	Treatment Discussion-3 pts from Lummi *Each clinic is asked to complete Z case presentation forms by Jan. 20*
3:30-4:15pm	Treatment Discussion-3 pts from Swinomish, Upper Skagit *Each clinic is asked to complete Z case presentation forms by Jan. 20*
4:15-4:30pm	Questions and Discussion

Barriers to HCV screening – CD Discussion

- Reminder gets lost among many other health maintenance/GPRA reminders
- Misdiagnosed HCV patients
- Unfilled nursing/MA positions that reduce capacity for ordering the test
- Higher use of locums clinicians
- Have we done enough to promote testing within communities?

Barriers to HCV screening – CD Discussion

- Reminder gets lost among many other health maintenance/GPRA reminders
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- Have we done enough to promote testing within communities?

Reminder Fatigue

Reminder Fatigue

- Reduce or eliminate clinically inconsequential alerts
- Tailor alerts to patient characteristics and critical integrated clusters of physiologic indicators
- Tier alerts according to severity
- Make only high-level (severe) alerts interruptive
- Apply human factors principles when designing alerts (e.g., format, content, legibility, and color of alerts)
- Delegate alerts

Misdiagnosis – Using ICD for Hepatitis for screening

- Found in every clinic
- Found in every Area
- Product of using a billing code for surveillance
- It is – unfortunately – the best we have
- Once it is "cleaned" once, it is 90% more useful
- Decide on a set of codes to use for certain tests

Testing and Treatment Brochures

Wellness Grows

Quinault Wellness Gardens

Apprentices & Quinault Gardeners Program

Where We Are...

Taholah

Medical Center

Daycare/Headstart

DPP/Urban Farm

Fitness Center

Queets

Senior Center & Headstart

Aberdeen

Urban Farm Model

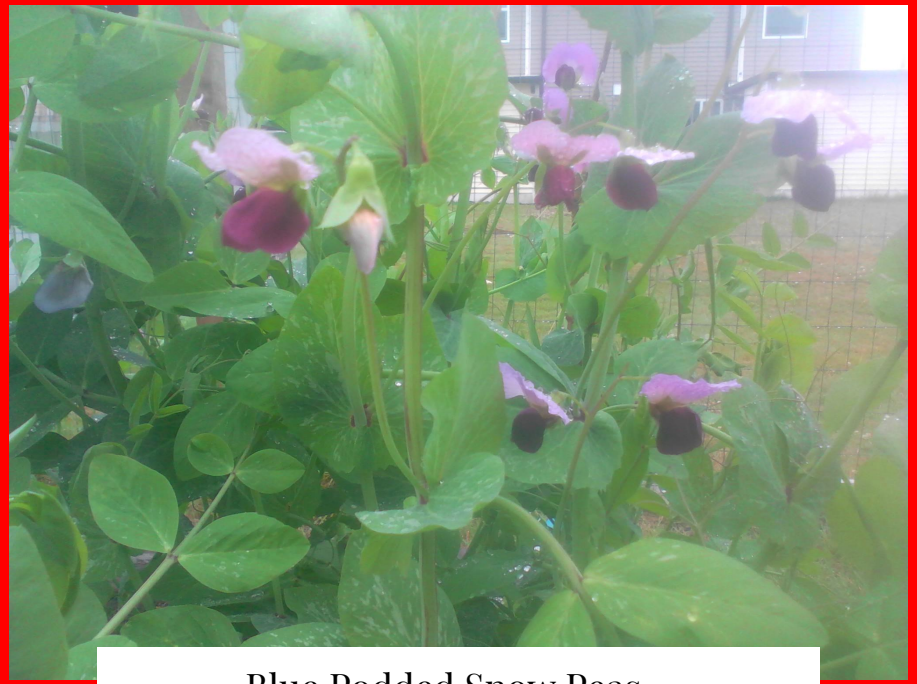
Increases Food Security by having access to and being able to afford nutritious, safe food—and enough of it.

Creates a Sense of Stewardship and planning for the next generations.

Produces Healthy, & Nutritious Food You Can Respect.

Provides Education, Training & Employment Opportunities.

Makes Efficient Use of Land.



Blue Podded Snow Peas...
Edible sprouts, flowers, pods & peas

Urban Farm Livestock

Specialty Growing Areas

Pollinator Pathway

Hugulkulture Berm

& Food Forests

Medicinal Tea Herbs

Edible Flowers

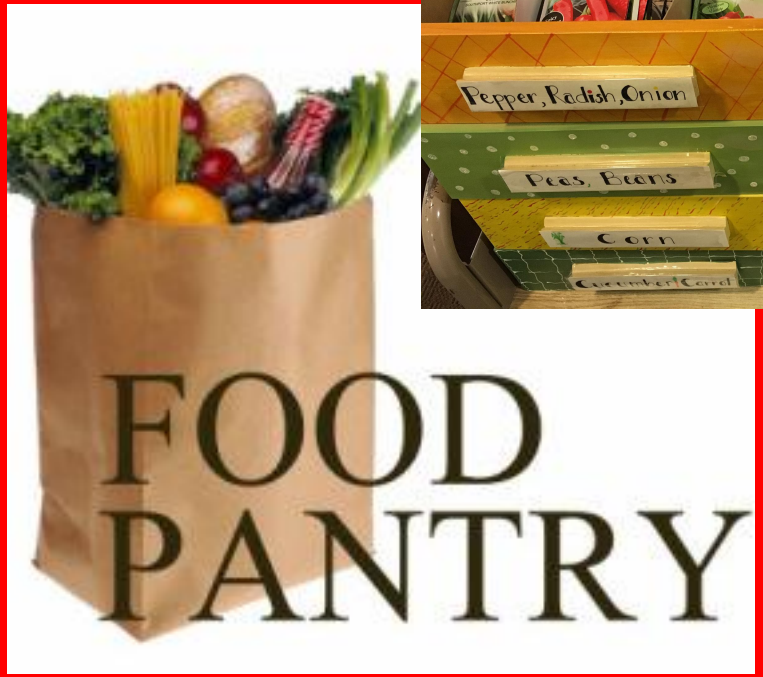
4 Sisters Garden

Biodiversity = Sustainability

Traditional Diet, Indigenous Foods and Native Species

Weekly Produce Distribution & CSA Program

Food Pantry, Seed Library & Wellness Cache



Composting = Less Inputs & More Outputs

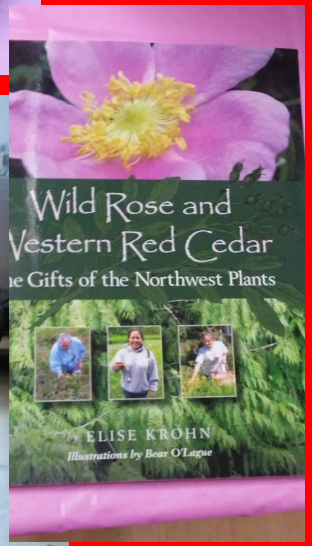
GREENS	BROWNS
• Fruit and vegetable scraps • Grass clippings • Bread and grains • Coffee grounds • Hair and fur	• Leaves • Twigs • Shredded newspaper • Cardboard rolls • Clean paper • Fireplace ashes

DO NOT ADD: dairy, meat, fats, bones, oils, pet waste, seafood scraps, plastic, stickers from fruits and vegetables, metals, glass, treated or painted wood

Youth in the Gardens

Classes


GARDENING CALENDAR
January
Protect your garden from frosts, winds and rain. Start planning garden plot for the next year.
February
Trim bushes and evergreen hedges. Prepare seed beds. Chit potato tubers.
March
Sow seeds. Trim winter shrubs. Clean up around the garden. Plant shallots, onion sets, early potatoes, summer-flowering bulbs.
April
Finish any digging. Start sowing outdoors. Sow hardy annuals and herb seeds. Watch out for late frosts.
May
Sow and plant out bedding. Earth up potatoes. Plant out summer bedding. Mow lawns weekly.
June
Hoe weeds regularly. Sow Beans. Water trees. Harvest lettuce, radish, other salads and early potatoes
July
Water tubs and new plants. Deadhead bedding plants. Harvest zucchini.
August
Water your garden. Prune summer-flowering bushes. Collect seeds. Harvest sweetcorn and other vegetables
September
Harvest fruits and vegetables. Pot up herbs. Sow broad beans and hardy peas. Plant spring flowering bulbs.
October
Clear up fallen leaves. Move tender plants into the greenhouse. Plant out spring cabbages.
November
Start a new compost heap. Plant tulip bulbs. Plant out winter bedding. Prune roses.
December
Check garden winter protection. Prune apples and pears. Take hardwood cuttings.


Wild Rose and
Western Red Cedar
e Gifts of the Northwest Plants
ELISE KROHN
Illustrations by Bear O'Logue

Plans for Later This Year, Next Year and Beyond...

Thank you for listening, learning, sharing and helping us grow.

Quinault Wellness Garden Team:

Roberta Harrison, RN
Kimberly McLaury, Nutritionist
Angel Capoeman, WIC
Tootie James, Manager
Christa Rodgers, RN
Rosie Reed, Data
Henri Capoeman Sharp, Fitness Manager

Sheilia Canada, Gardener, CPD, MG
Brody Capoeman Sharp, Garden Apprentice
Nickolas Canada, Garden Apprentice
Lydia Baldwin, Garden Apprentice
Chickens, Egg Production & Fertilizer
Duck, Egg Production & Slug Snatcher
Bees, Pollination Crew, Honey & Wax

WEAVE-NW Implementation Funding RFA OPEN AUGUST 2017

For more information please contact:
Email: weave@npaihb.org
Phone: 503-228-4185

- Between $1000-$10,000 to Portland Area Tribes for Policy, Systems, and Environment (PSE) focused activities (see list below) based on a completed RFA that will include:
    - Brief report on the utilization of the funds
    - Short narrative describing use of the funds
    - Evaluation of the success or failure of the objective
    - Financial sheet detailing the expenditures of the funds
    - Cover letter on Tribal Letter Head
    - Action Plan

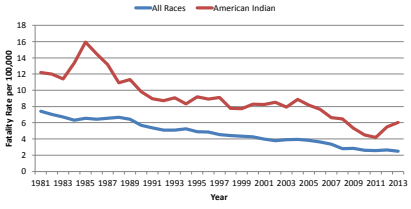
PSE Activity Examples:

- Establish and present community garden classes.
- Contract or stipend for a gardener and/or garden supplies
- Million Hearts Tribal Program: curriculum packets, evaluation, action guides, meeting supplies, in-service training
- Traditional Food Preparation classes: recipe books, elder's honoraria for Native Chef,
- Population Health or other health systems trainings, consultant, software
- Youth Risk Behavior Survey (YRBS) to include printing materials, pre-meeting costs, and funding for Youth Health Initiative based on YRBS results.
- Community-based assessment (eg. Community inventory, CHANGE Tool, Food Sovereignty Assessment, Environmental Physical Activity Assessment) that includes strategic planning towards implementation.
- Travel for Youth Presentation regarding PSE activities and/or implementation.
- Food Sovereignty Support including signage for gardens, informational materials, and meeting expenses.
- Meeting expenses for policy stakeholder meetings in preparation of a PSE sustainably focused policy initiative.
- Training for CHRs to identify PSE Changes within their community
- Production cost of editing and producing digital stories and media campaign materials focused on PSE Changes
- Develop and implement workplace wellness policy and/or committee for tribal employees
- Cultural adaptation of existing program or campaign materials focusing on breastfeeding, diabetes or heart disease prevention
- Develop and implement nutrition standard policies regarding availability of healthy foods and beverages in community vending machines, at community meetings or events
- Healthy Food or Beverage Policy Initiatives
- Physical Activity community based initiatives (eg. Funding could support bike library or walking path)

The Native CARS Atlas: Addressing Disparities in Motor Vehicle Fatalities through Improving Child Passenger Restraint Use

Child Motor Vehicle Fatalities

United States Unintentional Motor Vehicle Death Rates per 100,000, Ages 0-9 (3 year rolling averages), 1981-2013

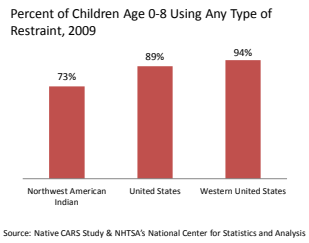


Source: WISQARS. NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates

Why the Disparity?

- Difference in road safety?
- Difference in types of vehicles driven?
- Longer EMS response time?
- Is it an urban/rural phenomenon?
  - 71% of American Indians live in urban areas, according to the 2010 US Census
- Difference in restraint use?

Child Restraint Use



Source: Native CARS Study & NHTSA's National Center for Statistics and Analysis

NATIVE CARS

NATIVE CHILDREN ALWAYS RIDE SAFE

Native CARS: Overall Goal

Design, implement and test effectiveness of tribal interventions to improve the use of child safety seats among AI/AN children via community-based participatory research (CBPR)

Native CARS: Study Design

- Early beginnings, 2003 observation survey
  - Age and size-appropriate child safety seat use ranged from *25% - 55% by tribe*
- Six tribes
  - 2 each in Idaho, Oregon, and Washington
- *All tribes* developed and implemented their own multi-faceted interventions
  - Staggered implementation
  - Controlled community trial
- Vehicle observation surveys at 3 time points – 2009, 2011 and 2013

All Facets of the Study are Community Driven

Why Tribe-Specific Data?

- Need to identify appropriate approach
  - Do we need to *build awareness*?
  - Should we add to existing *health or safety practices*?
  - Is the community ripe for *policy change*?
- Need to understand *community practices*, norms, beliefs, *strengths, barriers*
- Need to know which children are at *highest risk*
- Need to know if what tribes were doing at the start of Native CARS intervention addresses issues suggested by vehicle observation data
  - Do people *need child safety seats*?
  - Is current information *reaching drivers* ?

Methods

- Sequential Explanatory design

Quantitative ⇨ Qualitative

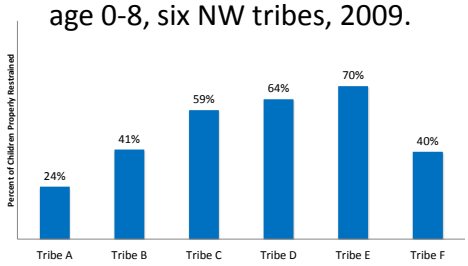
- Quantitative
  - Measured child passenger restraint use
  - Determined Children most at risk
- Qualitative
  - Helped explain, elaborate on the quantitative data
  - Examined facilitators and barriers of CSS use
  - Described social norms

Vehicle Observation Survey



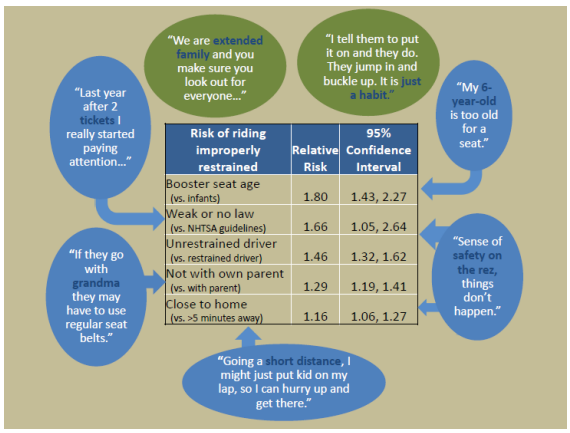


Percent of properly restrained children age 0-8, six NW tribes, 2009.



Risks for Inadequate or Unrestraint

- Booster seat age
- Weak or no law
- Unrestrained driver
- Not with own parent
- Close to home



Risk of riding improperly restrained	Relative Risk	95% Confidence Interval
Booster seat age (vs. infants)	1.80	1.43, 2.27
Weak or no law (vs. NHTSA guidelines)	1.66	1.05, 2.64
Unrestrained driver (vs. restrained driver)	1.46	1.32, 1.62
Not with own parent (vs. with parent)	1.29	1.19, 1.41
Close to home (vs. >5 minutes away)	1.16	1.06, 1.27

Data Driven Community Interventions

- Informed by community data
  - Review observation and elicitation data
    - Associations with use and non use
    - Barriers
    - Facilitators
    - Community strengths
- Developed by community
  - Site Coordinator, their supervisors, advisory members
  - Focus Groups
- Implemented by community

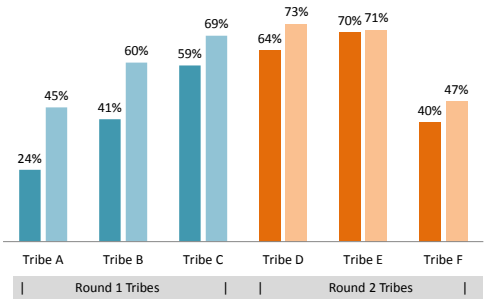
Impact Evaluation

- Did Awareness Increase?
  - 77% - 87% of Native drivers reported *seeing at least one of the Native CARS media materials*
  - Awareness of a tribal law
  - Awareness of techs, car seat availability

Impact Evaluation

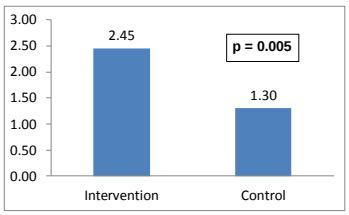
- Did opinions change?
  - Drivers who thought kids 7 & under could safely use seat belt
    - 2009: *43%*
    - 2011: *26%*
- Did reported reasons for not using a seat change?
- Did we observe seats from a tribal program?

Did proper restraint increase?



8. Outcome Evaluation

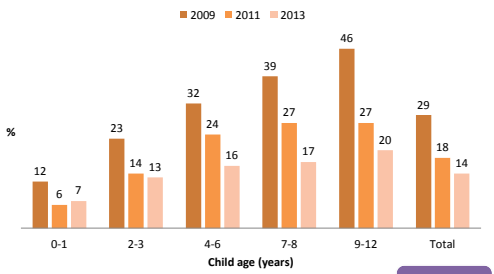
Did intervention tribes increase more than control tribes?



Age-adjusted relative increase in odds of proper restraint between 2009 & 2011 in intervention and control tribes

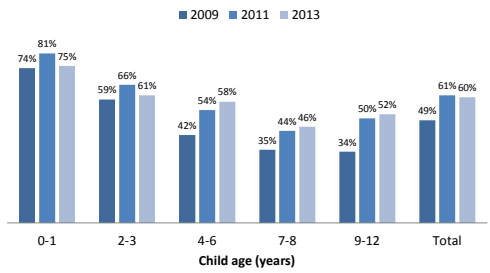
8. Outcome Evaluation

Unrestrained kids by age & year



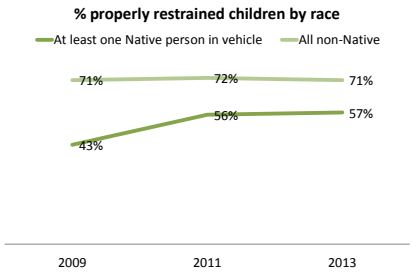
8. Outcome Evaluation

Properly restrained kids by age & year



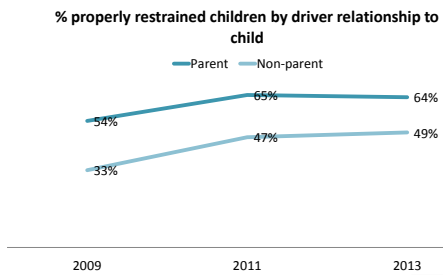
8. Outcome Evaluation

Did we reach our intended audience?



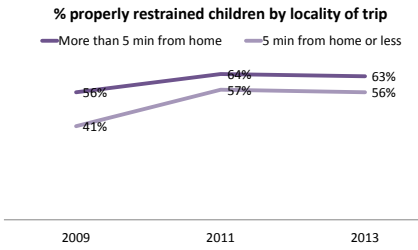
8. Outcome Evaluation

Did risk factors change over time?



8. Outcome Evaluation

Did risk factors change over time?



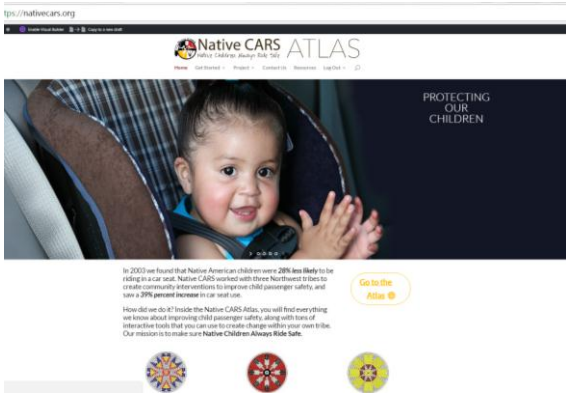
8. Outcome Evaluation

Native CARS: CBPR Success

- Native CARS tribes carried out interventions that improved child passenger restraint use
  - Focused on interventions that *strengthened community* and *enhanced tribal capacity*
  - Promote long-term sustainability
- The tenets of CBPR were absolutely essential to the success of the program
  - The value of community knowledge and input
- Site coordinators broadened their own skill sets - *"local experts"*

Native CARS: Dissemination Phase Goals

- Demonstrate that Native CARS interventions can be *translated to other tribes*.
- Use the *Native CARS Atlas* as a blueprint to address child passenger safety concerns in tribal communities
- *Reduce the number of fatalities and injuries* from motor vehicle crashes among tribal children

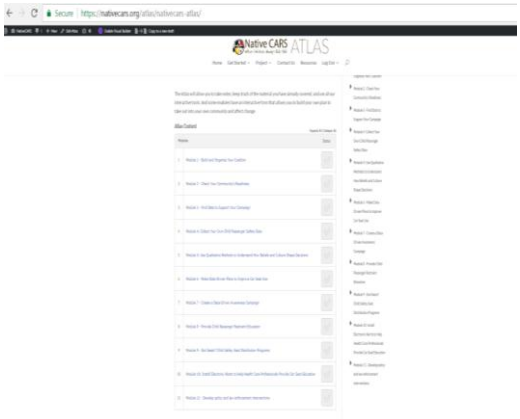


Atlas Contributing Authors

Left to right: Kootsie Cunial (Klamath Tribes), Iola Hernandez (Shoshone Bannock Tribes), Rebecca Hunt (Colville Tribes), Brandy Bishop (Grand Ronde Tribes), Bernadine Phillips (Colville Tribes), Crissy Garcia (Nez Perce Tribe)

Atlas Content Outline

- Build and organize your coalition
- Check your community's readiness
- Collect data
- Make data-driven plans to improve use
  - Create an awareness campaign
  - Provide education
  - Create a distribution program
  - Utilize EHR alerts to connect education with distribution
  - Policy & law enforcement interventions
- Demonstrate progress & success



Quick Links

- Get ideas about where to start
- Link my distribution program to RPMS
- Download posters for printing
- Browse media samples
- Learn how to become a CPS Tech
- Collect data to apply for a grant
- Install electronic alert to help health providers provide CSS education

Stories From the Field

I routinely tell myself that if I make a difference in how one parent safely transports their child, then I've succeeded. You deserve a pat on the back and a hug from this kid when he's older for this one.
— County Fire Fighter and EMT to Native CARS community project leader and certified child passenger seat technician after the EMT responded to a car crash that could have been fatal and was not. The child's mother reported that the Native CARS project leader had helped her get and install the car seat correctly.

4: Why & How to Collect & Use Data

- Find and use existing data resources
  - FARS, WISQARS, etc.
- Collect community-specific data
  - Do vehicle observations to determine the proportion of properly restrained kids
  - Determine groups at risk
  - Conduct Elicitation Interviews
  - Conduct focus groups

5: Make Data-Driven Plans to Improve Child Passenger Safety

- Pinpoint mode of intervention: awareness, education, behavior change, public health practice, policy
- Create & evaluate an intervention

6: Create a Data-Driven Awareness Campaign

- Determine messages & audience
- Create specific types of media
- Download Native CARS media, both ready to customize and ready to print

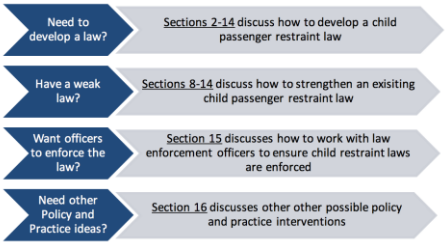
9: Got Seats? Child Safety Seat Distribution Programs

- Partner with an existing distribution program
- Identify funding for car seat resources
- Start a car seat distribution program
- Consider daily operations of distribution program
- Improve or expand your distribution program

10: Install Electronic Alerts and provide consults on EHR

- Downloading and installing the Electronic Health Reminder file for Car Seat Education.
- Using the EHR software

11: Develop Policy and Law Enforcement Interventions



Native CARS: Acknowledgements

- NPAIHB tribal delegates
- NW NARCH leadership
  - Early work funded via NIH grant # **U269400013**
- *Site coordinators !!!!*
- Vehicle survey data collectors
- Native CARS Study Group
- Members of participating tribes
- Intervention and Dissemination Phases funded via
  - National Institute of Minority Health and Health Disparities, grant # **R24MD002763**

Tribal Site Resources and Partners

- Washington Safety Restraint Coalition
- Washington Traffic Safety Commission
- Safe Kids
- Indian Health Service
- Tribal Target Zero Program
- Tribal Health Programs
- Tribal Early Childhood/ Head Start Programs
- Tribal Police
- Tribal Attorneys
- Tribal Health Boards
- Tribal Workgroups
- Neighboring Police Departments
- Fire and EMS Departments

Hy'shqe Si'am –Thank You

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Opportunities Presented by CMS Guidance Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility

Bruce Goldberg, MD
&
Laura Platero
April 19, 2017

Prior to February 26, 2016 Guidance

- States could claim 100% federal funding for services provided at an IHS/Tribal facility and furnished to Medicaid eligible AI/AN's
- States reimbursed for services provided to Medicaid eligible AI/AN's outside of an IHS/Tribal facility at a state's regular FMAP rate (~70/30 – 50/50 depending on state)

New Guidance – Feb. 26 Letter

- CMS has reinterpreted the scope of services considered to be "received through" an IHS/Tribal facility for purposes of eligibility for 100% FMAP
- Now includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules and that are also covered under the approved Medicaid state plan – also includes any services established in the future as a state plan benefit
- This includes long-term services and supports (LTSS) and Emergency and Non-Emergency Medical Transportation (EMT and NEMT).
- **This produces overall savings to the state**.

New Guidance – Feb. 26 Letter

- Allows 100% federal funding for services "received through" an IHS/Tribal facility and furnished to Medicaid eligible AI/AN's
- 100% federal funding now available for care provided to AI/ANs in private sector
- Opportunity for a state to claim 100% federal funds in circumstances where they had been paying 30-50% of the bill, thereby creating the possibility of substantial state fund savings.

To be Eligible for 100% FMAP Services:

- An IHS/Tribal facility must request the service
- There must be a care coordination agreement between the IHS/Tribal facility and the provider
- There is a relationship between the patient and the IHS/Tribal provider

Care Coordination Means

- The IHS/Tribal provider requests the service and sends the information to the provider receiving the referral
- The provider receiving the referral sends information back to the IHS/Tribal provider
- The IHS/Tribal provider continues to assume responsibility for the patient
- The IHS/Tribal provider puts the referral information in the patients medical record

OPPORTUNITY

- For a state to consult with Tribes and work together with them to improve the health of Tribal members by assuring that savings available through this program are reinvested in Tribal communities.
  - For example, create a Tribal Health Improvement Fund:
    - To improve access to care
    - Provide mental health services
    - Other health related issue

For Private Sector Providers

- No change in how they bill for and are paid for Medicaid clients.
- Potential funding to work with IHS/Tribal programs, and possibly urban programs, on projects of mutual interest

Some of What Is Needed

- **Agreement with state to share funds made available through this program!!**
- Care coordination agreements with providers
- Mechanisms to track/coordinate care and administer the referrals
- Mechanisms to: track funding, invoice and receive funds
- Audit and compliance for Tribal organizations
- Compliance documentation for State claiming:
  - Service delivered to eligible AI/AN who is patient of an IHS/Tribal provider per written referral request
  - Service is within scope of care coordination agreement
  - Rate of payment is authorized under State Plan
  - There is no duplicate billing

Oregon Experience To Date

- 9 Tribes and urban program working collaboratively with the state to implement this program
- First claims have been submitted
- State working with CMS to gain clarity on implementation

Governor Brown's Commitment

"I am committed to investing the savings from this change to Medicaid policy into Tribal programs and services that improve the health of American Indian and Alaska Native communities."

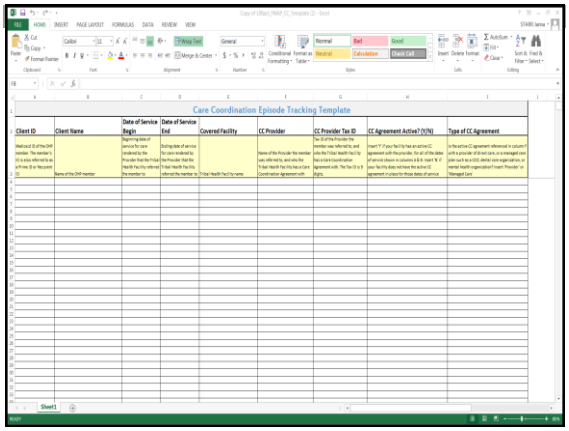
Governor Kate Brown (September 7, 2016)

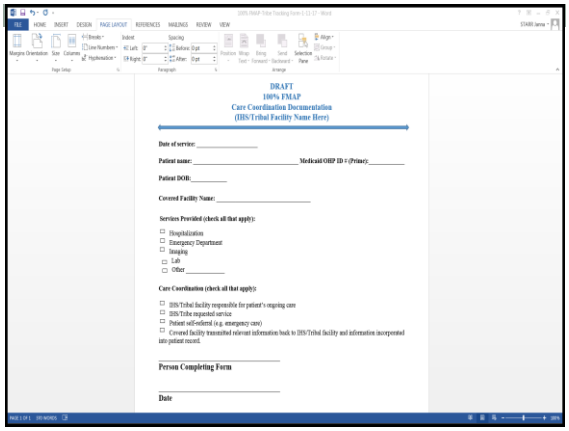
Progress

- Starting with hospital claims – as these are relatively low volume but high cost
- Expand to other providers
- Care Coordination agreements in place with 9 hospitals
- Procedure in place with Medicaid agency for claiming
- First claims submitted
- Currently a manual process – need to automate
- Working with CMS to clarify their policies
  - Initially CMS staff have taken a very literal and burdensome approach to claiming

Submitting Claims, Billing and Tracking: Tribal and Non-Tribal Providers

- Non-IHS/Tribal provider bills for the services for the Medicaid member referred by the IHS/Tribal facility and sends a copy of the billing to the IHS/Tribal provider.
- IHS/Tribal provider completes the “Care Coordination Episode Tracking Template” and submits to OHA.
- OHA acknowledges receipt of Care Coordination Episode Tracking Template from IHS/Tribal provider.
- OHA processes claim manually, completes claim adjustment to a 100% FMAP claim (This will be automated-no completion date yet)
- Pending discussion and agreements between State and Tribes regarding specifics regarding methodology, return the savings to IHS/Tribal providers





A Word about Documentation

The documentation must be sufficient to establish that:

- The item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner;
- The requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care;
- The rate of payment is authorized under the state plan and is consistent with federal requirements; and
- There is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

Is 100% FMAP Available for Services to AI/AN Medicaid Managed Care Members?

- **Yes, if**:
  - The service is furnished to an AI/AN Medicaid beneficiary enrolled in the managed care plan;
  - The service meets the same requirements to be considered "received through" an IHS/Tribal facility as would apply in the fee-for-service system;
  - The managed care plan maintains auditable documentation that those requirements are met;
  - The non-IHS/Tribal provider is a network provider of the enrollee's managed care plan; and
  - The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider's contractual agreement with the managed care plan.

Submitting Claims, Billing and Tracking: OHA

Interim process:

- OHA inserts patient/provider/date information in the MMIS.
- OHA pulls reports on a defined timeline.
- OHA completes prior period adjustments on claims that change claiming to 100% FMAP.
- MMIS automatically reviews and uses claims data.
- MMIS automatically claims 100% federal match.
- OHA calculates savings.
- OHA distributes savings to IHS/Tribal providers in a manner to be determined.

Oregon Health Authority

100% FMAP Care Coordination Claims & Savings

Member ID	Tribal Health Program/IHS Provider	Care Coordination Date Begin	Care Coordination Date End	Referral Provider Medicaid ID	Referral Provider NPI	Referral Provider Name	Referral Provider Type	ICN	Claim DOS From	Claim DOS To	Paid Date	Federal Fund	State Fund	Total Fund
HY320055	[redacted] COMMUNITY HEALTH CL	3/1/2017	3/1/2017	054598	1649276734	ST ANTHONY HOSPI	Hospital	90163400S133	3/1/2017	3/1/2017	3/9/2017	$151.68	**$83.59**	$235.27
HY320065	[redacted] COMMUNITY HEALTH CL	3/2/2017	3/5/2017	054599	1649276735	LINCOLN HOSPITAL	Hospital	90163400S134	3/2/2017	3/5/2017	3/12/2017	$2,375.00	**$456.00**	$2,831.00
LY320075	[redacted] COMMUNITY HEALTH CL	3/15/2017	3/15/2017	054600	1649276736	SPINAL SPECIALTIE	Billing Provid	90163400S135	3/15/2017	3/15/2017	3/22/2017	$544.00	**$109.00**	$653.00
KY320085	[redacted] COMMUNITY HEALTH CL	3/19/2017	3/19/2017	054601	1649276737	CARDIOVASCULAR	Billing Provid	90163400S136	3/19/2017	3/19/2017	3/26/2017	$312.00	**$73.00**	$385.00
LY320095	[redacted] COMMUNITY HEALTH CL	3/20/2017	3/29/2017	054598	1649276734	ST ANTHONY HOSPI	Hospital	90163400S137	3/20/2017	3/29/2017	4/5/2017	$11,050.00	**$2,743.00**	$13,793.00
												Savings =	**$3,464.59**	

100% FMAP Going Forward

- OHA is currently in the process of identifying IT systems changes and will move to implement processes that will simplify and streamline the 100% FMAP process as quickly as possible.
- Tribes are discussing how to disburse the savings.
- Ongoing work with CMS.

- Note: We'd like to acknowledge Janna Starr at OHA who gave us permission to use some of her slides.

Questions?

For more information:

DRAFT

MEMORANDUM OF UNDERSTANDING TO COORDINATE CARE BETWEEN (NAME) AND [NAME OF PROVIDER]

I. Purpose and Summary

This Care Coordination Memorandum of Understanding (hereinafter "Agreement") is made between [name of PROVIDER] (hereinafter "Provider") and [Name of Tribal Facility] (hereinafter "Covered Facility") . The purpose of this Agreement is to implement written care coordination, identify the parties to this Agreement and describe their roles and responsibilities. The parties desire for this Agreement to help ensure that practitioners at the Covered Facility will be able to coordinate and manage the care furnished to their eligible American Indian and Alaska Native patients who are also Medicaid beneficiaries (hereinafter "Patient" or "Patients") by Provider, on request by the Covered Facility practitioners, so that such individuals will receive appropriate care.

II. Definitions

a. "Care coordination" means, for purposes of this agreement, determining the Patient's needs; overseeing and managing the Patient's care, including diagnosis, treatment, including prescriptions, and follow-up, and ensuring the care is fully recorded in the Patient's medical records.
b. "Indian Health Service (IHS) program" means a health care clinic or office operated in Oregon by an Indian Tribe or Tribal organization under the auspices of the Indican Health Service (IHS) within the U.S. Department of Health and Human Services established by IHCIA Section 601, 25 USC § 1661.
c. "Patient" means, for purposes of this agreement, a Medicaid-eligible and OHP-enrolled American Indian or Alaska Native eligible to receive covered services from the IHS, per 42 CFR Part 136; for purposes of this Agreement, the same as an "OHP-Enrolled IHS Beneficiary".
d. "Telehealth and Related Technologies" means the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration.
e. "Tribal health program" has the meaning given in IHCIA Section 4(25), 25 U.S.C. § 1603(25).

III. Care Coordination Arrangement

a. In General. Care coordination means that the practitioners at the Covered Facility will be responsible for determining the Patient's needs and coordinating and managing the Patient's care; that all such care, including diagnosis, treatment, and prescriptions, will be recorded in the Covered Facility's medical records for the Patient; and that such records will be available to inform the Covered Facility's practitioners' ongoing management of the course of care for the Patient.

b. Existing Patient Relationship. A Covered Facility practitioner must have established a patient-practitioner relationship with the Patient before requesting services from Provider under this Agreement, and maintain that relationship during the provision of care by the Provider. The Covered Facility practitioner may establish a patient-practitioner relationship through telehealth and related technologies.

c. Scope of Practice. The Covered Facility practitioner, consistent with the scope of practice under applicable law, may request that Provider furnish a service to an eligible American Indian or Alaska Native beneficiary in accordance with this Agreement. The Covered Facility practitioner is not required to request the services of Provider exclusively, and nothing in this Agreement shall affect the right of Patients to their freedom of choice of provider.

d. Scope of Services. The service requested by the Covered Facility practitioner must be within the scope of services that are authorized under the Indian Health Care Improvement Act and that are also covered under the approved [STATE] Medicaid Plan, including long-term services and supports, and transportation if covered as a service under the state Medicaid Plan.

e. Form of Request. The request for services from the Covered Facility practitioner to Provider may be transmitted electronically or by paper copy, and must include a clear description of the identity of the Patient and the specific requested service or services to diagnose or treat the Patient for an identified episode of care. The request should also include the date of the request and any additional medical information necessary for provision of the requested service in accordance with the practitioner's determination of the Patient needs and the course of care. The Covered Facility must maintain documentation of the request; documentation may be electronic or in writing.

f. Provision of Services. On accepting a request for a service from a Covered Facility practitioner, Provider will furnish the requested service to the Patient as soon as feasible.

g. Follow-Up and Medical Records. Within no more than [ ] days of furnishing the requested service, Provider will transmit, electronically or in writing, the medical information, test results, and any diagnostic findings and treatment procedures and recommendations resulting from the provision of the service to the requesting practitioner directly Such information must be transmitted more promptly when medically warranted, such as in emergency circumstances. In any such transmission, Provider] will specifically identify needs for additional care and treatment, including follow-up care. Upon receiving this transmission, the Covered Facility practitioner will ensure that the information is incorporated into the Patient's medical record being maintained by the Covered Facility, either through the "Health Information Exchange," as applicable, or other agreed-upon means. The Covered Facility practitioner will review the medical information, test results, and any diagnostic findings and treatment recommendations received from Provider and take medically appropriate follow-up action as indicated, including, when necessary, furnishing or requesting additional services to the Patient. The Covered Facility practitioner shall remain responsible for overseeing his or her Patient's care and the Covered Facility shall retain control of the Patient's medical record being maintained by the Covered Facility.

h. Billing For Services. Provider shall be the party responsible for billing Medicaid for services under this agreement.

IV. Obligations of Provider

a. Provider agrees to carry out and comply with the requirements of this Agreement.

b. Provider shall enroll in the [STATE] Medicaid program, if not already enrolled, and remain in good standing as a participating provider in such program.

c. Provider shall maintain malpractice insurance in the form and minimum amount required by the State in which the services are performed, and shall keep and maintain all required records of care, referrals, invoices, and billing documents. Services provided by Provider pursuant to this Agreement are not covered by the Covered Facility's Federal Tort Claims Act coverage.

V. Obligations of Covered Facility

a. Covered Facility agrees to carry out and comply with the requirements of this Agreement.

b. Covered Facility shall enroll in the [STATE] Medicaid program, if not already enrolled, and remain in good standing as a participating provider in such program.

c. Covered Facility shall keep and maintain all required records of care, referrals, invoices, and billing documents for a minimum of seven (7) years after the date of service and make them available upon request, for authorized purposes under state or federal law or regulation, to authorized entities, including the Oregon Health Authority (OHA), the Oregon Secretary of State's Office or Department of Justice and the federal Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS), in accordance with all applicable state and federal laws and regulations regarding transfer of records.

VI. General Provisions

a. On February 26, 2016, CMS issued guidance in SHO letter 16-002, on when services are considered to be "received through" an IHS/Tribal facility by a Patient who is a Medicaid beneficiary. Medicaid covered services ordered by a Covered Facility and provided by Provider to a Patient pursuant to and in accordance with this Agreement are considered to be services "received through" a tribal facility for the purposes of SHO letter 16-002.

b. OHP-Enrolled IHS Beneficiares may not be required to receive services through Covered Facility or that facility's referred Provider for the purpose of qualifying the service for 100% FMAP. Nothing in this Agreement shall affect the entitlement of OHP-Enrolled IHS Beneficiares to freedom of choice of provider under section 1902(a)(23) of the Social Security Act or to exemption from managed care enrollment.

c. Persons who are documented American Indian and Alaskan Native (AI/AN) may not be required to enroll in a managed care entity such as a coordinated care organizarion (CCO) for the purpose of qualifying a service for 100% FMAP. These beneficiaries are exempt from auto assignment or mandatory enrollment in managed care plans, as specified in 42 USC 1932, 2 (C), and OAR 410-141-0060 (4), but may elect voluntary enrollment

d. Both Parties will independently comply with the laws and regulations applicable to them regarding the confidentiality and security of health information.

e. This Agreement will remain in effect until terminated. The Agreement may be terminated by either Party by giving 30-days written notice.

_____	_____
TRIBE	CEO, [Name of Provider]
_____	_____
Date	Date

Date of Service Begin	Date of Service End	Covered Facility	CC Provider	CC Provider Tax ID	CC Agreement Active? (Y/N)	Type of CC Agreement	Client ID	Client Name
Beginning date of service for care rendered by the Provider that the Tribal Health Facility referred the member to	Ending date of service for care rendered by the Provider that the Tribal Health Facility referred the member to	Tribal Health Facility name	Name of the Provider the member was referred to, and who the Tribal Health Facility has a Care Coordination Agreement with	Tax ID of the Provider the member was referred to, and who the Tribal Health Facility has a Care Coordination Agreement with. The Tax ID is 9 digits.	Insert 'Y' if your facility has an active CC agreement with the provider, for all of the dates of service shown in columns A & B. Insert 'N' if your facility does not have the active CC agreement in place for those dates of service	Is the active CC agreement referenced in column F with a provider of direct care, or a managed care plan such as a CCO, dental care organization, or mental health organization? Insert 'Provider' or 'Managed Care'	Medicaid ID of the OHP member. The member's ID is also referred to as a Prime ID or Recipient ID	Name of the OHP member

DRAFT
100% FMAP
Care Coordination Documentation
(IHS/Tribal Facility Name Here)

Date of service: _____

Patient name: _____ **Medicaid/OHP ID # (Prime):**_____

Patient DOB:_____

Covered Facility Name: _____

Services Provided (check all that apply):

- ☐ Hospitalization
- ☐ Emergency Department
- ☐ Imaging
- ☐ Lab
- ☐ Other _____

Care Coordination (check all that apply):

- ☐ IHS/Tribal facility responsible for patient's ongoing care
- ☐ IHS/Tribe requested service
- ☐ Patient self-referral (e.g. emergency care)
- ☐ Covered facility transmitted relevant information back to IHS/Tribal facility and information incorporated into patient record.

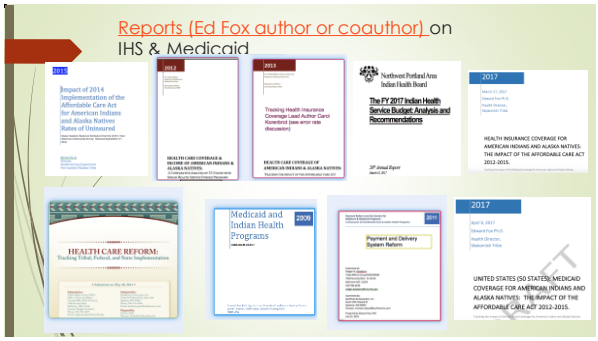
_____

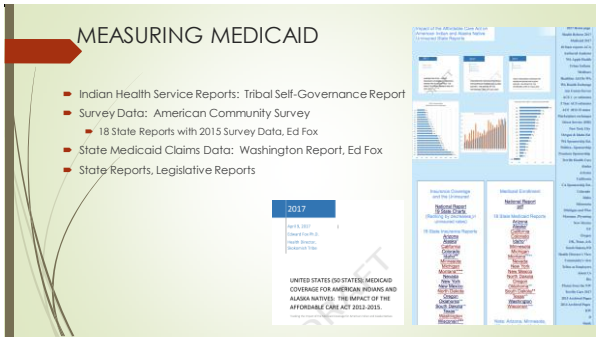
Person Completing Form

_____

Date

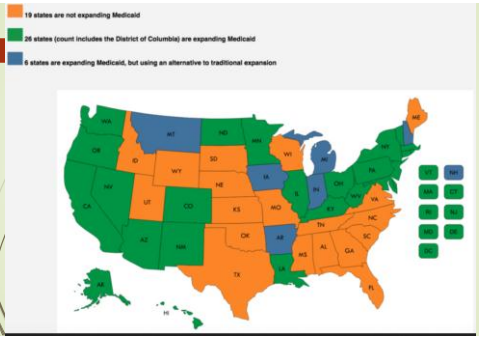

Medicaid
Edward Fox, Health Director, Skokomish Tribe


Reports (Ed Fox author or coauthor) on IHS & Medicaid
Impact of 2014 Implementation of the Affordable Care Act for American Indians and Alaska Natives Rates of Uninsured
Tracking Health Insurance Coverage Lead Author Carol Korenbrot (see error rate discussion)
Northwest Portland Area Indian Health Board
The FY 2017 Indian Health Service Budget: Analysis and Recommendations
HEALTH INSURANCE COVERAGE FOR AMERICAN INDIANS AND ALASKA NATIVES: THE IMPACT OF THE AFFORDABLE CARE ACT 2012-2015.
HEALTH CARE REFORM:
Medicaid and Indian Health Programs
Payment and Delivery System Reform
UNITED STATES (50 STATES) MEDICAID COVERAGE FOR AMERICAN INDIANS AND ALASKA NATIVES: THE IMPACT OF THE AFFORDABLE CARE ACT 2012-2015.


MEASURING MEDICAID
Indian Health Service Reports: Tribal Self-Governance Report
Survey Data: American Community Survey
18 State Reports with 2015 Survey Data, Ed Fox
State Medicaid Claims Data: Washington Report, Ed Fox
State Reports, Legislative Reports
UNITED STATES (50 STATES) MEDICAID COVERAGE FOR AMERICAN INDIANS AND ALASKA NATIVES: THE IMPACT OF THE AFFORDABLE CARE ACT 2012-2015.

Key elements of Increases in Medicaid Enrollment, aka Medicaid Expansion

- 1. Support for Outreach and Enrollment
- 2. Effective Website enrollment
- 3. One year eligibility, Easy annual renewal
- 4. Childless adults eligible
- 5. No requirement to provide AIAN tribal documentation
- 6. Expansion of income threshold to 138% of FPL—Known as Medicaid expansion



American Community Survey

Response rate is over 95%

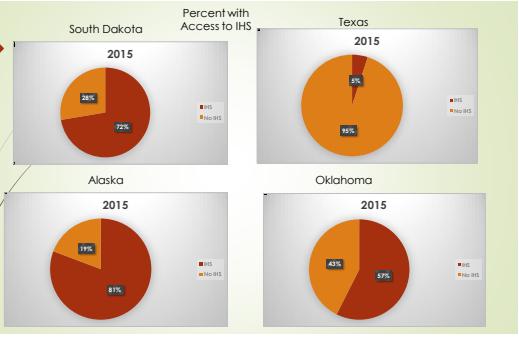
What is Person 2's race? *Mark (X) one or more boxes.*

- White
- Black or African Am.
- American Indian or Alaska Native — *Print name of enrolled or principal tribe.*

16 **Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans?** *Mark "Yes" or "No" for EACH type of coverage in items a – h.*

	Yes	No
a. Insurance through a current or former employer or union (of this person or another family member)		
b. Insurance purchased directly from an insurance company (by this person or another family member)		
c. Medicare, for people 65 and older, or people with certain disabilities		
d. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability		
e. TRICARE or other military health care		
f. VA (including those who have ever used or enrolled for VA health care)		
g. Indian Health Service		
h. Any other type of health insurance or health coverage plan – *Specify*		

	Total Population 2012	Total Population 2015	Change Total Population	% change Total Population	With IHS Access 2012	With IHS Access 2015	% w IHS access 2015
Alaska	145,202	143,916	(1,286)	-1%	123,285	121,286	84%
Arizona	344,541	369,688	25,147	7%	171,801	198,834	54%
California	654,333	637,910	(16,423)	-3%	71,888	70,034	11%
Colorado	95,706	105,795	10,089	11%	7,370	8,905	8%
Idaho	34,772	41,237	6,465	19%	13,024	15,805	38%
Kansas	59,514	56,437	(3,077)	-5%	10,491	10,229	18%
Michigan	131,828	134,346	2,518	2%	24,062	24,087	18%
Minnesota	103,083	97,722	(5,361)	-5%	35,936	36,508	37%
Mississippi	22,705	21,355	(1,350)	-6%	7,684	6,606	31%
Montana	86,156	85,517	(639)	-1%	55,255	56,164	66%
Nevada	51,120	55,809	4,689	9%	18,473	15,048	27%
New Mexico	217,755	221,442	3,687	2%	144,477	155,597	70%
New York	147,913	166,315	18,402	12%	15,007	7,805	5%
North Dakota	42,347	51,110	8,763	21%	29,827	32,148	63%
Oklahoma	510,587	516,582	5,995	1%	308,492	303,581	59%
Oregon	118,034	116,553	(1,481)	-1%	31,195	25,359	22%
South Dakota	84,281	88,710	4,429	5%	63,927	66,432	75%
Texas	281,742	306,370	24,628	9%	13,183	22,262	7%
Washington	194,178	199,991	5,813	3%	56,015	57,296	29%
Wisconsin	93,553	96,247	2,694	3%	24,296	25,200	26%
	3,419,350	3,513,052	93,702	3%	1,225,688	1,259,186	36%
USA	4,935,998	5,112,521	176,523	4%	1,299,666	1,350,477	26%
	69%	69%	53%		94%	93%	



TSGAC Request for IHS Data on Insurance Status of Active Users, by Service Unit

- On January 6, 2017, the TSGAC requested a data run include the following limited set of elements
- 1) Total Active Users
- 2) Medicare (Part A, B, C and/or D)
- 3) Medicaid (without Medicare)
- 4) Private health insurance (without Medicare and/or Medicaid)
- 5) Other / no insurance: no Medicare, no Medicaid, and/or no PHI
- Total Active Users 1,622,270
- ACS Estimate (previous slide) 1,350,000 "With Access to IHS."
- 665,000 of registrants (of 1.6 million) listed with Medicaid coverage
- ACS Estimate 453,000 "With Access to IHS."

ALL IHS AREAS

End of FY 2016 (9/30/2016) Health Insurance Status, Selected Single Insurance Categories

Area	FY 2016 Active Indian Registrants	Medicare Only	Medicaid Only	Private Insurance Only	Without Any Insurance Information
Alaska	158,674	11,563	31,782	52,209	63,120
Albuquerque	84,411	8,872	46,390	14,729	14,420
Bemidji	110,526	10,664	37,097	33,235	29,530
Billings	72,719	6,638	29,769	11,165	25,147
California	88,934	7,973	35,626	23,876	21,459
Great Plains	129,991	10,430	54,192	20,933	44,436
Nashville	56,620	5,263	13,194	18,607	19,556
Navajo	244,209	29,523	147,541	31,811	35,334
Oklahoma City	361,052	44,385	105,644	101,639	109,384
Phoenix	176,048	13,777	94,486	33,026	34,759
Portland	111,122	10,758	52,609	26,816	20,939
Tucson	27,964	2,360	17,605	5,294	2,705
All Areas	**1,622,270**	**162,206**	**665,935**	**373,340**	**420,789**

PORTLAND AREA

DATE End of FY 2016 (9/30/2016) Health Insurance Status, Selected Single Insurance Categories

Aggregation Code	Area/Service Unit	Service Unit Grouping	FY 2016 Active Indian Registrants	Medicare Only	Medicaid Only	Private Insurance Only	Without Any Insurance Information
	Portland Area - Total		**111,122**	**10,758**	**52,609**	**26,816**	**20,939**
A	Coeur d'Alene *	ACFL	20,311	1,925	7,279	5,537	5,570
C	Fort Hall *	ACFL					
F	Northern Idaho *	ACFL					
L	Umatilla *	ACFL					
B	Colville *	BGNE	22,351	2,578	12,085	4,491	3,197
E	Neah Bay *	BGNE					
G	Northwest Washington *	BGNE					
N	Wellpinit *	BGNE					
D	Klamath *	DJMO	25,198	2,749	12,032	6,793	3,624
J	Southern Oregon *	DJMO					
M	Warm Springs *	DJMO					
O	Western Oregon *	DJMO					
H	Puget Sound *	KPHI	43,262	3,506	21,213	9,995	8,548
I	Puyallup *	KPHI					
K	Taholah *	KPHI					
P	Yakama *	KPHI					

2017

UNITED STATES (50 STATES): MEDICAID COVERAGE FOR AMERICAN INDIANS AND ALASKA NATIVES: THE IMPACT OF THE AFFORDABLE CARE ACT 2012-2015.

50 States: 2012 to 2015 Medicaid Enrollment
Total American Indian and Alaska Native, With IHS and No IHS Access

Total Pop	2012	2015	Increase 12-15	% increase
Total Pop	1,458,746	1,674,558	215,812	15%
Male	674,495	784,701	110,206	16%
Female	784,251	889,857	105,606	13%
IHS	2012	2015	Increase 12-15	
Total Pop	383,847	453,310	69,463	18%
Male	179,065	209,872	30,807	17%
Female	204,782	243,438	38,656	19%
No IHS	2012	2015	Increase 12-15	
Total Pop	1,074,899	1,221,248	146,349	14%
Male	495,430	574,829	79,399	16%
Female	579,469	646,419	66,950	12%

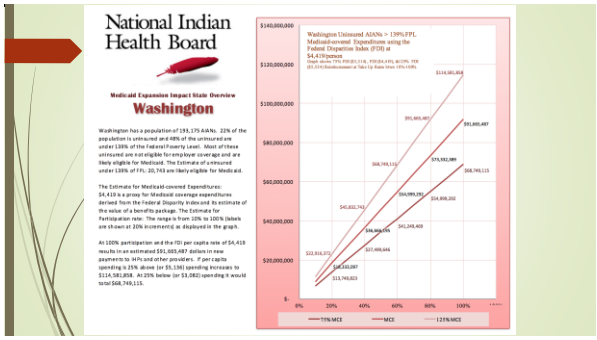
Medicaid Estimates from ACS

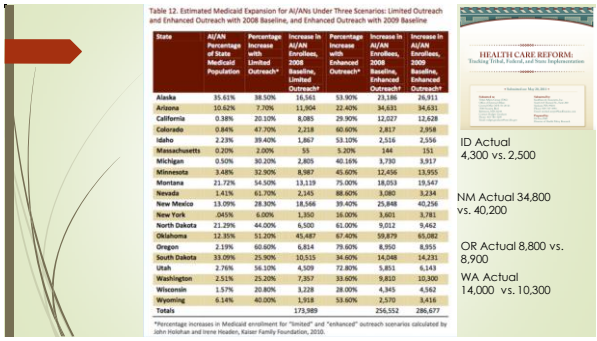
ACS Estimate vs. IHS Active Use 2016				
	ACS	2016 IHS Active User	ACS % of IHS	Comments
Idaho	13,024	16,700	78%	ACS under 'predicts' Active User
Oregon	31,195	28,442	110%	ACS over 'predicts' Active User
Washington	56,015	67,715	83%	ACS under 'predicts' Active User
PAO	100,234	112,857	89%	ACS under 'predicts' Active User

Medicaid Enrollment change 2013 to 2015

	2013 Medicaid	2014 Medicaid	2015 Medicaid	2013-2015 Change	% change
US	1,457,190	1,605,298	1,674,558	217,368	15%
Alabama	10,302	15,486	12,536	2,234	22%
Alaska	45,853	43,286	49,519	3,666	8%
Arizona	127,782	150,579	148,249	20,467	16%
California	189,276	213,693	232,060	42,784	23%
Colorado	27,854	46,002	36,756	8,902	32%
Connecticut	9,569	12,242	13,361	3,792	40%
Florida	26,944	30,990	32,338	5,394	20%
Idaho	8,973	8,782	11,803	2,830	32%
Illinois	26,983	25,576	22,454	(4,529)	-17%
Iowa	10,199	8,628	10,730	531	5%
Kansas	11,621	12,037	12,702	1,081	9%
Louisiana	16,499	12,585	15,193	(1,306)	-8%
Maine	11,198	13,043	10,939	(259)	-2%
Massachusetts	17,869	15,134	20,933	3,064	17%
Michigan	47,933	49,208	51,614	3,681	8%
Minnesota	42,201	40,297	36,735	(5,466)	-13%
Mississippi	5,983	6,464	8,752	2,769	46%
Montana	29,939	26,359	28,997	(942)	-3%
Nebraska	8,653	9,326	9,244	591	7%
Nevada	12,878	13,821	18,733	5,855	45%
New Mexico	82,033	90,687	105,554	23,521	29%
New York	57,617	65,139	58,012	395	1%
North Carolina	57,324	57,062	57,116	(208)	0%
North Dakota	16,608	18,408	17,061	453	3%
Ohio	24,764	31,840	44,912	20,148	81%
Oklahoma	122,912	116,508	121,030	(1,882)	-2%
Oregon	32,802	51,928	45,453	12,651	39%
Rhode Island	2,726	5,890	6,674	3,948	145%
South Carolina	9,309	11,088	8,997	(312)	-3%
South Dakota	37,480	36,518	36,255	(1,225)	-3%
Texas	56,645	50,850	69,895	13,250	23%
Utah	11,905	12,741	12,832	927	8%
Washington	57,753	74,564	72,956	15,203	26%
Wisconsin	31,678	28,314	32,458	780	2%
Wyoming	6,552	6,156	3,906	(2,646)	-40%

	Medicaid 2012	Medicaid 2015	Change Medicaid	% Change 2012 to 2015	% of Medicaid 2012	% 0f Pop Medicaid 2015	% change
Idaho	7,487	11,803	4,316	58%	22%	29%	7%
Nevada	12,017	18,733	6,716	56%	24%	34%	10%
New Mexico	70,676	105,554	34,878	49%	32%	48%	15%
North Dakota	12,045	17,061	5,016	42%	28%	33%	5%
Colorado	26,545	36,756	10,211	38%	28%	35%	7%
California	179,526	232,060	52,534	29%	27%	36%	9%
Washington	55,956	69,895	13,939	25%	29%	35%	6%
Oregon	36,673	45,453	8,780	24%	31%	39%	8%
Michigan	42,320	51,614	9,294	22%	32%	38%	6%
Arizona	127,576	148,249	20,673	16%	37%	40%	3%
Mississippi	5,688	6,606	918	16%	25%	31%	6%
Texas	62,870	69,895	7,025	11%	22%	23%	0%
Montana	28,997	31,656	2,659	9%	34%	37%	3%
New York	54,514	58,012	3,498	6%	37%	35%	-2%
Alaska	48,369	49,519	1,150	2%	33%	34%	1%
Minnesota	37,746	36,735	(1,011)	-3%	37%	38%	1%
Oklahoma	125,126	121,030	(4,096)	-3%	25%	23%	-1%
Wisconsin	34,756	32,458	(2,298)	-7%	37%	34%	-3%
South Dakota	39,819	36,255	(3,564)	-9%	47%	41%	-6%
Kansas	16,426	12,702	(3,724)	-23%	28%	23%	-5%
20 States	1,025,132	1,192,046	166,914	16%	30%	34%	4%
USA	1,458,746	1,674,558	215,812	15%	30%	33%	3%
	70%	71%	77%				



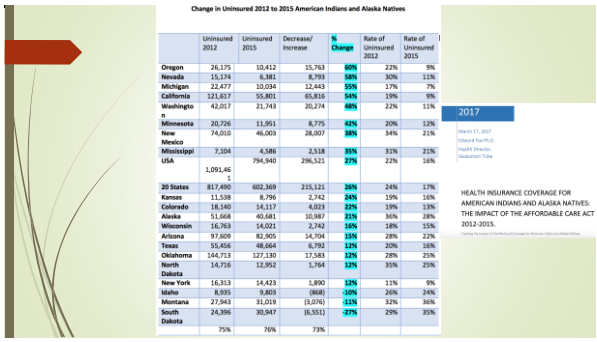


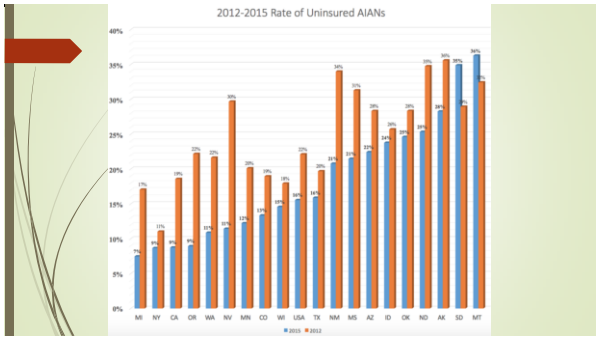
ID Actual
4,300 vs. 2,500

NM Actual 34,800
vs. 40,200

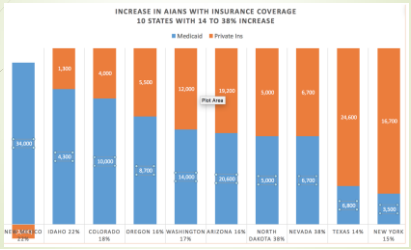
OR Actual 8,800 vs.
8,900

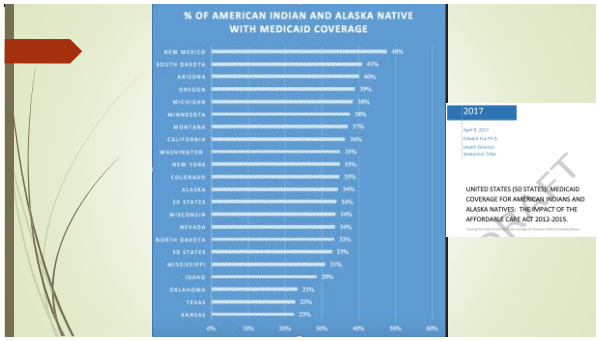
WA Actual
14,000 vs. 10,300





Medicaid's Role in Reducing the Uninsured under the Affordable Care Act 2012 to 2015





Medicaid Claims Data

- 2014 Report Washington Health Care Authority
- 18,000 American Indian and Alaska Native patients at our health programs.
- Ed Fox
- HCA Staff Jessie Dean, Mike Longnecker and other staff
- Linked to create estimates of payments for Indian Health Program Patients.

Medicaid Payments for AIANs only	2014	2013	Increase 2014	% increase
	$52,189,715	$37,738,370	$14,451,345	38%
Puyallup	$7,391,138	$5,462,701	$1,928,437	35%
Muckleshoot	$3,090,988	$1,639,344	$1,451,644	89%
Cowlitz	$3,604,623	$2,325,447	$1,279,176	55%
Squaxin Island	$1,946,760	$890,625	$1,056,135	119%
Nooksack	$3,898,046	$3,024,863	$873,183	29%
Yakama	$3,604,151	$2,791,855	$812,296	29%
Makah	$1,964,107	$1,211,703	$752,404	62%
Quinault	$1,592,449	$864,355	$728,094	84%
Swinomish	$1,594,108	$899,536	$694,572	77%
Lower Elwha	$2,213,920	$1,581,034	$632,886	40%
Lummi	$5,890,961	$5,310,037	$580,924	11%
Port Gamble	$2,155,202	$1,617,659	$537,543	33%
Spokane	$1,354,463	$908,735	$445,728	49%
Nisqually	$853,079	$443,597	$409,482	92%
Tulalip	$2,390,000	$1,997,633	$392,367	20%
Skokomish	$783,589	$434,043	$349,546	81%
Quileute	$665,619	$394,083	$271,536	69%
Suquamish	$729,945	$477,673	$252,272	53%
Stillaguamish	$2,428,740	$2,188,459	$240,281	11%
Chehalis	$692,463	$475,751	$216,712	46%
Kalispel	$344,350	$134,230	$210,120	157%
Snoqualmie	$914,291	$710,910	$203,381	29%
Jamestown	$255,550	$143,779	$111,771	78%
Shoalwater Bay	$180,877	$104,195	$76,682	74%
Colville	$1,650,296	$1,706,123	$(55,827)	-3%

Yakama Nation $4 million increase (+80%)

2014 Medicaid Paid Claims

The State of Washington paid about $114 million for AIANs Medicaid health care services in 2014. $62 million was paid directly to Tribal and IHS programs. $50 million was paid to outside providers and for Medicaid eligible services.

Source: WA Health Care Authority, September 2015 Data Pull of 2014 payments/claims matching Provider ID for those served in IHS-funded programs to payments for those same patients outside IHS funded-programs. Note: Preliminary Data.

2014 Paid Claims

Claim type	IHS & Tribal	Urban	All Other	Total
Professional	$ 50,112,587	$ 497,818	$ 14,968,180	$ 65,578,586
Pharmacy	$ 4,236,317	$ 35,855	$ 8,056,619	$ 12,328,792
Outpatient Hospital	$ -	$ -	$ 11,406,833	$ 11,406,833
Inpatient Hospital	$ -	$ -	$ 9,739,738	$ 9,739,738
Dental	$ 6,471,508	$ 30,207	$ 2,043,986	$ 8,545,703
DME, Non-DME, & Supplies	$ 156,960	$ -	$ 1,748,758	$ 1,905,718
EPSDT	$ 1,088,228	$ 3,782	$ 273,473	$ 1,365,484
Nursing Facility	$ 154,855	$ -	$ 1,107,253	$ 1,262,108
Medicare Part B Crossover	$ 312,347	$ -	$ 132,384	$ 444,732
Ambulatory Surgical Center	$ -	$ -	$ 250,050	$ 250,050
Medicare Part A Crossover	$ -	$ 179	$ 226,105	$ 226,284
Kidney Center	$ -	$ -	$ 201,990	$ 201,990
Home Health	$ -	$ -	$ 76,685	$ 76,685
Hospice	$ -	$ -	$ 59,457	$ 59,457
Total	$ 62,932,802	$ 567,841	$ 50,291,511	$ 113,792,160

2017

MEDICAID COVERAGE FOR AMERICAN INDIANS AND ALASKA NATIVES: THE IMPORTANCE OF MEDICAID FOR INDIAN HEALTH PROGRAMS

Estimate of 2016 Medicaid Payments for the Patients of Indian Health Programs

		Paid to IHP	ALL OTHER PAYMENTS Rx, Hospitals, Specialists, Transportation, etc., for IHP patients	Total est. 2016
1	Alaska	$265,000,000	$50,000,000	$315,000,000
2	Arizona	$400,000,000	$200,000,000	$600,000,000
3	Minnesota	$75,000,000	$75,000,000	$150,000,000
4	Montana	$50,000,000	$50,000,000	$100,000,000
5	New Mexico	$175,000,000	$100,000,000	$275,000,000
6	North Dakota	$45,000,000	$55,000,000	$100,000,000
7	Oklahoma	$100,000,000	$100,000,000	$200,000,000
8	Oregon	$30,000,000	$35,000,000	$65,000,000
9	South Dakota	$80,000,000	$120,000,000	$200,000,000
10	Washington	$60,000,000	$65,000,000	$125,000,000
	10 states	$1,280,000,000	$850,000,000	$2,130,000,000

Thank You
Ed Fox 360 490-6277

Washington State Health Care Authority

Washington Medicaid Integration of Physical and Behavioral Health Services and Administration

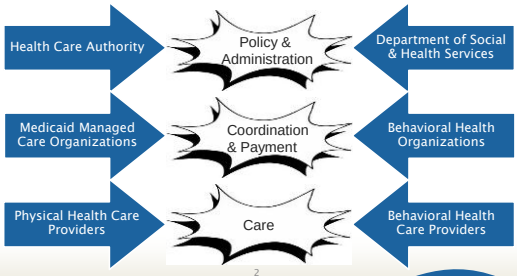
Northwest Portland Area Indian Health Board Meeting

Jessie Dean
Administrator, Tribal Affairs & Analysis

Libby Watanabe
Healthier Washington Tribal Liaison

April 17, 2017

Today: Three Levels of Breakdown



2

Integration of State Agencies

- Today

Health Care Authority

Department of Health & Social Services

Division of Behavioral Health & Recovery

- Mid-2018

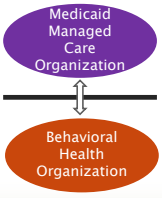
Health Care Authority
- Physical Health
- Behavioral Health
- Dental
- Transportation

Department of Health & Social Services

3

Integration of Managed Care

- Today

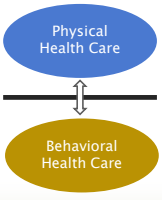


- By January 1, 2020

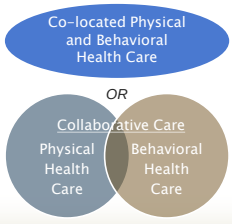
4

Integration of Care

- Today



- Goals



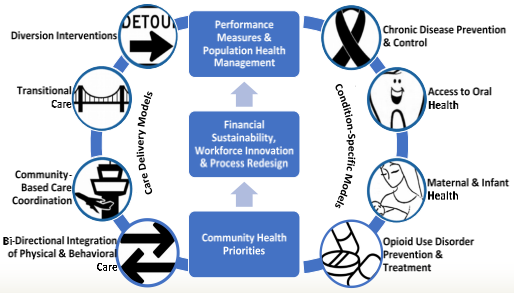
5

Medicaid Transformation 1115 Waiver

- Delivery System Reform Incentive Payment Program
  - Through Accountable Communities of Health
  - Directly from State for Tribal/Urban Indian Health Projects
- Project Plans
  - Over Five Years with Milestones
  - Achieve Milestones to Receive Payment
  - Focus on Care Delivery Reform and System Reform
- One of Eight Project Categories: Bidirectional Integration of Physical and Behavioral Health Care

6

Medicaid Transformation 1115 Waiver



7

Questions?

HCA Tribal Affairs Contact Information:

Jessie Dean
Administrator, Tribal Affairs & Analysis
360-725-1649
jessie.dean@hca.wa.gov

Libby Watanabe
Healthier Washington Tribal Liaison
360-725-1808
elizabeth.watanabe@hca.wa.gov

8

NPAIHB CHAIRMAN REPORT
JANUARY-APRIL 2017

In my role as Chair, I attended several meetings this quarter:

I attended NIHB Board Meeting on January 24-26, 2017 in Washington, DC. In addition to our regular board business, we spent a significant amount of time setting legislative and policy priorities related to the new administration.

From February 13-16, 2017, I attended NCAI's Executive Council Winter Session in Washington, DC. I also made about 10 Hill visits with Board staff and spoke with Congressional Representatives for Washington, Oregon and Idaho and had meetings with majority and minority staff of the Senate Committee on Indian Affairs. We advocated for preservation of Medicaid expansion and 100% FMAP, opposition to block granting, and preservation of the Indian Health Care Improvement Act and Indian provisions in the Affordable Care Act. We also advocated for permanent authorization and increased funding for the Special Diabetes Program for Indians, IHS Advance Appropriations, IHS Exemption from Sequestration, parity with VA funding for Hepatitis C treatment, among many other requests.

I then attended the FY 2019 IHS National Budget Work Session from February 16-17, 2017 in Crystal City. I was re-nominated as co-Chair and look forward to continuing in this role. At the meeting, IHS acknowledged Portland Area's request for full funding at (42%). There was also an

inquiry to Acting Director Chris Buchanan as to unspent IHS funds being returned to the Treasury. Acting Director Buchanan will provide a detailed response in the future.

On March 9, 2017, I testified at an Oversight Hearing for the Subcommittee on Indian, Insular and Alaska Native Affairs (under the House Committee on Natural Resources) on "Improving and Expanding Infrastructure in Tribal and Insular Communities." I asked the Subcommittee to do everything in its power to ensure that Congress addresses Indian health facilities needs when it drafts legislation to implement the expected Trump administration infrastructure initiative. I also asked the Subcommittee to direct the IHS to distribute a significant portion of any facilities construction funds that may be available under an infrastructure initiative through an Area Distribution Fund to ensure that all IHS areas have an opportunity to address facility needs.

On March 30, 2017, I attend the U.S. Department of Health & Human Services, 19th Annual Tribal Budget and Policy Consultation. Tribal leaders from across Indian country attended the meeting to discuss budget and policy concerns with leadership from several federal agencies. As a co-Chair of the National Tribal Budget Formulation Workgroup, I made a needs-based budget request to IHS of $32 billion to be phased in over a 12-year period. I also discussed the impact of cuts to the Low Income Home Energy Assistance Program (LIHEAP), the Meals on Wheels Program, and the Low Income Student Foods Assistance Program; recent passage of bill in Washington state allowing dental health aide therapists (DHATs) to work in Tribal communities, and need to get DHATs approved for reimbursement under Medicaid; Indian

country's oral health disparities, the need for DHATs, and the Indian Health Care Improvement Act's restriction on use of DHATs without state authorization; importance of Headstart; funding for traditional healing and the Tribal Behavioral Health Agenda; and other concerns. For the Colville Tribe, I talked about working with the State on obtaining the inpatient encounter rate for our convalescent center and in-home care and long term care needs. HHS Secretary Tom Price attended the consultation during the last hour. I was able to speak directly with the Secretary and reiterate several of the concerns that I expressed to the federal agencies.

Last week, on April 10, 2017, I attended the HHS Region 10 Tribal Consultation hosted by the Suquamish Tribe. Representatives from the various federal agencies were at the meeting. I brought up the need for Hepatitis C Treatment, the prevalence of cancer in our communities, concern about the cut to LIHEAP funding, the CMS 4 Walls Limitation, and the need for funding for elders for in-home and long-term care.

Behavioral Health Committee

Tuesday April 18, 2017
Quinault Beach Resort- Ocean Shores, WA 98569

	Name and Title	Organization	Phone/FAX/E-mail
1	Alan Ham, Health committee Member	Confed. Tribes of Grand Ronde	AlanHam1951@Hotmail.com 503-949-2721
2	Caroline M. Cruz Hlth Dir	CTWS	541-553-0497 caroline.cruz@ctwstribes.org
3	Darryl Scott Behavioral Health Prog. Mgr.	CTWS	541-460-8649 darryl.scott@ctwstribes.org
4	Marilyn M. Scott Tribal Council	upper Skagit Tribe	360 854-7039 marilyns@upperskagit.com
5	Kevin Collins Health Director	Stillaguamish Tribe	kcollins@stillaguamish.com 360-391-3875
6	Lisa Guzman Healthcare Admin	Kalispel Tribe	lguzman@camashealth.com 509-789-7614
7	Kay Culbertson Cowlitz Tribal Health Director	Cowlitz Tribe	Kculbertson@cowlitz.org
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Northwest Portland Area Indian Health Board
April 2017 Quarterly Board Meeting
Quinault Beach Resort – Ocean Shores, WA
April 17-19, 2017
Behavioral Health Committee

Attendance: Alan Ham, Grand Ronde; Caroline Cruz, CTWS; Darryl Scott, CTWS; Marilyn Scott, Upper Skagit; Kevin Collins, Stillaguamish; Lisa Guzman, Kalispel; Kay Culbertson, Cowlitz; Jessica Leston, NPAIHB Staff

Ongoing Behavioral Health Committee questions –

- **Presentation Idea:** Marijuana medical uses-Puyallup cancer center and their research efforts; effects of marijuana/substance use and the effects on the brain; process to legalize-case studies from Tribes; provide a policy analysis template.
    - **Update:**
- **Presentation Idea:** Update on NARA tx center. Can some of the treatment facilities come and present on what they offer, how patients are eligible, who to contact, and what insurances are taken? Possible presenters include NARA, Healing Lodge, Northwest Treatment Center, etc.
    - **Update:**
- **Presentation Idea:** Tribes with integrated care models would present on their journey to their systems change, successes, challenges, tips for other tribes trying to streamline and di-silo clinical processes. Example – possibly Tulalip or Stillaguamish to present on their roads to health systems integration.
    - **Update:**
- **Presentation Idea:** Marijuana in the Tribes and the findings of any studies around cancer treatment and the use of marijuana? Also, what are the effects of marijuana short and long-term on kids and teens? Does it affect the lungs and possibly lead to lung cancer like tobacco does?
    - **Update:**
- **Presentation Idea:** Update on Community Health Aid Practitioners and Behavioral Health Aids in the lower 48
    - **Update:**
- **Presentation Idea:** 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). In WA, they are requesting that 100% of FMAP savings return to tribal programs. In OR, the saving is split with the Tribes
    - **Update:**
- **Request:** Identify contact at Tulalip's and CTCLUSI's courts and send it out to the committee members so they can follow-up with these contacts and learn more about the system.
    - **Update:**
- **Request:** List of treatment centers that can be accessed by tribes and each center would have a description of services offered, treatment models used, patient eligibility requirements and age ranges, number of beds, what accreditations the facility has, and what diagnoses are accepted i.e. is co-occurring accepted?
    - **Update:**
- **Request:** Can the NPAIHB provide more information around co-occuring treatment and Evidence Based Practices.

    - **Update:**
- **Request:** Can the NPAIHB help assist with the large problem many rural tribes face around recruiting and sustaining professional staff at their clinics? Licensed behavioral health staff are not applying for the open positions at many rural tribes. Can we learn more about psychiatric consultations? Chandra Yates from Klamath is looking into this method of having an off-site psychiatrist consult with staff on site about patients. This may help ease the need a little but does any other Tribe have this issue or is any other tribe finding other solutions to lack of professional applicants?
    - **Update:**
- **Request:** Can NPAIHB look into the need for more regional coordination in behavioral health services. **Question**: What happened to recruiting Dale Walker?
    - **Update:** *Colbie asked Joe before the Jan. QBM and let the committee know that Joe spoke with Dale & he is currently enjoying retirement so likely would continue it until a grant opportunity interested him a lot & if we wrote him in as a consultant.*

Elders Committee

Tuesday April 18, 2017
Quinault Beach Resort- Ocean Shores, WA 98569

	Name and Title	Organization	Phone/FAX/E-mail
1	Patty Kinswa-Gaiser	Coulitz/ Tribal Council Chair	360-520-2578 pattygaiser@
2	DAN GLEASON	CHEHALIS	360-273-5911 gmail.com dgleason@chehalistribe.org
3	Janice	USCT	541-553-1194
4	Andy	Colville	509 634 4406
5	Twila Teeman	Burns Paiute	541-573-8049
6	Valerie Switzler	CTWS	541-553-3257
7	Clarice Charger	NPAIHB-Staff	503-416-3256
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Elder Committee Meeting Minutes

April 18, 2017

Quinault Beach Resort – Ocean Shores, WA

Members: Patty Kinswa-Gaiser – Cowlitz Tribe
Janice Clements – Warm Springs Tribe
Twila Teeman – Burns Paiute Tribe
Valerie Switzler – Warm Springs Tribe
Andy Joseph – Colville Tribe
Dan Gleason – Chehalis Tribe

NPAIHB Staff: Clarice Charging

Dan asked Andy to open the meeting with a prayer.

Dan asked for a motion to approve the October 2016 minutes. Andy motioned. Patty seconded. Motion approved.

UPDATES

Cowlitz: Iliani (*To sing to*) Casino will have a VIP opening on Saturday, April 22nd from 6:00 – 9:00 pm, and will open to the public on Monday, April 24th at 10:00 am.

Tribal elders were invited by the Quileute Tribe to attend their Welcoming The Whales ceremony and were overnight guests at their resort.

Burns Paiute: Tribe is working on acquiring a bus and remodeling the Senior Center.

Colville: Andy has been to Washington, DC, focusing on lobbying efforts for tribal funding. Several programs with uncertain funding are energy assistance, free lunches for children, and Impact Aid (area school assistance).

Elder dinner will be held in Omak, May 2017.

Warm Springs: Elder Day will be May 12th in Warm Springs and they anticipate strong attendance.

Valerie' teaches in the Rise-n-Shine Program for elementary students, teaching language, culture, song, and dance. The program meets Monday through Friday from 7:30 – 8:50 am, and students receive breakfast before attending their classroom programs. Seventy-three students will be attending the Language Bowl on May 5th in Pendleton, where they will compete against others with their knowledge of the Warm Springs, Wasco, and Paiute languages.

Chehalis: Tribe has opened up their buffet at the casino and their hotel, and parking expansion will be completed by December 2017.

Legislative/Resolution Committee

Tuesday April 18, 2017
Quinault Beach Resort- Ocean Shores, WA 98569

	Name and Title	Organization	Phone/FAX/E-mail
1	Greg Abrahamson (Council)	Spokane	509-458-6507
2	Nicholaus Lewis	Lummi	360 303 6084
3	Joe Finkbonner	NPAIHB	
4	Karol Dixon	Port Gamble S'Klallam	360-620-4378
5	John Stephens	Swinomish	360 466 7216
6	Christina Peters	NPAIHB	
7	Gerald Hill	Klamath Tribes	541 892 2922
8	Jim Wallis	Yellowhawk	541 278 7526
9	Lance Colby Director	Lower Elwha Klallam	~~360~~ lance.colby@elwha.org
10	Ann Tim	Shoshone-Bannock	(208) 478-3744
11	Andy Joseph Jr.	Colville Tribe	509 631 4406
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Legislative Committee Report
April 18, 2017

Attendees: Greg Abrahamson (Spokane), Nicholaus Lewis (Lummi), Karol Dixon (Port Gamble Sklallam), John Stephens (Swinomish), Gerald Hill (Klamath Tribe), Jim Wallis (Umatilla), Lance Colby (Lower Elwha Klallam), Ann Jim (Shoshone-Bannock), Andy Joseph, Jr. (Colville)

Staff: Joe Finkbonner, Laura Platero, Christina Peters

Eight resolutions were considered by the Legislative Committee and acted upon:

1. **Preserve the Indian Health Care Improvement Act, No. 17-03-01**

   This resolution supports and requests permanent reauthorization of the Indian Health Care Improvement act as to any repeal of the Affordable Care Act.

   Action: This resolution was approved by the Executive Committee on February 8, 2017. Motion to pass resolution along to full board for ratification by Spokane, second by Lummi, then unanimous vote approving same.

2. **Supporting Native Expectant and Parenting Teens, Women, Fathers and Their Families, No. 17-03-02**

   This resolution endorses the EpiCenter's proposal in response to the AH-SP1-17-001: Support for Expectant and Parenting Teens, Women, Fathers, and Their Families.

   Action: This resolution was approved by the Executive Committee on February 8, 2017. Motion to pass resolution along to full board for ratification by Spokane, second by Lummi, then unanimous vote approving same.

3. **"Office of Minority Health Partnerships to Achieve Health Equity Competitive Grant" Improving Data and Enhancing Access-Northwest (IDEA-NW), No. 17-03-03**

   This resolution endorses and supports the staff of the EpiCenter, under guidance of the Executive Director, to submit a grant application to the Office of the Secretary, Office of Minority Health requesting funding for initiative titled "MP-CPI-001 Partnerships to Achieve Health Equity.

   Action: This resolution was approved by the Executive Committee on March 21, 2017. Motion to pass along resolution to full Board for ratification by Spokane, second by Lummi, then unanimous vote approving same.

4. **Supporting Nomination of Dr. Charles W. Grim for the Director of the Indian Health Services, Department of Health and Human Services, No. 17-03-04**

   This resolution supports the nomination of Dr. Charles W. Grim for Director of the Indian Health Service, DHHS.

Actions: This resolution was approved by the Executive Committee on April 7, 2017. Motion to pass along resolution to full Board for ratification by Spokane, second by Swinomish, then unanimous vote approving same.

5. **Northwest Native American Research Center for Health Renewal**

This resolution supports the application of the Northwest NARCH program as it to strives to reduce health disparities for tribal peoples in the Northwest and beyond.

Actions: Motion to pass resolution to full Board for consideration by Spokane, second by Lummi, then unanimous vote approving same.

6. **Approval and Adoption of the Health Reimbursement Arrangement for Employees of NPAIHB**

The Health Reimbursement Arrangement will reimburse employees up to $500 after they have met a $1,000 deductible and the employee has accumulated in excess of $1,000 in Qualifying Medical Expenses.

Specifically, this resolution states that the Health Reimbursement Arrangement and Summary Plan Description (Attachment A) effective January 1, 2017, presented to this meeting is hereby approved and adopted and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan. In addition, this resolution states that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

Actions: Motion to pass resolution to full Board for consideration by Spokane, second by Lummi, then unanimous vote approving same.

7. **Opposition to FY 2018 Proposed Budget Cuts to U.S. Department of Health and Human Services**

There was a discussion about the President's FY 2018 Proposed Budget Cuts to the U.S. Department Health and Human Services and elimination of programs of the Office of Community Services which includes the Low Income Housing Energy Assistance Program (LIHEAP) which is important for our low income tribal members in the Northwest.

Action: The Committee directed NPAIHB staff to prepare a resolution opposing FY 2018 budget cuts to the U.S. Department of Health and Human Services, including opposition to the elimination of LIHEAP.

8. **Support for Reauthorization of the Special Diabetes Program for Indians**

There was also discussion about the expiration of the reauthorization of SDPI in September, 2017, and the need to have a resolution supporting reauthorization.

Action: The Committee directed NPAIHB staff to prepare a resolution supporting reauthorization of SDPI.

Other:

There was a discussion about the shortage of nurses and physicians to fill vacant positions at IHS/Tribal clinics. One Tribe stated that they have had to use a rent a nurse services to fill positions. There was a discussion about the IHS Scholarship Program and how it should fully fund all AI/AN students interested in health professions. There was also discussion about the need for an upward bound type program for health professions to get more youth interested in health professions. There was also suggestion to watch the "We are Healers" video series.

Personnel Committee

Tuesday April 18, 2017
Quinault Beach Resort- Ocean Shores, WA 98569

	Name and Title	Organization	Phone/FAX/E-mail
1	Andra Wagner HR Coordinator	NPAIHB	awagner@npaihb.org
2	Cassandra S Reed	Cowlitz Indian	csellardsreed@hotmail.c
3	Shawna Gavin	[illegible]	[illegible]@[illegible].org
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Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Minutes

April 18, 2017

Start Time: 12:00 pm

Members Present: Cassandra Sellards-Reck, Shawna Gavin

Staff Present: Andra Wagner

- Personnel update was read by Andra Wagner
    - 2 new hires
    - 0 promotions/transfers
    - 2 temps
    - 0 resignations
- No open position
- Background checks were conducted for all THRIVE conference chaperones and volunteers and for all new staff and temps.

Public Health Committee

Tuesday April 18, 2017
Quinault Beach Resort- Ocean Shores, WA 98569

	Name and Title	Organization	Phone/FAX/E-mail
1	Karen Hanson Health Director	Kootenai Tribe	208-267-5223 208-267-8419 Fax Karen@kootenai.org
2	Kelle Little Tribal Health Director	Coquille Tribe	kelle.little@coquilletribe.org
3	Jim Steinruck Health Administrator	Tulalip	jsteinruck@tulaliptribes-nsn.gov
4	Andrew Skogren Health Director	Quileute Tribe	Same
5	Bridget Canniff ~~NPAIHB~~ Proj Dir	NPAIHB	bcanniff@npaihb.org
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Public Health Committee Meeting Minutes
April 18, 2017

In Attendance:
Karen Hanson, Health Director, Kootenai Tribe
Kelle Little, Tribal Health Director, Coquille Tribe
Jim Steinruck, Health Administrator, Tulalip Tribe
Andrew Shogren, Health Director, Quileute Tribe
Bridget Canniff, Project Director, NPAIHB
Victoria Warren-Mears, Director, NWTEC, NPAIHB

Meeting began with brief welcome.

Public Health Expansion:

The group discussed public health expansion efforts that are occurring in both Washington and Oregon States.

In Washington, Victoria has attended the Advocacy Committee for the *Public Health is Essential* campaign. The committee is trying to get more tribal involvement in this effort. Victoria shared some of their materials, particularly around the longer-term cost-saving potential of public health investments, and suggested that NPAIHB might produce something similar for tribes. Many tribal leaders have been involved in various committees throughout the process. One key challenge in the state of Washington is that the amount of funding being requested in the Secretary's budget provides only a small amount of funds to the 39 counties in Washington. There is no current request for tribal funds. It was expressed that the concept, while valuable, has little return on time invested for tribes at this time, due to the small amount of potential funding available. Participation is challenging, given the multiple responsibilities of tribal leaders.

In Oregon, Coquille is the pilot site for data collection for the State's project. The EpiCenter will also provide pilot data. There is a kick off call with Burke consulting and Coquille very soon. The EpiCenter is available to provide TA for any tribes needing help with this evaluation.

Public Health Accreditation Planning:

Bridget held a call with Carrie Sampson (Umatilla) and Kelle Little (Coquille) to discuss future group calls on public health accreditation. There is a general sentiment that these calls could be highly supportive for tribes seeking more information on public health accreditation readiness. Bridget is exploring a teleconference platform for these calls and hopes to establish a regular call time beginning in May.

Potential Future Grant Topics:

Victoria will be sending out a survey to tribal leaders to gauge interest in participating in two potential grant opportunities; please respond when you receive the survey. The two grant opportunities are from NIH NIDDK. The first is PAR 17-178 entitled "Evaluating Natural Experiments in Healthcare to Improve Diabetes Prevention and Treatment." It requires that clinics have established policies for community and clinical linkages in place, and are willing to provide clinical data. The second is entitled, "Grants for Pragmatic Research in Healthcare Settings to Improve Diabetes and Obesity Prevention and Care." It is

focused on the prevention of pre-diabetes, diabetes, and obesity. The Board will use its usual procedure to determine if tribes are planning to apply. If no tribe is planning to apply, we will seek partners on this project.

Environmental Health Project:

We held a brief discussion of the interaction of public health and environmental health. The EpiCenter has a small grant from CDC to look at the state data portal in Oregon and determine what tribal environmental health is doing in the 9 Oregon tribes. The EpiCenter is looking to identify meaningful intersection between public health and environmental health. Two tribal examples were brought forward: one example where interaction is limited, and another where interaction is more robust around housing issues and public health, specifically in relationship to asthma.

EpiCenter Funding:

We discussed funding for the NWTEC. In FY 2018, money from CDC and from NIH will not be included in the Core EpiCenter funding as it previously had been. This is due to issues with the way the current (and previous) EpiCenter grants were written. The issue is with the authority for the Interagency Agreements (IAA) between other Federal partners and IHS. The EpiCenter RFP did not include information about sources outside of IHS providing part of the funding. Our funding from CDC will come through another mechanism; however our NIH funding, which is $50,000 per year, has not been approved for another mechanism. This means that in FY 2018, the EpiCenter funding could decrease by $50,000. There are two potential solutions for this issue: NIH could release a competitive application for the funding for all 12 EpiCenters ($50,000 each), or IHS could terminate the current EpiCenter grant after year 2 of this cycle and fix the issues, thus reopening the competition and being transparent in where the funding comes from.

Until we have resolution on this issue, we are applying for additional grants in the hopes of minimizing any fiscal impact.

Veterans Committee

Tuesday April 18, 2017
Quinault Beach Resort- Ocean Shores, WA 98569

	Name and Title	Organization	Phone/FAX/E-mail
1	DAVID SCOTT	NIMIIPUU HEALTH LAPWAI, ID.	(208) 816-0677 dscott@nezperce.org
2	Jon McConville	Nimiipuu Health Board Lapwai ID	208 790-1507 jmcconville@gmail.com
3	Cindy Harris Dir.	Sauk-Suiattle	CHarris@Sauk-Suiattle.com
4	Ronda Metcalf	Sauk Suiattle	rmetcalf@sauk-suiattle.com
5	Lou Schmitz	American Indian Health Commission for WA State	lou.schmitz.aihc@outlook.com
6	Don Head	NPAIHB	dhead@npaihb.org
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Veteran's Committee Meeting, Quinault, April 18, 2017

In attendance:
David Scott, Nimiipuu Health
Jon McConville, Nimiipuu Health Board
Cindy Harris, THD Sauk-Suiattle,
Ronda Metcalf, Sauk-Suiattle
Lou Schmitz, American Indian Health Board
Don Head, NPAIHB, staff

The minutes of the January 2017 meeting were read to the committee.

Introductions were made, and branch and service dates were offered from the veterans.

Ronda Metcalf (Sauk-Suiattle) mentioned that Representative Cathy McMorris Rodgers (WA-R) has introduced legislation (Caring for Our Heroes in the 21st Century) that would privatize the Veteran's Health Administration. This eliminates the trust responsibility in place for our Native veterans, since the organization that would oversee VA services has no standing to negotiate with Tribes. It also turns the VA from a service into a business model, and would get in the way of delivery of services to veterans.

David Scott (Nimiipuu Health) said that he works with homeless veterans in Lapwai, ID. He addresses barriers to service with veterans that are not coming out of the shadows, or not accessing services for a variety of reasons. The grant he is working out of is running out, so he hopes to find another source of funding soon.

Cindy Harris (Sauk-Suiattle) wanted to know how to connect veterans to services in her community. There was a training offered, Tribal Veterans Representative Training, but it was this week. Cindy also talked about staff turnover at the clinic, and the program they are using to get local Natives into positions at the tribe and the clinic. This would result in less turnover, and the staff would be more invested in their job and community.

The Veterans Choice Program was discussed. This program, which is staffed by non-veterans, connects veterans who live farther than 30 miles from a VA facility to clinics that are closer to the veteran. However, this program is becoming another obstacle to services, since they question the veteran looking for services, even when they have been referred to Veterans Choice by a provider.

Lou Schmitz, American Indian Health Commission, talked about setting up an agreements with the VA for pharmacy services. The challenges involved in entering into the agreement involved numerous VA staff that needed to be briefed over and over about the tribe's willingness to provide pharmacy services for their veterans. Eventually, the agreement was in place due to the tribe's tenacity and eagerness to help their veterans.

Ronda Metcalf discussed the need for staff from Veteran's Affairs to be at the committee meetings, so that they could provide updates and information on continuing VA issues to the committee.

Action Items:
Don Head will contact the Terry Bentley, of the Office of Tribal Government Relations, and invite her to the Joint NPAIHB/CRIHB meeting in July.

Don Head will contact VISN 20, the Northwest Native Network, and invite them to attend the Joint NPAIHB/CRIHB in July.

Ronda Metcalf will contact the new Seattle Veteran's Representative, and invite them to the October QBM.

Meeting adjourned.

Youth Committee

Tuesday April 18, 2017
Quinault Beach Resort- Ocean Shores, WA 98569

	Name and Title	Organization	Phone/FAX/E-mail
1	Sharon Stamphill	Cow Creek	Stamphill@cowcreek.com 541-672-8533/541-677-5521/
2	Melody Pfeifer	Cowlitz	~~tcp~~ mpfeifer@cowlitz.org 360-562-5185
3	Kim Thompson	Shoalwater Bay	kzillyett@shoalwaterbay-nsn.gov 360/267-8138(P) 360-267-6217(F)
4	Lottie Sam	Yakama Nation	(509) 930-0867/(509) 865-5121 x4345
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Youth Committee
Tuesday April 18, 2017
Quinault Beach Resort- Ocean Shores, WA
NPAIHB Quarterly Board Meeting

Attendees
Yakama Nation- Lottie Sam lotties@yakama.com
Shoalwater Bay – Kim Thompson kzillyett@shoalwaterbay-nsn.org
Cowlitz Health & Youth Board- Melody Pfeifer mpfeifer@cowlitz.org
Cowcreek Health & Wellness Center- Sharon Stanphil
NPAIHB- Nanette Star Yandell nyandell@npaihb.org

Discussion
- Introductions
- Previous Youth Committee meeting notes review
    - Resources for youth in communities and review of resource sheet.
    - Document brought to each QBM as a resource with updates
- Summer Youth Conference Opportunities
- Joint QBM Youth Workshop Registration and Tentative Agenda
    - Review of Registration form
    - Discussed role of Consent form for chaperone
    - Discussed number of youth and waitlist

Action
Include youth in details of youth committee from local area (How is still pending)

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz Indians
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Band of Umpqua
Cowlitz Indian Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Nation
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Indian Nation
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribes
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Indian Nation

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Portland, OR 97201
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www.npaihb.org

Resolution # 17-03-01
Preserve the Indian Health Care Improvement Act

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, the Indian Health Care Improvement Act (IHCIA) (P.L. 94-437) was enacted in 1976 to provide "the highest possible health status to Indians and to provide existing Indian Health Services with all resources necessary to effect that policy;" and

WHEREAS, IHCIA serves as fundamental legislation for the Indian Heath Service, tribal, and urban Indian health programs in fulfillment of the federal government's trust responsibility; and

WHEREAS, permanent reauthorization of the IHCIA (S. 1790) was enacted in 2010 with the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148); and

WHEREAS, IHCIA had been worked on for over a decade and was tacked onto the ACA as a vehicle to get IHCIA passed;

WHEREAS, IHCIA passed with the ACA but is separate from the ACA; and

WHEREAS, a repeal of the ACA in its entirety would also repeal the permanent reauthorization of IHCIA and Indian provisions in the ACA, such as, Section 2901(b)-Payor of Last Resort, 2901(c)-Facilitating Enrollment of Indians Under Express Lane Option, 2902-Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics, and Title IX, Section 9021-Exclusion of Health Benefits Provided by Indian Tribal Governments as Taxable Income; and

WHEREAS, IHCIA and Indian provisions in the ACA have significantly improved and strengthened the Indian health care system; and

WHEREAS, IHCIA has improved workforce development and recruitment of health professionals in Indian country; and

WHEREAS, IHCIA provided new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs; and

WHEREAS, IHCIA created opportunities to improve access and financing of health care services for Indians such as the provision for the Indian Health Service to carry out long term care related services and reimbursement for same; and

WHEREAS, IHCIA has been instrumental in modernizing the delivery of health services provided by IHS.

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board does hereby support and request preservation of the permanent reauthorization of Indian Health Care Improvement Act as to any repeal of the Patient Protection and Affordable Care Act.

BE IT FURTHER RESOLVED that the Northwest Portland Area Indian Health Board also hereby supports and requests retention of the Indian provisions in the ACA.

CERTIFICATION

NO. 17-03-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 5 **for,** 0 **against,** 0 **abstain on** February**, 2017.**

Andrew C. Joseph Jr.

Chairman

2/8/2017

Date

Gregg J. Abrahamson

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz Indians
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Band of Umpqua
Cowlitz Indian Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Nation
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Indian Nation
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribes
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Indian Nation

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Resolution # 17-03-02

Supporting Native Expectant and Parenting Teens, Women, Fathers, and Their Families

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

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

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

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

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

WHEREAS, the NW Tribes recognize that, despite the progress that has been made nationwide in reducing teen and unintended pregnancy, significant disparities continue to exist for American Indians and Alaska Natives (AI/AN); and

WHEREAS, the NW Tribal EpiCenter has extensive experience conducting Tribal needs assessments and Tribal Action Plans to guide program planning and delivery; and

WHEREAS, the NW Tribal EpiCenter has a proven track record providing high-quality, culturally-tailored capacity-building technical assistance to Tribes and tribal organizations to support their delivery of comprehensive health programs, including programs addressing sexual and reproductive health, sexual violence, and maternal and child health (MCH); and

WHEREAS, the NPAIHB has long standing, successful working relationships with the NW Tribes, State Health Departments, OAH, and NPC, who are committed to working collaboratively with the NPAIHB to support AI/AN expectant and parenting teens, women, fathers, and their families in the Pacific Northwest (OR, WA, and ID).

THEREFORE, BE IT RESOLVED that the NPAIHB endorses the EpiCenter's proposal in response to AH-SP1-17-001*: Support for Expectant and Parenting Teens, Women, Fathers, and Their Families*.

CERTIFICATION

NO. 17-03-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 5 **for,** 0 **against,** 0 **abstain on** February 8**, 2017.**

Andrew C. Joseph Jr.

Chairman

2/8/2017

Date

Gregg J. Abrahamson

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz Indians
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Band of Umpqua
Cowlitz Indian Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Nation
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Indian Nation
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribes
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Indian Nation

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Resolution 17-03-03

"Office of Minority Health Partnerships to Achieve Health Equity Competitive Grant" Improving Data and Enhancing Access-Northwest (IDEA-NW)

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, in furtherance of this goal in 1997, NPAIHB established the Northwest Tribal Epidemiology Center (*EpiCenter*) in an effort to improve the quality of American Indian and Alaska Native (AI/AN) epidemiology data; and

WHEREAS, The *EpiCenter* continually demonstrates the design and execution of innovative projects to reach, focus and impact the health and quality of life of Northwest tribes and has served as a national model for other Indian Health Service (IHS) areas to emulate in establishing their *EpiCenter* programs; and

WHEREAS, Section 214 of the Indian Health Care Improvement Act (P.L. 110-148) amends current law to continue authority for operation and funding of Tribal Epidemiology Centers and gives EpiCenters the status as public health authorities for purposes of the Health Insurance Portability and Accountability Act of 1996, thus granting access to health data needed to perform their mission; and

WHEREAS, the Improving Data and Enhancing Access-Northwest (IDEA-NW) project has successfully conducted data linkages with the Northwest Tribal Registry to reduce misclassification of American Indians and Alaska Natives in state cancer registries, vital records, hospital discharge records, and other public health datasets; and

WHEREAS, IDEA-NW has utilized linkage-corrected data to provide Northwest Tribes with accurate health data for community health assessment and health improvement projects; and

WHEREAS, IDEA-NW is seeking opportunities to improve and expand its data linkage, data analysis, dissemination, and training activities; and

WHEREAS, *IDEA-NW* is seeking opportunities to continue and expand its work with tribal, state, and national partners to improve its record linkage activities; develop new methods to provide Tribes with health data; and provide Tribes with training and mentorship related to collecting, sharing, and interpreting health data ; *and*

WHEREAS, the Department of Health and Human Services Office of Minority Health has invited proposals for the funding opportunity "Partnerships to Achieve Health Equity"; and

WHEREAS, a successful proposal for this funding would allow IDEA-NW to partner with the Indian Health Service and State Health Departments to improve its data linkage process, develop tools and trainings to support data linkage projects nationwide, and apply data linkages to improve states' surveillance of health and disease in AI/AN communities; and

WHEREAS, a successful proposal would allow IDEA-NW to develop methods (such as a data portal) to more efficiently and securely share health data with Northwest Tribes;

WHEREAS, a successful proposal would allow IDEA-NW to develop and provide trainings and mentorship to Northwest Tribes to increase knowledge and use of health data, increase collection of data for community health improvement, and promote data sharing projects that support tribal sovereignty;

WHEREAS, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the *EpiCenter*.

THEREFORE BE IT RESOLVED, that the NPAIHB endorses and supports the staff of the *EpiCenter,* under guidance of the Executive Director, to submit a grant application to the Office of the

Secretary, Office of the Minority Health requesting funding for the initiative entitled *"MP-CPI-001 Partnerships to Achieve Health Equity ("Partnership")*.

CERTIFICATION

NO. 17-03-03

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 4 **for,** 0 **against,** 0 **abstain on** March 21**, 2017.**

Andrew C. Joseph Jr.

Chairman

March 21. 2017

Date

Gregg J. Abrahamson

Secretary

NORTHWEST
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AREA
INDIAN
HEALTH
BOARD

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RESOLUTION NO.: 17-03-04

A RESOLUTION SUPPORTING NOMINATION OF DR. CHARLES W. GRIM FOR DIRECTOR OF THE INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 Director of the Indian Health Service (IHS) is a key role for American Indians/Alaska Natives (AI/AN) in the federal government, and responsible for executing the IHS mission of raising the health status of AI/AN to the highest possible level; and

WHEREAS, Dr. Charles W. Grim, a citizen of the Cherokee Nation, has served exemplary as IHS Director from 2002-2007, and has extensive experience with operation of large health systems, not only for IHS but also at the Tribal level; and

WHEREAS, Dr. Grim is a retired Assistant Surgeon General and Rear Admiral (upper half) in the Commissioned Corps of the United States Public Health Services (USPHS); and

WHEREAS, the IHS and Tribal governments will greatly benefit from the demonstrated leadership skills of Dr. Grim for Indian health.

THEREFORE BE IT RESOLVED, the Northwest Portland Area Indian Health Board hereby supports nomination of Dr. Charles W. Grim for Director of the Indian Health Service, Department of Health and Human Services.

CERTIFICATION

NO. 17-03-04

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 3 for, 0 against, 0 abstain on April 7, 2017.

Andrew C. Joseph Jr.

Chairman

April 7, 2017

Date

Gregg 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

April 7, 2017

President Donald Trump
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

Re: Support for Nomination of Dr. Charles W. Grim for Director of the Indian Health Service

Dear President Trump:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that advocates on health care issues for the 43 federally-recognized tribes in Oregon, Idaho and Washington. I am writing to you as the Chairperson of NPAIHB. The purpose of this letter and the attached resolution is to demonstrate our strong support for nomination of Dr. Charles W. Grim as Director of the Indian Health Service (IHS), Department of Health and Human Services.

Dr. Grim, a citizen of the Cherokee Nation, currently serves as the Deputy Director for Health Services for the Cherokee Nation. In this role he is the second line executive in charge of a health system that includes the Cherokee Nation 60 bed W.W. Hastings Hospital (CNWWH), eight outpatient health centers, an EMS service, finance and billing services, facilities management, Jack Brown Youth Regional Treatment Center and a host of public health and community health services and programs.

Although Dr. Grim is not from our area, Northwest tribes are very familiar with the work of Dr. Grim as Director of the IHS. The Director of the IHS is a key role for American Indian/Alaska Natives in the federal government, and responsible for executing the IHS mission of raising the health status of AI/AN to the highest possible level. Dr. Grim was appointed by President George W. Bush and received unanimous Senate confirmation as the Director of the IHS. Dr. Grim administered the nationwide multi-billion dollar health care delivery program from August 2002 until September 2007. Dr. Grim has a strong health management background and during a 26 year career with the IHS held numerous clinical, administrative and executive leadership positions within the Agency prior to being appointed its Director. Dr. Grim was exemplary in his role as IHS Director and is an excellent and experienced candidate for this important position.

It is the wish of the Northwest tribes that Dr. Grim be nominated to serve another term as IHS Director.

Sincerely,

Andrew C. Joseph Jr.

Andy Joseph, Jr.
Chairman, NPAIHB
Colville Tribal Council

cc: NPAIHB Delegates
Secretary Tom Price
Senate Committee on Indian Affairs
Congressman Mark Wayne Mullin

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Resolution No# 17-03-05
"Northwest Native American Research Center for Health" (NARCH) Renewal

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

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

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

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

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

WHEREAS, the Northwest Native American Research Center for Health is a program administered by NPAIHB, within the Northwest Tribal Epidemiology Center (TEC); and

WHEREAS, the strategies and programs developed and evaluated by NARCH have furthered the education and health research efforts in support of the goal of the Board; and

WHEREAS, the NARCH program provides technical assistance to tribes in the Northwest and nationwide to improve tribal health related research; and

WHEREAS, the goals of the NW NARCH program are aligned with those of the EpiCenter (TEC) and of the Board; and

WHEREAS, NW NARCH program has had a long and successful funding stream with the federal NARCH program; and

WHEREAS, the NW NARCH application to the federal NARCH program will not compete with funding for the Northwest Tribes for similar projects

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board supports the application of the NW NARCH program as it strives to reduce health disparities for tribal peoples in the Northwest and beyond.

CERTIFICATION

NO. 17-03-05

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 34 **for,** 0 **against,** 0 **abstain on** April 20**, 2017.**

Andrew C. Joseph Jr.

Chairman

April 20, 2017

Date

Gregg J. Abrahamson

Secretary

NORTHWEST
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RESOLUTION #17-03-06

Approval and Adoption of Health Reimbursement Arrangement for Employees of NPAIHB

WHEREAS, the Northwest Portland Area Indian Health Board {hereinafter "NPAIHB," "Board" or "Employer") 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 USC §450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

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

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

WHEREAS, the NPAIHB also wishes to provide health insurance for its employees in order that they may have access to health services near their place of employment; and

WHEREAS, the overall costs of the NPAIHB benefit of a health insurance plan can be reduced, without reducing the access to health care for its employees, by NPAIHB maintaining a Health Reimbursement Arrangement (Attachment A) policy; and

WHEREAS, the Health Reimbursement Arrangement will reimburse employees up to $500 after they have met a $1,000 deductible and the employee has

accumulated in excess of $1,000 in Qualifying Medical Expenses.

THEREFORE, BE IT RESOLVED, that the Health Reimbursement Arrangement and Summary Plan Description (Attachment A) effective January 1, 2017, presented to this meeting is hereby approved and adopted and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

BE IT FURTHER RESOLVED, that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

CERTIFICATION

NO. 17-03-06

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 34 **for,** 0 **against,** 0 **abstain on** April 20**, 2017.**

Andrew C. Joseph Jr.

Chairman

April 20. 2017

Date

Gregg J. Abrahamson

Secretary

SELF-ADMINISTERED HEALTH REIMBURSEMENT ARRANGEMENT

BASIC PLAN DOCUMENT

FOR

NORTHWEST PORTLAND
AREA INDIAN HEALTH BOARD

TABLE OF CONTENTS

HEALTH REIMBURSEMENT ARRANGEMENT

As used in this Plan, the following words and phrases shall have the meanings set forth herein unless a different meaning is clearly required by the context:

ARTICLE I
DEFINITIONS

1.1 "Administrator" means the individual(s) or committee appointed by the Employer to carry out the administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

1.2 "Affiliated Employer" means any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 "Code" means the Internal Revenue Code of 1986, as amended.

1.4 "Coverage Period" means the time period as set forth in the Adoption Agreement.

1.5 "Dependent" means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)).

1.6 "Effective Date" means January 1, 2017.

1.7 "Eligible Employee" means any Eligible Employee as elected in the Adoption Agreement and as provided herein. An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors. Furthermore, Employees of an Affiliated Employer will not be treated as "Eligible Employees" prior to the date the Affiliated Employer adopts the Plan as a Participating Employer.

However, a self-employed individual as defined under Code Section 401(c) or a 2-percent shareholder as defined under Code Section 1372(b) shall not be eligible to participate in this Plan.

1.8 "Employee" means any person who is employed by the Employer. The term "Employee" shall also include any person who is an employee of an Affiliated Employer and any Leased Employee deemed to be an Employee as provided in Code Section 414(n) or (o).

1.9 "Employer" means Northwest Portland Area Indian Health Board, and any successor which shall maintain this Plan and any predecessor which has maintained this Plan. In addition, unless the context means otherwise, the term "Employer" shall include any Participating Employer which shall adopt this Plan.

1.10 "Employer Contribution" means the amounts contributed to the Plan by the Employer.

1.11 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.12 "Leased Employee" means, effective with respect to Plan Years beginning on or after January 1, 1997, any person (other than an Employee of the recipient Employer) who, pursuant to an agreement between the recipient Employer and any other person or entity ("leasing organization"), has performed services for the recipient (or for the recipient and related persons determined in accordance with Code Section 414(n)(6)) on a substantially full time basis for a period of at least one year, and such services are performed under primary direction or control by the recipient Employer. Contributions or benefits provided a Leased Employee by the leasing organization which are attributable to services performed for the recipient Employer shall be treated as provided by the recipient Employer. Furthermore, Compensation for a Leased Employee shall only include Compensation from the leasing organization that is attributable to services performed for the recipient Employer.

A Leased Employee shall not be considered an employee of the recipient Employer if: (a) such employee is covered by a money purchase pension plan providing: (1) a nonintegrated employer contribution rate of at least ten percent (10%) of compensation, as defined in Code Section 415(c)(3), but for Plan Years beginning prior to January 1, 1998, including amounts contributed pursuant to a salary reduction agreement which are excludable from the employee's gross income under Code Sections 125, 402(e)(3), 402(h)(1)(B), 403(b), or for Plan Years beginning on or after January 1, 2001 (or as of a date, no earlier than January 1, 1998, as specified in an addendum to the Adoption Agreement), 132(f)(4), (2) immediate participation, and (3) full and immediate vesting; and (b) leased employees do not constitute more than twenty percent (20%) of the recipient Employer's nonhighly compensated workforce.

1.13 "Participant" means any Eligible Employee who has satisfied the requirements of Section 2.1 and has not for any reason become ineligible to participate further in the Plan.

1.14 "Plan" means this Basic Plan Document and the Adoption Agreement as adopted by the Employer, including all amendments thereto.

1.15 "Premiums" mean the Participant's cost for any health plan coverage.

1.16 "Qualifying Medical Expenses" means any expense eligible for reimbursement under the Health Reimbursement Arrangement which would qualify as a "medical expense" (within the meaning of Code Section 213 and the rulings and Treasury regulations thereunder) of the Participant, the Participant's spouse or a Dependent and not otherwise used by the Participant as a deduction in determining the Participant's tax liability under the Code or reimbursed under any other health coverage, including a health Flexible Spending Account. Qualifying Medical Expenses covered by this Plan are limited as elected in the Adoption Agreement. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

ARTICLE II
PARTICIPATION

2.1 Eligibility

Any Eligible Employee shall be eligible to participate hereunder on the date such Employee satisfies the conditions of eligibility elected in the Adoption Agreement.

2.2 Effective Date of Participation

An Eligible Employee who has satisfied the conditions of eligibility pursuant to Section 2.1 shall become a Participant effective as of the date elected in the Adoption Agreement.

If an Employee, who has satisfied the Plan's eligibility requirements and would otherwise have become a Participant, shall go from a classification of a noneligible Employee to an Eligible Employee, such Employee shall become a Participant on the date such Employee becomes an Eligible Employee or, if later, the date that the Employee would have otherwise entered the Plan had the Employee always been an Eligible Employee.

If an Employee, who has satisfied the Plan's eligibility requirements and would otherwise become a Participant, shall go from a classification of an Eligible Employee to a noneligible class of Employees, such Employee shall become a Participant in the Plan on the date such Employee again becomes an Eligible Employee, or, if later, the date that the Employee would have otherwise entered the Plan had the Employee always been an Eligible Employee.

2.3 Termination of Participation

This Section shall be applied and administered consistent with any rights a Participant and the Participant's Dependents may be entitled to pursuant to Code Section 4980B, Section 7.13 of the Plan, or any election on the Adoption Agreement. In the case of the death of the Participant, any remaining balances may only be paid out as reimbursements for Qualifying Medical Expenses and shall not constitute a death benefit to the Participant's estate and/or the Participant's beneficiaries.

ARTICLE III
BENEFITS

3.1 Establishment of Plan

(a) This Self-Administered Health Reimbursement Arrangement is intended to qualify as a Health Reimbursement Arrangement under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder.

(b) Participants in this Self-Administered Health Reimbursement Arrangement may submit claims for the reimbursement of Qualifying Medical Expenses as defined under the Plan and the Adoption Agreement. Unless otherwise elected in the Adoption Agreement, this Plan shall reimburse any expenses only after amounts in all other Plans that could reimburse the expense have been exhausted.

(c) The Employer shall make available to each Participant an Employer Contribution as elected in the Adoption Agreement, for the reimbursement of Qualifying Medical Expenses. No salary reductions may be made to this Health Reimbursement Arrangement.

(d) This Plan shall not be coordinated or otherwise connected to the Employer's cafeteria plan (as defined in Code Section 125), except as permitted by the Code and the Treasury regulations thereunder, to the extent necessary to maintain this Plan as a Health Reimbursement Arrangement.

3.2 Nondiscrimination Requirements

(a) It is the intent of this Self-Administered Health Reimbursement Arrangement not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) If the Administrator deems it necessary to avoid discrimination under this Health Reimbursement Arrangement, it may, but shall not be required to reduce benefits provided to "highly compensated individuals" (as defined in Code Section 105(h)) in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

3.3 Expense Reimbursement

(a) The Administrator shall direct the reimbursement to each eligible Participant for all Qualifying Medical Expenses. All Qualifying Medical Expenses eligible for reimbursement pursuant to Section 3.1(b) shall be reimbursed during the Coverage Period, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Qualifying Medical Expenses were incurred during a Coverage Period. Claims must include receipts or documentation that the expense being incurred is eligible for reimbursement, in order to claim reimbursement. Expenses may be reimbursed in subsequent Coverage Periods. However, a Participant may not submit claims incurred prior to beginning participation in the Plan and/or the Effective Date of the Plan, whichever is earlier.

(b) Notwithstanding the foregoing, if elected in the Adoption Agreement, Qualifying Medical Expenses shall not be reimbursable under this Plan if eligible for reimbursement and claimed under the Employer's Health Flexible Spending Account.

(c) Claims for the reimbursement of Qualifying Medical Expenses incurred in any Coverage Period shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the period elected in the Adoption Agreement immediately following the end of the Coverage Period, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

(d) Reimbursement payments under this Plan shall be made directly to the Participant.

(e) If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, such remainder shall be carried forward to another Coverage Period or forfeited, as elected in the Adoption Agreement.

ARTICLE IV
ERISA PROVISIONS

4.1 Claim for Benefits

Any claim for Benefits shall be made to the Administrator. The following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Administrator will provide written or electronic notification of any claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

4.2 Named Fiduciary

The "named Fiduciaries" of this Plan are (1) the Employer and (2) the Administrator. The named Fiduciaries shall have only those specific powers, duties, responsibilities, and obligations as are specifically given them under the Plan including, but not limited to, any agreement allocating or delegating their responsibilities, the terms of which are incorporated herein by reference. In general, the Employer shall have the sole responsibility for providing benefits under the Plan; and shall have the sole authority to appoint and remove the Administrator; and to amend the elective provisions of the Adoption Agreement or terminate, in whole or in part, the Plan. The Administrator shall have the sole responsibility for the administration of the Plan, which responsibility is specifically described in the Plan. Furthermore, each named Fiduciary may rely upon any such direction, information or action of another named Fiduciary as being proper under the Plan, and is not required under the Plan to inquire into the propriety of any such direction, information or action. It is intended under the Plan that each named Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan. Any person or group may serve in more than one Fiduciary capacity.

4.3 General Fiduciary Responsibilities

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

4.4 Nonassignability of Rights

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

ARTICLE V
ADMINISTRATION

5.1 Plan Administration

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;

(d) To limit benefits for certain highly compensated individuals if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To approve reimbursement requests and to authorize the payment of benefits; and

(f) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 105(h) and the Treasury regulations thereunder.

5.2 Examination of Records

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

5.3 Indemnification of Administrator

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE VI
AMENDMENT OR TERMINATION OF PLAN

6.1 Amendment

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant.

6.2 Termination

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further reimbursements shall be made.

ARTICLE VII
MISCELLANEOUS

7.1 Plan Interpretation

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 7.11.

7.2 Gender and Number

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

7.3 Written Document

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 105 and any Treasury regulations thereunder.

7.4 Exclusive Benefit

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

7.5 Participant's Rights

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

7.6 Action by the Employer

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

7.7 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

7.8 Indemnification of Employer by Participants

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Medical Expense such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

7.9 Funding

Unless otherwise required by law, amounts made available by the Employer need not be placed in trust, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

7.10 Construction of Plan

This Plan and Trust shall be construed and enforced according to the Code, ERISA, and the laws of the state or commonwealth in which the Employer's principal office is located (unless otherwise designated in the Adoption Agreement), other than its laws respecting choice of law, to the extent not pre-empted by ERISA.

7.11 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

7.12 Headings

The headings and subheadings of this Plan have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

7.13 Continuation of Coverage

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each qualified beneficiary (as defined in Code Section 4980B) will be entitled to continuation coverage as prescribed in Code Section 4980B.

7.14 Family and Medical Leave Act

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Proposed Regulation 1.125-3.

7.15 Health Insurance Portability and Accountability Act

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

7.16 Uniformed Services Employment and Reemployment Rights Act

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

CERTIFICATE OF ADOPTING RESOLUTION

The undersigned Principal of Northwest Portland Area Indian Health Board (the Employer) hereby certifies that the following resolutions were duly adopted by the board on _____, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the Health Reimbursement Arrangement effective January 1, 2017, presented to this meeting is hereby approved and adopted and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

The undersigned further certifies that attached hereto is a true copy of the Health Reimbursement Arrangement and the Summary Plan Description approved and adopted in the foregoing resolutions.

By: _____

Title: _____

Date: _____

SELF-ADMINISTERED HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

FOR

NORTHWEST PORTLAND
AREA INDIAN HEALTH BOARD

TABLE OF CONTENTS

SELF-ADMINISTERED
HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

We are pleased to establish this Self-Administered Health Reimbursement Arrangement to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

I
ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan.

2. When is My Entry Date?

You can join the Plan on the same day you can enter our group medical plan.

3. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are not eligible to receive medical benefits under our group medical plan.

II
BENEFITS

1. What Benefits Are Available?

The plan allows you to be reimbursed by the Employer for any deductibles which you have to meet under our Kaiser Health plan which are incurred by you or your dependents as illustrated in table 2.1.

HRA Insurance Deductible Benefit Schedule (In Sequence)		
	HRA Deductible (employee pays first)	**HRA Benefit**
Employee	$1,000	**$500**
Employee & Dependent	$1,000	**$500**
Family	$1,000	**$500**

Table 2.1

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including our health flexible spending account.

2. When Must Expenses Be Incurred?

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each calendar year.

3. When Will I Receive Payments From The Plan?

During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 60 days after the end of each year. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

4. What Happens If I Terminate Employment?

If your employment is terminated during the Plan Year for any reason, your participation in the Plan will cease and any unused amounts are forfeited. However, you must make your requests for reimbursements no later than 60 days after termination of employment.

Under Federal law, if you lose coverage under this Plan, then you may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if

you lose coverage. Generally, if we (and any related companies) employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available.

If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage.

A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse;
- Your becoming eligible to receive Medicare benefits;
- Your Dependent child's ceasing to qualify as a Dependent.

Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. Plan continuation must be made available for a maximum period of 18 months, if the reason coverage ends is either termination of your employment or a reduction in hours of employment that makes you ineligible to participate in the HRA plan. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, termination of our HRA plan, or a "for cause" termination of coverage for reasons such as fraud.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

5. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions,

you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

6. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Self-Administered Health Reimbursement Arrangement under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

III
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Northwest Portland Area Indian Health Board Health Reimbursement Plan is the name of the Plan.

Your Employer has assigned Plan Number 508 to your Plan.

The provisions of your Plan become effective on January 1, 2017.

2. Employer Information

Your Employer's name, address, and identification number are:

Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300
Portland, OR 97201
93-0718154

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Administrator.

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300
Portland, OR 97201
503-228-4185

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

5. Service of Legal Process

The Employer is the Plan's agent for service of legal process.

6. Type of Administration

The Plan is a self-administered Health Reimbursement Arrangement. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

IV
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

2. How to Submit a Claim

When you have a Claim to submit for payment, you must:

(1) Obtain a claim form from the Plan Administrator.

(2) Complete the Employee portion of the form.

(3) Attach copies of all bills from the service provider for which you are requesting reimbursement.

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether Claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by Participant	45 days
Review of Claim denial	60 days

The Plan Administrator will provide written or electronic notification of any Claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the your right to bring a civil action under Section 502 of ERISA following a denial on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the Claim determination;

(2) was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;

(4) or constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

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 #17-03-07
Opposition to FY 2018 Budget Cuts to U.S. Department of Health and Human Services

WHEREAS, the Northwest Portland Area Indian Health Board {hereinafter "NPAIHB" or "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 USC §450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

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

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

WHEREAS, AI/ANs have significant health disparities and have some of the highest rates of poverty nationwide; and

WHEREAS, the median income for AI/ANs in the Northwest is $9,770 lower than the regional average and about 27% of AI/AN in the Northwest live in poverty, compared to 15.5% of the general population; and

WHEREAS, DHHS funding to the Indian Health Services honors the federal government's trust responsibility and treaty obligations to Tribes; and

WHEREAS, DHHS includes several federal agencies that fund or provide programs and services to Tribes and AI/AN communities that is part of federal government's trust responsibility and

treaty obligations, including the Centers for Disease Control and Prevention, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, and Centers for Medicare and Medicaid Services, among others; and

WHEREAS, the DHHS Office of Community Services' Low Income Housing Energy Assistance Program (LIHEAP) and the Community Service Block Grant Program provides critical services to low income AI/ANs that otherwise would not be able to pay their energy or heating bill or access other needed services; and

WHEREAS, the President's FY 2018 "America First: A Budget Blueprint to Make America Great Again" proposes a 17.9% cut to DHHS and proposes elimination of the discretionary programs within the Office of Community Services, including the Low Income Home Energy Assistance Program (LIHEAP) and Community Service Block Grant program; and

WHEREAS, AI/ANs rely on funding, programs and services through DHHS and funding cuts will have a negative impact on the health and well-being of AI/ANs; and

WHEREAS, the federal government has a trust responsibility and treat obligations to ensure that Tribes and AI/AN communities are fully funded to meet their health care and service needs.

THEREFORE BE IT RESOLVED, the Northwest Portland Area Indian Health Board opposes any FY 2018 budget cuts to the U.S. Department of Health and Human Services, including the Indian Health Service, and elimination of discretionary programs within the Office of Community Services such as LIHEAP and Community Service Block Grant Program, as this is a violation of the federal government's trust responsibility and treaty obligations to Tribes.

CERTIFICATION

NO. 17-03-07

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 34 **for,** 0 **against,** 0 **abstain on** April 20**, 2017.**

Andrew C. Joseph Jr.

Chairman

April 20th 2017

Date

Gregg 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
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Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Indian Nation
Samish Indian Nation
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Shoalwater Bay Tribe
Shoshone-Bannock Tribes
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Indian Nation

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RESOLUTION #17-03-08
Support for Reauthorization of the Special Diabetes Program for Indians

WHEREAS, the Northwest Portland Area Indian Health Board {hereinafter "NPAIHB" or "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 USC §450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

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

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

WHEREAS, AI/AN adults are 2.3 times more likely to have diagnosed diabetes compared with non-Hispanic whites; and

WHEREAS, the death rate due to diabetes for AI/ANs is 1.6 times higher than the general U.S. population; and

WHEREAS, the Balanced Budget Act of 1997 established the Special Diabetes Program for Indians (SDPI) for "the prevention and treatment of diabetes in American Indians and Alaska Natives (AI/AN) for five years; and

WHEREAS, Congress reauthorized SDPI for one to three year periods from 2002 to 2015; and

WHEREAS, the current renewal of SDPI expires in September, 2017; and

WHEREAS, SDPI provides grants for diabetes treatment and prevention services to over 330 IHS, Tribal, and Urban Indian health programs in 35 states and funds Community Directed Grant Programs; and

WHEREAS, SDPI has had positive clinical and community outcomes, including: the average blood sugar level (A1c) decreased from 9.0% in 1996 to 8.1% in 2010; the average LDL ("bad" cholesterol) declined from 118 mg/dL in 1998 to 95 mg/dL in 2010; and more than 80% of SDPI grant programs now use recommended public health strategies to provide diabetes prevention activities and serves for AI/AN children and youth; and

WHEREAS, Tribes in the Northwest have successful SDPI programs with consistent positive clinical and community outcomes; and

WHEREAS, Northwest Tribes' support permanent reauthorization of SDPI at $200 million per year with medical inflation rate increases annually or, in the alternative, reauthorization of SDPI for 2018 to 2024 at $150 million in 2018 with medical inflation rate increases annually thereafter.

THEREFORE BE IT RESOLVED, the Northwest Portland Area Indian Health Board supports permanent reauthorization of SDPI at $200 million per year with medical inflation rate increases annually or, in the alternative, reauthorization of SDPI for 2018 to 2024 at $150 million per year in 2018 with medical inflation rate increases annually thereafter.

CERTIFICATION

NO. 17-03-08

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 34 **for,** 0 **against,** 0 **abstain on** April 20 **, 2017.**

Andrew C. Joseph Jr.

Chairman

April 20, 2017

Date

Gregg 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

April 2017

Policy

The Marketplace Offers Continued "Sponsorship" Opportunities

By Doneg McDonough
Technical Advisor - Tribal Self-Governance Advisory Committee - IHS
Lead Consultant - Health System Analytics

By Joshua Kotzman
Public Health Policy & Payment Issues - Researcher

"Sponsorship"[1] is a term frequently used to refer to the purchase of health insurance coverage by a Tribe or Tribal health organization (T/THO) on behalf of Tribal members, including dependents of enrolled Tribal members[2]. The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) created expanded opportunities for T/THOs to access federal resources through Sponsorship.

IN THIS ISSUE:

Despite the uncertainty over the ACA emanating from Washington, D.C., T/THOs are increasingly looking to Sponsorship as a means of leveraging capped federal funding in order to secure substantial new health care resources to meet the needs of Tribal citizens. And even under congressional proposals to "repeal" the ACA, Sponsorship opportunities created under the Affordable Care Act are expected to continue, at least through January 2020.

Background

For some time[3], T/THOs have engaged in Sponsorship of Tribal members by paying the health insurance premiums under federal programs, such as Medicare Part B (for physician and other ancillary services) and Medicare Part D (for pharmaceutical coverage).[4] Under Medicare Part B, most enrollees pay 25% of the premium, with the federal government subsidizing the remainder of the cost.[5] The federal government also covers 75% of prescription drug costs for most enrollees under Medicare Part D.[6]

In addition, and particularly for Tribes with members dispersed across the country, some T/THOs have viewed securing health insurance coverage—even if unsubsidized by federal assistance—as the most efficient and effective means of providing timely access to necessary health care services for Tribal members. As a result, some T/THOs have purchased, or provided through a self-insured plan, health insurance coverage through the individual or group insurance market for some or all of their Tribal members.

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Northwest Portland Area Indian Health Board

Executive Committee Members

Andy Joseph, Jr., *Chair*
Confederated Tribes of Colville Tribe
Cheryle Kennedy, *Vice Chair*
Confedrated Tribes of Grand Ronde
Greg Abrahamson *Secretary,*
Spokane Tribe
Shawna Gavin, *Treasurer*
Confederated Tribes of Umatilla
Kim Thompson, *Sergeant-At-Arms,*
Quinault Nation

Delegates

Twila Teeman, Burns Paiute Tribe
Dan Gleason, Chehalis Tribe
Leta Campbell, Coeur d'Alene Tribe
Andy Joseph Jr., Colville Tribe
Vicki Faciane, Coos, Lower Umpqua & Siuslaw Tribes
Eric Metcalf, Coquille Tribe
Sharon Stanphill, Cow Creek Tribe
Cassandra Sellards-Reck, Cowlitz Tribe
Cheryle Kennedy, Grand Ronde Tribe
Lisa Martinez, Hoh Tribe
Brent Simcosky, Jamestown S'Klallam Tribe
Darren Holmes, Kalispel Tribe
Gerald Hill, Klamath Tribe
Velma Bahe, Kootenai Tribe
Francis Charles, Lower Elwha S'Klallam Tribe
Nick Lewis, Lummi Nation
Nathan Tyler, Makah Tribe
Maria Starr, Muckleshoot Tribe
Sam Penney, Nez Perce Tribe
Jean Sanders, Nisqually Tribe
Lona Johnson, Nooksack Tribe
Hunter Timbimboo, NW Band of Shoshone Indians
Jaime Aikman, Port Gamble S'Klallam Tribe
Vacant, Puyallup Tribe
Andrew Shogren, Quileute Tribe
Vacant, Quinault Nation
Joanne Liantonio, Samish Tribe
Rhonda Metcalf, Sauk-Suiattle Tribe
Kim Thompson, Shoalwater Bay Tribe
Tino Batt, Shoshone-Bannock Tribes
Gloria Ingle, Siletz Tribe
Ed Fox, Skokomish Tribe
Robert de los Angeles, Snoqualamie Tribe
Greg Abrahamson, Spokane Tribe
Bonnie Sanchez, Squaxin Island Tribe
Kevin D. Collins, Stillaguamish Tribe
Vacant, Suquamish Tribe
Cheryl Raser, Swinomish Tribe
Melvin Shelton, Tulalip Tribe
Shawna Gavin, Umatilla Tribe
Marilyn Scott, Upper Skagit Tribe
Janice Clements, Warm Springs Tribe
Frank Mesplie, Yakama Nation

Chairman's Notes

By Andrew Joseph, Jr.,
Colville Tribal Council
NPAIHB Chair

Hello,

I wanted to share with everyone that I attended the U.S. Department of Health & Human Services, 19th Annual Tribal Budget and Policy Consultation, on March 30, 2017. Tribal leaders from across Indian country attended the meeting to discuss budget and policy concerns with leadership from several federal agencies, including: HHS Office of Intergovernmental Affairs, HHS Office of Budget, Administration of Children and Families, Administration for Community Living, Administration for Native Americans, Administration on Aging, National Institutes of Health, Centers for Disease Control and Prevention, Substance Abuse Mental Health Services Administration, Centers for Medicare and Medicaid Services, and Indian Health Service.

As a co-Chair of the National Tribal Budget Formulation Workgroup, I made a needs-based budget request to IHS of $32 billion to be phased in over a 12-year period. I also discussed the impact of cuts to the Low Income Home Energy Assistance Program (LIHEA), the Meals on Wheels Program, and the Low Income Student Foods Assistance Program; recent passage of bill in Washington state allowing dental health aide therapists (DHATs) to work in Tribal communities, and need to get DHATs approved for reimbursement under Medicaid; Indian country's oral health disparities, the need for DHATs, and the Indian Health Care Improvement Act's restriction on use of DHATs without state authorization; importance of Headstart; funding for traditional healing and the Tribal Behavioral Health Agenda; and other concerns. For the Colville Tribe, I talked about working with the State on obtaining the inpatient encounter rate for our convalescent center and in-home care and long term care needs.

Tribal leaders also met with HHS Secretary Tom Price. Secretary Price acknowledged the trust responsibility and government-to-government relationship with Tribes. He genuinely seemed interested in our concerns and expressed interest in visiting Tribes. I was able to speak directly with him and reiterate several of the concerns that I expressed to the federal agencies. It was full day!

I am honored to represent my Tribe and the Board at these meetings and always welcome your input and concerns.

Way límˈlímx (Thank you)
Yəx̌ʷyəx̌ʷúɬxn (Badger)

Andrew C. Joseph Jr.
HHS Chair
Colville Tribal Council
NPAIHB Chair
ATNI 3rd Vice Chair
NIHB Member

Northwest Portland Area Indian Health Board

Administration
Joe Finkbonner, Executive Director
Jacqueline Left Hand Bull, Administrative Officer
Mike Feroglia, Business Manager
Eugene Mostofi, Fund Accounting Manager
Nancy Scott, Accounts Payable/Payroll
James Fry, Information Technology Director
Chris Sanford, IT Network Administrator
Andra Wagner, Human Resources Coordinator
Geo.Ann Baker, Office Manager

Program Operations
Laura Platero, Policy Analyst
Lisa Griggs, Program Operations Project Assistant
Katie Johnson, EHR Intergrated Care Coordinator
Tara Fox, Grants Management Specialist

Northwest Tribal Epidemiology Center
Victoria Warren-Mears, Director
Amanda Gaston, IYG Project Consultant
Antoinette Aquirre, Cancer Prevention Coordinator/ Office Assistant
Birdie Wermy, EpiCenter National Evaluation Specialist
Bridget Canniff, PHIT/IPP Project Director
Candice Jimenez, CARS Research Assistant
Celena McCray, THRIVE Project Coordinator
Clarice Charging, IRB & Immunization Project
Colbie Caughlan, Suicide Prevention Manager - THRIVE
David Stephens, PRT Multimedia Project Specialist
Don Head, WTD Project Specialist
Eric Vinson, Cancer Project Coordinator
Erik Kakuska, WTD Project Specialist
Jenine Dankovchik, WEAVE Evaluation Specialist
Jessica Leston, STD/HIV/HCV Clinical Service Manager
Jodi Lapidus, Native CARS Principal Investigator
Kerri Lopez, WTDP & NTCCP Director
Luella Azule, PHIT/Injury Prevention Coordinator
Monika Damron, IDEA-NW Biostatistican
Nancy Bennett, EpiCenter Biostatistican
Nanette Yandell, WEAVE Project Director
Nicole Smith, Biostatistician
Nora Alexander, WEAVE Project Specialist
Ryan Sealy, Tobacco Project Specialist
Sarah Hatcher, CDC Epidemic Intelligence Officer (EIS), assigned to NWTEC
Stephanie Craig Rushing, PRT, MSPI, Project Director
Sujata Joshi, IDEA-NW/Tribal Registry Director
Tam Lutz, Native CARS Director
Ticey Mason, Dental Project Manager
Tom Becker, NARCH & Cancer Project Director
Tom Weiser, PAIHS, Medical Epidemiologist, assigned to NWTEC
Tommy Ghost Dog, Jr., PRT Assistant
Vacant, WTD Project Assistant

Northwest Projects
Christina Peters, NDTI Project Director
Pam Johnson, NDTI Project Specialist
Tanya Firemoon, NDTI Project Coordinator

Impacts on tribal health programs

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

This article briefly discusses some of critical issues that have arisen during the first 100 days of Congress, along with updates on a number of other developments, including: the status of the ACA "repeal and replace" efforts; Indian Health Service appropriations for FY 2017; the FY 2018 Budget; the Redding Rancheria litigation and proposed CHEF rules; "Section 105(l)" lease proposals under the ISDEAA; and an update on contract support costs developments.

ACA "Repeal and Replace" Efforts on Hold, For Now

Despite an intense push by the White House and Republican congressional leadership over the last several weeks, the effort to repeal and replace the Affordable Care Act (ACA, also known as Obamacare) appears to have stalled—at least for now. Leadership was hoping to deliver on the Republicans' campaign promise to repeal and replace the landmark healthcare law through a budget reconciliation measure, which requires only a simple majority to pass the Senate but limits the subject matter of the legislation to budget-related matters. Draft legislation was unveiled on March 6, 2017 and subsequently amended in attempts to address concerns by both moderate and conservative Republicans in the House of Representatives, but on March 24 a House floor vote was cancelled after Republican leadership failed to muster enough votes for the bill to pass.

Indian Country has been closely monitoring the ACA repeal and replace effort for its potential impact on the Indian health system. Critically, the Indian Health Care Improvement Act (IHCIA) was permanently reauthorized as Section 10221 of the ACA, so a wholesale repeal of the ACA would also repeal the IHCIA. In addition, there are several Indian-specific provisions in the ACA that provide critical resources and protections to American Indians and Alaska Natives and to the IHS and tribal health programs, including: Section 2901 (which makes the IHS and tribal and urban Indian health programs the payor of last resort by statute, enabling them to collect reimbursement from third party sources); Section 2902 (which grants IHS and tribal health programs permanent authority to collect reimbursements for all Medicare Part B services by removing the "sunset" date that had applied to authority to collect for some Part B services previously); and Section 9021 (which ensures that the value of health benefits provided by a tribe to its members are not considered taxable income). In addition, Medicaid Expansion (enacted as part of the ACA) has significantly increased Medicaid reimbursements to the IHS and tribal health programs in expansion states.

The budget reconciliation measure recently proposed by the House Republican leadership would not have impacted the IHCIA, or several of the other key Indian-specific ACA provisions. However, the bill proposed to defund Medicaid Expansion effective in 2020 and would have made other significant changes to the Medicaid program, including a per capita cap on federal Medicaid contributions and a state block grant option. Tribal advocates were successful in their efforts to exclude services received through the IHS and tribal health programs from being included in the proposed cap. However, the cap could still have had a major impact on tribal health programs by forcing states to roll back eligibility and coverage unless they could afford to subsidize the program with additional state funds. Additionally, the bill proposed to replace the existing ACA premium tax credits with less generous portable tax credits and to eliminate the ACA cost sharing protections, including those for American Indians and Alaska Natives now in effect. The bill, though supported by the White House, was widely criticized and ultimately rejected by both conservative Republicans (who felt the bill was too similar to the existing ACA) and more moderate House members (who were concerned that the bill, among other things, would result in a loss of coverage for many of their constituents).

Impacts on tribal health programs

Immediately following cancellation of the House floor vote on March 24, both President Trump and House Speaker Paul Ryan indicated that they would be dropping the effort and moving on to other matters. More recent news reports suggest that there is still some appetite among at least some legislators to pursue healthcare legislation, but it is uncertain as to whether and when such efforts may begin.

In addition to the legislative efforts, administrative efforts are underway to make significant changes in implementation of the ACA and Medicaid. For example, on March 14, 2017, Health and Human Services (HHS) Secretary Tom Price and Seema Verma, the new Administrator for the Centers for Medicare & Medicaid Services (CMS), sent a letter to state governors calling Medicaid expansion a "clear departure" from the mission of the program and outlining possible changes to Medicaid requirements. The letter suggested that CMS might approve new waiver applications submitted by states that would impose work requirements on Medicaid recipients, alluding to innovations that involve "training, employment, and independence," and said that states may want to consider new premium or contribution requirements, cost-sharing models, emergency room co-pays, and waivers of presumptive eligibility and retroactive coverage. In addition, the Administration has indicated it is open to taking steps that would affect Marketplace coverage under the ACA, including waiving fines for not enrolling in coverage; rolling back outreach on marketplace coverage; tightening enrollment and collecting unpaid premiums; and shortening open enrollment periods. These measures could all be adopted without Congressional action. In addition, there is ongoing litigation regarding the Administration's ability to use available appropriations to fund cost sharing subsidies under the ACA, and the new Administration's position in the litigation is not yet clear.

Indian Country will need to monitor these issues closely, and be prepared to work with Congress and the administration to ensure that any changes to the ACA or the Medicaid program do not have a negative impact on Indian country.

Congress Endeavoring to Put Together a FY 2017 Omnibus Appropriations Bill to Fund the Remaining Five Months of the Fiscal Year

With the clock ticking on the FY 2017 Continuing Resolution (CR) – the source of current funding of most federal agencies – Congress is now trying to pull together a FY 2017 omnibus appropriations bill to fund the remaining five months of the fiscal year for all federal agencies for which appropriations bills have not been enacted. The current CR expires midnight of April 28, 2017. Given that Congress will be out for a break April 8-23, that leaves eight legislative days (as of April 3) for the necessary House and Senate consideration of what would be a massive piece of legislation. The House and Senate Appropriations Committees have been negotiating these final bills behind the scenes and reportedly, they are close to being completed. The fact that the first seven months of the fiscal year have been funded via a CR, primarily at pro rata FY 2016 funding levels and conditions, there is some limitation on the changes that can effectively be made at this point in time.

Other than for Military Construction/Veterans Administration, Congress has not enacted any FY 2017 appropriations bills. The FY 2017 Defense bill has been negotiated and introduced and likely will be the vehicle on which to attach an Omnibus Appropriations bill or a CR.

Should an omnibus appropriations bill not be viable, Congress would again need to resort to a CR – either very short term while negotiations continue – or through the end of the fiscal year. Should there be another CR it might contain some differences ("anomalies") from the FY 2016 funding levels. If so, that is an opportunity to obtain some increases over FY 2016.

The House and Senate Appropriations Committees' FY 2017 Interior, Environment and Related Agencies bills differ in some significant ways with regard to the IHS. The House-passed bill recommended significantly more than the Senate for IHS built-in costs, Purchased/

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Policy as a Community Health Tool

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

In a fickle political environment, it is easy to feel the uncertainty that may negatively impact our budgets, intervention programs, and public health strategies. How can we plan for the future when the funding for programs may not be available? What ways can we help our communities if resources are finite?

Policies may lead to a more sustainable approach to public health strategies while simultaneously helping your communities.

If policies are defined as a binding fixed document, then it is more difficult to view them as sustainable or having a lasting support to make a change. What if we expand our definition of policy to be inclusive to the cultural and traditional values for the people the policy is written to represent? Expanding the definition of policy to include the unwritten rules within the community through tradition and culture may increase the sustainability and effectiveness of implementation. Tribes are in a unique position to create lasting policy change.

Elders' Wisdom is Policy

A local tribal community wanted to decrease the high consumption of sugar-sweetened beverages during cultural activities on their reservation, especially for youth. The Tribal Council knew that signing and posting a written policy would not necessarily change the drinks that were brought to different gathering areas; they also knew that as soon as an Elder stated a guideline sharing their wisdom, the community listened. An expanded view of policy was that when multiple Elders stated to the youth that sugar drinks were no longer allowed in the public gathering centers, no one questioned these words. In addition, because community members knew the message came from a good place, they told their friends and relative and implementation of this policy could be actively seen within the week.

The story above does not mean that written policies are obsolete, rather it is an example of community culture as a guide when writing a policy. Adhering to traditions, wisdom, and embracing the strategies that already exist bring lasting changes in a time of uncertainty.

The WEAVE-NW (Good Health and Wellness in Indian Country) project, focuses on decreasing chronic disease through upstream approaches that lead to long-term sustainable change. This often includes policies focused on improving access to healthy, safe, and affordable foods for Tribal communities across the Pacific Northwest. WEAVE-NW funds over seven gardens in tribes across Oregon and Washington that include Tribal food sovereignty initiatives. These projects have policies that come in many forms. For example, over the past year policies have been created on Food Handling Protocols, Food Voucher Programs that link Tribal Clinics with their Community Gardens, and community involvement of Tribal Council for support of the gardens beyond the funding years.

It is imperative that community leads the way when making policies. This includes the youth, our future Tribal Leaders. Policy is not created for policy sake, instead community-driven policy leads to sustainable efforts that will exist well beyond the current political climate. Including youth is key to ensuring healthier communities for our future generations.

Listening for the Answer

Another great community health policy success is in a community that wanted to increase walking and bike use on their reservation. They have trails and a bike lending library, and both were underutilized. For their project, Tribal Council asked community members why they were not checking out bikes and what may help them be encouraged to use the trails more. They learned that there were dogs running

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Policy as a Community Health Tool

lose on the reservation throughout the day and in particular, people were afraid of being bitten. Tribal Council unanimously passed an ordinance within a few months requiring dogs to be locked up at their homes or on a leash during the day. Within six months the bike use and trail use increased substantially.

Although the original project aim was to increase physical activity in the community by adding opportunities such as a walking club and other outdoor opportunities, that is not exactly what the community needed. The best way to increase physical activity in this specific community came to light by listening to what the community said were their specific barriers. When it comes to improving the health of our communities it is key to listen to the stories of everyday life to hear the role the environment has on increasing overall health.

Where we live, work, play, and gather all has an impact on our health. Policies that include the culture and traditions of our community including our relationship with the natural and built environment are more likely to address the root of health issues and provide long term sustainable changes. Health truly can be included in all policies!

For more policy information please contact:
weave@npaihb.org

Nez Perce Tribe – Community Overview

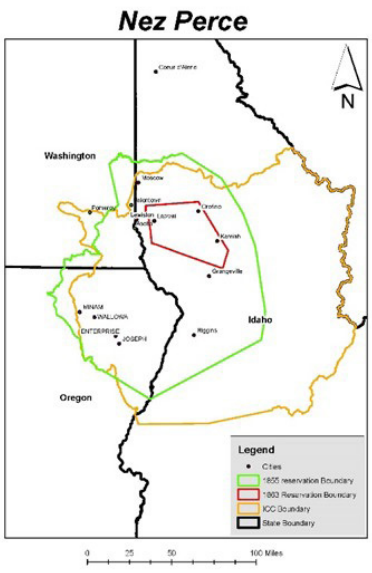
The Nez Perce Tribe is located in North Central Idaho, includes five rural counties: Nez Perce, Clearwater, Lewis and Latah. The reservation encompasses 770,000 acres, primarily thinly-populated agricultural and forest lands, including 107,000 acres owned by the Tribe or tribal members.

The Nez Perce Tribal community is a close net community. As generations grow up in the community, families develop close ties with other families through sports, culture activities, work, sorrow, school activities and community events.

Nez Perce Tribe – Community Overview

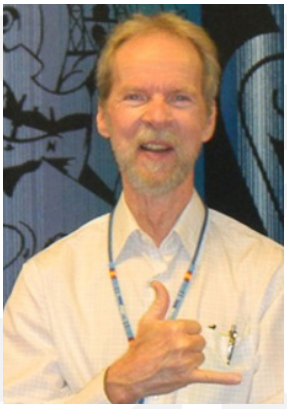
The Nez Perce people who live on the Nez Perce Reservation reside in one of the three main communities. Lapwai is where the Nez Perce Tribal headquarters, Nimiipuu Health, Housing and other Tribal Programs are stationed. In Lapwai there is one school grades K-12, a community building for events and a Grocery Store, Restaurant and gas station. Lapwai has a population of 1,146. Most families travel to Lewiston, which is 16 miles away, for shopping. Orofino is 36 miles up the Clearwater River from Lapwai. This community has a small population of Nez Perce Tribal members. In Orofino there is a small building designated for Community events and meetings and next door the Nez Perce Tribal Fisheries Offices. Kamiah is 60 miles upriver from Lapwai along the Clearwater River. Kamiah's population is 1,320. In Kamiah, there is a school K-12, Community Building and several privately owned businesses.

The Nez Perce Tribe owns and operates two Casinos, on in Kamiah and one at the edge of the Nez Perce Reservation boundary near Lewiston, Idaho. The tribe also has the Appaloosa Express Transportation Department servicing transportation throughout the Nez Perce Reservation and to the Lewiston area. The Appaloosa Club is active and the appaloosa horses are being raised within the Nez Perce Reservation.



Nimiipuu Health is the primary care for most Nez Perce Tribal members within the Nez Perce Reservation. Nimiipuu Health has approximately 4,761 patients.

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 ground breaking 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 tbecker@npaihb.org or Tanya Firemoon, NW NARCH Coordinator tfiremoon@npaihb.org.

Misty Blue (White Earth Nation)
NW NARCH Fellow
Masters of Public Health, Maternal and Child Health Concentration, Evaluation Minor

How did I learn about the NW NARCH Fellowship?
I learned about the NW NARCH Fellowship during my attendance at the American Public Health Association Annual Meeting in 2014. Representatives from NW NARCH were at a poster session that I attended.

Why did I choose my specific degree?
I have always been passionate about health. Growing up, I felt that good health was the first step to being able to accomplish any goal that I had for myself. I continued this interest on a personal level throughout my life. After working at a domestic violence agency, participating in KWESTRONG, and becoming a mother, it became clear that creating ways for women and children to be safe and healthy was the path that I wanted to continue on.

After graduating, what are my career goals and/or educational goals?
I just accepted a job in the applied research and evaluation field. The agency that I work for, Rainbow Research Inc., has a long history and great reputation of using a community-engaged practice. Data is valuable, and I am committed to making meaning out of disjointed data that communities can use.

How did the NW NARCH fellowship help in furthering my education?
NW NARCH fellowship was an incredibly supportive experience. The financial aspect of the fellowship strengthened my resolve to work diligently on my degree, as I did not have to stress about finances. I even finished earlier than anticipated! Also a single mother, having less stress really allowed me to be a better, more present caregiver to my daughter.

The trainings that NW NARCH provided me with were also so energizing. I learned great material, and was able to meet other Natives doing this work in different places across the country. In an MPH program that did not have much diversity, I gained confirmation that I was on the right path and others were beside me.

Finally, having Tanya and Dr. Becker as additional supports during my degree program has been invaluable. Knowing that I have mentors all the way on the west coast who are encouraging, hoped for, and believed in my abilities to succeed was integral to my accomplishment.

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(NW NARCH)

What would you share with others who are seeking financial assistance?
I would urge students who are seeking financial assistance to be proactive and build relationships at every opportunity they encounter. Throughout my entire graduate school experience, I have met so many people who were ready to assist me in any way possible, i.e. letters of recommendations, advice about funding, leads on jobs, etc.

Most people recognize that graduate school is a difficult path with obstacles, but are eager to help each other out. People and programs are available and excited to support native students as they pursue advanced degrees, especially in the health sciences. Now that I have finished and have received so much support from my communities and circles, I feel very grateful and appreciative. And ready to help guide others just beginning their programs.
Year of Graduation:
December 2016

State Medicaid Programs Still Withholding Cure for Hepatitis C

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

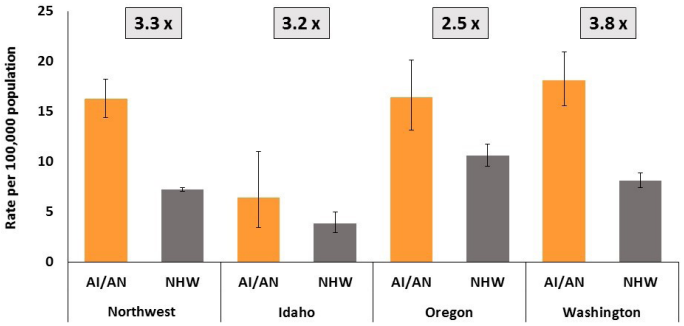
Jessica Leston, *MPH HIV/STI/HCV Clinical Programs Director, NPAIHB*

Sarah Hatcher, *PhD Epi Intelligence Service Officer, CDC, NPAIHB*

Hepatitis C virus (HCV) is a chronic infection and a deadly disease. If HCV is left untreated, the virus slowly destroys the liver. The American Indian/Native Alaska population is disproportionately affected by hepatitis C virus (HCV). The most recent national data show American Indian/Alaska Native people with both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any US racial/ethnic group. In the Northwest from 2006–2012, the American Indian/Alaska Native HCV-related mortality rate was over three times that of non-Hispanic whites. This disparity has persisted over time, demonstrating the need for access to treatment for American Indians and Alaska Natives in the Northwest.

State Medicaids Still Withholding Cure for Hepatitis C

Age-Adjusted Hepatitis C-Related Mortality – Northwest, 2006–2012



About 20,000 persons die from HCV each year, despite the availability of new medications that have a 95 percent success rate and can cure patients in as little as eight weeks. Improvements in new treatment options for HCV could have a major effect on the health of American Indians/Alaska Natives. These new medications have high rates of achieving sustained virologic response with few contradictions or adverse effects. These advances represent a major shift in treatment options for HCV and have the ability to reduce HCV-related deaths.

But because the drugs can be expensive, state Medicaid programs have been restricting access to them to only people in the advanced stages of the liver destroying disease.

Restricting Access
In 2015, there were at least 34 states who had restrictions in place that limited access to treatment, determined by the level of damage to and scarring on the liver.

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State Medicaid Programs Still Withholding Cure for Hepatitis C

Currently in the Northwest:

- **Idaho** – Patients must have advanced liver scarring (referred to as Metavir stage F2-F4), and have no history of alcohol or substance abuse within 6 months prior to treatment. To learn more about Idaho's Medicaid policy and inclusion criteria for HCV medication, visit: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/PrescriptionDrugs/HepatitisCTherapeuticGuidelines.pdf

- **Oregon** – Patients must have advanced liver scarring (Metavir stage F3-F4), and be enrolled in a treatment program under the care of an addiction specialist if they are actively using illicit drugs or abusing alcohol. To learn more about Oregon's Medicaid policy and inclusion criteria for HCV medication: http://www.oregon.gov/oha/healthplan/tools/Oregon%20Medicaid%20PA%20Criteria,%20January%202017.pdf

- **Washington** – Will approve payment for nearly every patient with chronic HCV (as of June 2016), including patients who are actively injecting drugs and/or using alcohol. To learn more about Washington's Medicaid policy and inclusion criteria for HCV medication, visit: https://www.hca.wa.gov/assets/billers-and-providers/WA-Apple-Health-HepatitisC-Clinical-Policy.pdf

As of April 2017, Washington has the most open access to HCV medications for Medicaid patients, but this was not always the case. In 2015, the Washington Health Care Authority (HCA) approved guidelines restricting access to HCV drugs. A class action lawsuit ensued, claiming the restrictions violate federal law.

In response to the class action lawsuit, a federal judge ordered the state Health Care Authority to cover hepatitis C drugs for all patients with HCV, not just those who are sickest. The lawsuit was in response to a policy that restricted Medicaid patient's access to the medications based on the amount of liver scarring that was present.

Only those with the most liver scarring were able to get the curative treatment.

After the federal judge's order, patients with less severe cases of HCV are now also able to access the medications. Unfortunately this is not the case in Oregon or Idaho, mainly due to the cost of the medication.

In March, Health Board staff Jessica Leston and David Stephens went to Oregon's capital advocating for expanded access to HCV medication. Currently, Oregon Medicaid restricts access to medication for only those who with the most liver scarring.

In Oregon, AI/AN reported cases of HCV are more than twice as high, cases of liver cancer are 50% higher, and HCV related deaths are twice as high compared to whites. These are deadly outcomes and expensive as well. Each hospital visit averaged over $25,000 and hospital visits associated with liver cancer averaged over $50,000. This cost could be avoided, but only those Medicaid patients in Oregon or Idaho who have advanced liver scarring, are given access to these curative drugs, and in some cases must be abstinent from alcohol and injection drug use. These criteria are not based on medical evidence, and in fact go against what national medical experts recommend. The American Association for the Study of Liver Diseases and the Infectious Diseases Society of America

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Hepatitis C

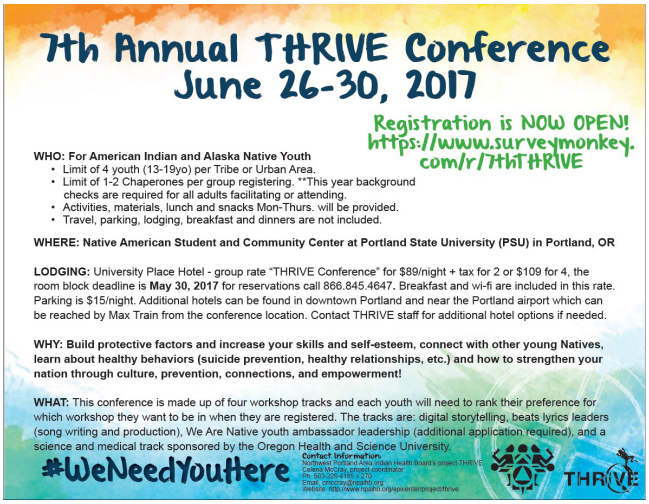
recommend HCV treatment as soon as possible rather than waiting for their liver to be heavily damaged.

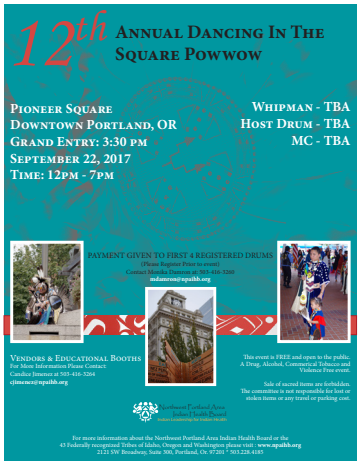
From a public health perspective, rates of new infection will continue to rise unless a considerable number of people with chronic HCV who continue to inject drugs are treated. Many providers have therefore adopted a treatment-as-prevention approach when treating patients with HCV and finding ways other than getting reimbursed through Medicaid to cover the medications.

Medicaid or private insurance companies may block access to medications with an outright denial. If a patient's medication request is rejected, or a patient simply prefers not to apply for insurance given the ACA's Indian health coverage exemption, patient assistance programs exist for all currently available HCV medications. Medication assistance programs and patient advocacy foundations help patients who are uninsured, underinsured, denied coverage, or need co-pay assistance. The process of acquiring approval for medications, and applying to patient assistance programs can be confusing and time-consuming, but almost all patients can get medication for free or reduced price without any cost to the tribe or medical facility. For an extensive list of programs, and to learn more about the process to acquire direct-acting antivirals for patients, please visit: http://www.hepatitisc.uw.edu/go/evaluation-treatment/cost-access-medications/core-concept/all or contact David Stephens (dstephens@npaihb.org).

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

David Stephens, BSN, RN *HCV Clinical Services Manager, Northwest Portland Area Indian Health Board*
Jessica Leston, MPH *HIV/STI/HCV Clinical Programs Director, Northwest Portland Area Indian Health Board*
Sarah Hatcher, PhD *Epidemic Intelligence Service Officer, CDC, Northwest Portland Area Indian Health Board*





Congrats Nancy Scott! Employee of the Year!

Happy Retirement Leslie Wosnig!

Blue Zones Project success
KTHFS first tribe approved in Pacific Northwest

By JOHANNA BERNHARD
H&N Staff Reporter
February 23, 2017

Klamath Tribal Health and Family Services (KTHFS) became the first tribal organization in the Pacific Northwest to become Blue Zones Project approved on Wednesday.

KTHFS, a primary care health center owned and operated by the Klamath Tribes, is responsible for providing healthcare services to the Native American population living in Klamath County.
On Wednesday afternoon, KTHFS employees, the Klamath Tribal Council and members of the Klamath Falls Blue Zones Project gathered at the tribal headquarters in Chiloquin to recognize the organization's success with a ribbon cutting ceremony.

KTHFS began working to become Blue Zones approved in May 2016, after Tribal Chairman Don Gentry proposed the idea. While the organization already had various health practices in place, it created a wellness committee to promote more healthy choices and well-being for its employees, wellness committee member Martha Decker-Hall said. "We found that it was a good fit as a lot of the best practices we had already adopted as an organization," she said. "It went fast for us because we were already on that path."

From the outset, the wellness committee implemented a series of healthy steps, including standing or walking meetings to encourage movement throughout the day; the installation of equipment offering health benefits, such as standing desks, wireless headsets and exercise balls; and posting positive messages throughout the offices, Director of Health Planning and Education Shawn Jackson said. The 121 KTHFS employees are also given 30 minutes of wellness time every day, which they can use to "do something healthy to energize themselves." Some staff opt to go for a walk on the trail, while others use the weight room, Jackson said. "It feels great that we have been approved," he said. "A healthy employee is a happy employee."

Blue Zones Project Organization Lead Jessie Hecocta, who works closely with KTHFS, recognized the organization's achievements and the wellness committee's future plans before presenting Jackson, the wellness committee team leader, with the Blue Zones Project certificate.

"Klamath Tribal Health and Family Services are working hard at changing some of the risk factors that affect our tribal nations," she said. "What they have realized is they can't help people be well if their employees are not well themselves." Hecocta added that the wellness committee are looking to provide a space for breastfeeding and pumping and will restructure the organization's current fitness policy to make it work around employee's schedules. The Blue Zones Project will also hold an overall well-being assessment of the organization to ensure it stays on track and achieves its healthy goals.

As an enrolled tribal member of the Klamath Tribes and passionate about well-being, Hecocta said she is proud the tribe wants to move in a healthier direction. As the first Blue Zones approved tribal organization in the Pacific Northwest, she said KTHFS has the opportunity to act as a guide for other services across the country.

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The Marketplace Offers Continued "Sponsorship" Opportunities

The ACA provides new opportunities for Sponsorship. Under the ACA, a Health Insurance Marketplace (Marketplace) was established in each state, with new types of federal assistance funneled through the Marketplaces. To date, for roughly 85% of enrollees in health plans through a Marketplace, federal premium tax credits (PTCs) have reduced the health insurance premiums due from the enrollees (or their T/THO "sponsors").[7] And, comprehensive, Indian-specific cost-sharing reductions (CSRs) are available through a Marketplace for American Indians and Alaska Natives (AI/ANs) meeting the definition of "Indian" under the ACA.[8] These cost-sharing protections alone transfer 40% of the average health insurance costs from the enrollee and/or T/THO sponsor to the federal government.

There are threats to continued Marketplace operations—and the opportunities for Sponsorship available through them—but the impact of these potential legislative changes is not likely to occur in the short-term. Under several pending congressional legislative proposals to "repeal and replace" the Affordable Care Act, the current PTCs would be significantly altered, with low- to medium- income households and older enrollees experiencing the greatest increases in premiums.[9] And CSRs would be completely eliminated, both for Indians as well for the general population, under some proposals. But enactment of these proposals is far from certain, and even if enacted, the changes to the PTCs and CSRs would not be fully felt for a number of years. The leading legislative proposal from the House of Representatives, for example, would not make significant modifications to the current PTCs and CSRs until January 1, 2020, more than 2 ½ years in the future.[10]

Likewise, there are administrative threats to the operation of the Marketplaces, but these challenges are manageable if the intention of Congress and the Administration is to maintain access to health insurance coverage during a transition to any new approach, if enacted. Given these dynamics, it is reasonable to anticipate, and beneficial to consider, that the Marketplaces will continue to offer Sponsorship opportunities able to generate substantial new health care resources over the short-term, even if not permanently.

Results of Sponsorship Activities

Over the last decade, T/THOs have established Sponsorship programs that vary greatly. Most programs involve a single Tribe, with modest enrollment levels. Other programs are Service Unit-specific, with eligibility open to all uninsured Tribal members who are Active Users in the Service Unit. At least one program is statewide, involving dozens of T/THOs.

In Table 1 below, the net health insurance costs are shown for Marketplace enrollees living in Multnomah County, Oregon, for the lowest-cost bronze preferred provider organization (PPO) plan. AI/ANs meeting the ACA's definition of Indian who enroll in Marketplace coverage have no cost-sharing, such as deductibles, coinsurance, and co-payments. As such, the premium amounts shown are the entire costs for health insurance coverage for these individuals/families.

TABLE 1: Net Annual Household Contribution for Marketplace Premium for Lowest Cost Bronze Plan: PPO[1, 2]

HH size:	1-p HH	2-p HH	3-p HH	
# enrolled:	1 enrollee	2 enrollees	2 enrollees	Average
FPL	Multnomah County, OR			
140%	$434	$499	$696	$543
150%	$595	$717	$970	$761
175%	$961	$1,209	$1,590	$1,253
200%	$1,396	$1,796	$2,329	$1,840
225%	$1,825	$2,375	$3,057	$2,419
250%	$2,306	$3,024	$3,874	$3,068
Average per HH	$1,253	$1,603	$2,086	$1,647
Average per person	$1,253	$802	$1,043	$1,032

[1] Bridge Span Bronze HDHP 6000 RealValue

[2] PPO = Preferred Provider Organization (broader network of providers)

As shown in Table 1, for instance, a family of three with a household income at 225% of the federal poverty level ($45,360 per year) and two enrollees in the Marketplace would have a total annual household premium of $3,057, or $1,529 per enrollee. For these enrollees, per person health care services received under the plan would average $5,100 per year, with no out-of-pocket costs for the AI/AN enrollees. The net gain in health service resources over the coverage year

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The Marketplace Offers Continued "Sponsorship" Opportunities

for these two previously uninsured individuals would be $7,143 ($10,200 – $3,057).

The example above illustrates the great potential that Sponsorship holds for T/THOs. In one recent case, a Tribe implementing a Sponsorship program in another state found that, for the first 300 enrollees in the program, the federal government contributed an average of $5,278 in PTCs per person and was expected to make an additional $2,100 in average cost-sharing payments on behalf of each enrollee. Taken together, the federal government is projected to finance in excess of 78% of enrollee health insurance costs.

Under another Sponsorship program comprised of a coalition of T/THOs, over the first 15 months of the program, the T/THOs generated more than $6 million in net cash collections (after subtracting program premium and overhead costs), resulting in a return on investment (ROI) of 294%. An additional $1.6 million in payments to non-THO providers was made on behalf of the Sponsored individuals, resulting in substantial savings to the THO Purchased/Referred Care (PRC) programs and increasing the ROI to the T/THOs.

An analysis for T/THOs in South Dakota provides an additional example of the potential of Sponsorship through a Marketplace. Enrolling one-half of the currently uninsured AI/ANs in the state, including the lowest-income AI/ANs who have an income too low to qualify for PTCs, could generate a net increase in health care resources of $48 million per year. This would represent a substantial increase in health care resources over the annual congressional appropriation to South Dakota Tribes for PRC and Hospitals and Clinics funding.

Conclusion

Recent deliberations in Congress create uncertainty over the continuation of the PTCs and CSRs provided under the ACA, as well as the associated value of Sponsorship through a Marketplace. But at least for the near term, the PTCs and CSRs currently accessible through a Marketplace are expected to continue. As such, Sponsorship of Tribal members through a Marketplace—as well as under Medicare—continues to hold promise for T/THOs and their Tribal members.

[1]Sponsorship also is described as "Tribally-sponsored" health insurance coverage or "Tribal Premium Sponsorship."

[2]Tribal members are defined here as persons eligible for services from the Indian Health Service, Indian Tribes and Tribal organizations, or urban Indian organizations.

[3]Section 402 of the Indian Health Care Improvement Act (IHCIA) was modified and clarified by section 152 of the Indian Health Care Improvement Reauthorization and Extension Act, which was contained in the ACA.

[4]See TSGAC, Tribal Sponsorship of Medicare Part B and Part D Premiums (Washington, DC: Nov. 23, 2016) at http://www.tribalselfgov.org/wp-content/uploads/2016/12/TSGAC-Memo-Tribal-Sponsorship-of-Medicare-Part-B-D-Premiums-2016-11-....pdf.

[5]Higher-income Medicare beneficiaries pay a larger share of the Part B premium. See Social Security Administration, Medicare Premiums: Rules for Higher-Income Beneficiaries (Washington, DC: Jan. 2017) at https://www.ssa.gov/pubs/EN-05-10536.pdf.

[6]For 2017, the Part D standard benefit requires enrollees to pay a $400 deductible and 25% coinsurance until they reach a coverage limit of $3,700 in total drug costs, followed by a coverage gap. In the coverage gap, enrollees must pay for a larger share of their total drug costs than in the initial coverage period, until their total out-of-pocket spending reaches $4,950. After enrollees reach the catastrophic coverage threshold, they must pay either 5% of their total drug costs or $3.30/$8.25 for each generic/brand-name drug, respectively. See Kaiser Family Foundation, The Medicare Part D Prescription Drug Benefit (Washington, DC: Sep. 26, 2016) at http://files.kff.org/attachment/Fact-Sheet-The-Medicare-Part-D-Prescription-Drug-Benefit.

[7]The figure is for 2016 in states using the Healthcare.gov platform. See HHS ASPE, Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report (Washington, DC: Mar. 11, 2016) at https://aspe.hhs.gov/system/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf.

[8]The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (i.e., member of an Indian tribe or shareholder in an Alaska Native regional or village corporation).

[9]See TSGAC, Review of Congressional ACA Repeal and Replace Legislation (Washington, DC: Mar. 15, 2017) at http://www.tribalselfgov.org/health-reform/webinars/03152017-tsgac-webinar-acaihcia-outreach-education-webinar/.

[10]The legislation is the American Health Care Act of 2017 (H.R. 1628). See the text of the bill at https://www.congress.gov/115/bills/hr1628/BILLS-115hr1628rh.pdf.

[11]See TSGAC, Next on the Affordable Care Act: Funding for Cost-Sharing Protections and Marketplace Stability Programs (Washington, DC: Mar. 27, 2017) at http://www.tribalselfgov.org/wp-content/uploads/2017/04/TSGAC-Brief-Next-on-ACA-2017-03-27d-2.pdf.

[12]See TSGAC, "Success Stories," accessed on Apr. 10, 2017, http://www.tribalselfgov.org/health-reform/success-stories/.

[13]Premiums for the lowest-cost bronze exclusive provider organization (EPO) plan are lower than those for the PPO plan shown.

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Impacts on tribal health programs

Referred Care and Urban Indian Health. The Senate Committee bill, on the other hand, would provide significantly more than the House for Behavioral Health and would fund a Small Ambulatory Health Facilities program. We do not know how these differences may have been resolved in recent negotiations on an omnibus bill or whether any of these programs might receive an increase by being included as an anomaly in any FY 2017 Continuing Resolution.

We note that on March 27, 2017, the Trump Administration circulated details on their proposal to cut FY 2017 domestic discretionary spending by $18 billion below the spending cap, in part to increase funding for defense and for a down payment on construction of a wall on the southern U.S. border. The response from Congressional appropriators of both parties has been to dismiss it as too late at this point in the process. Included in the recommendations is a $25 million reduction from IHS for "preventive" programs, including the Community Health Representatives program. Democrats in Congress have sent a strong signal that any FY 2017 bill which includes funding for construction of a wall on the southern U.S. border will be met with strong opposition.

FY 2018 Budget

On March 16, 2017 the Trump Administration submitted its proposed FY 2018 Budget Blueprint (Blueprint), a 53-page document which addresses discretionary spending for each federal department. This document is also called the "skinny budget". It lists for each department the proposed overall increase or decrease. Only Defense, Homeland Security and Veterans Affairs are recommended for increases. Interior, for instance, is recommended for a 12 percent decrease and HHS for a 17.9 percent decrease. The proposal has been criticized from both parties as being unrealistic. While targeting some programs for reduction or elimination, it is lacking in detail, and simply notes that funding will be eliminated for "duplicative" or "ineffective" programs.

The Blueprint describes the IHS and Community Health Centers as a "high priority" but provides no numbers. It also states in the Interior Department section that the Administration supports tribal sovereignty and self-determination but also that they will propose reductions for recent demonstration projects and initiatives which serve only a few tribes.

The Trump Administration FY 2018 Blueprint would, by proposing a $54 billion increase for defense and a $54 billion decrease for discretionary domestic spending, would require an amendment to the Budget Control Act.

With regard to scheduling, the House Appropriations Subcommittee on Interior, Environment and Related Agencies has said they would like to schedule a hearing for public witnesses on Indian programs but as of this writing no date has been set. The Administration's detailed proposed FY 2018 budget, including recommendations for both discretionary and mandatory spending, is expected to be available in mid-May.

Update on Redding Rancheria v. Price in the U.S. District Court for the District of Columbia

An oral argument was held before Judge Rosemary Collier on March 24, 2017, in the U.S. District Court for the District of Columbia in Redding Rancheria v. Price, Civ. No. 14-2035 (RMC). The primary issue before the court was whether the Redding Rancheria's self-insured health plan for tribal members is an alternate resource to the IHS Catastrophic Health Emergency Fund (CHEF). The NPAIHB and several Tribes in the Northwest joined an amicus brief that was filed in the case in support of the Redding Rancheria's position.

As background, the CHEF is established in § 202 of the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1621a. CHEF is administered in IHS Headquarters for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses. CHEF reimburses IHS service units and tribal health programs for the cost of treating

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Impacts on tribal health programs

any victim of a catastrophic illness or disaster over a certain threshold amount established by the IHS.

The Redding Rancheria (Rancheria) adopted a self-insured health plan for tribal members (Member Plan) to supplement its compacted Patient Referred Care (PRC) program. Tribal members are generally eligible for both PRC and the Member Plan. In order to take advantage of the PRC program's ability to pay for health care services at Medicare-Like Rates (MLR), the Rancheria adopted a Combined Master Plan Document to coordinate the benefits its PRC program and Member Plan. The Combined Master Plan provides for PRC payment of provider claims for which the provider would accept MLR. Provider claims for which a provider would not accept MLR are paid by the Member Plan. Coordinating the benefits of the PRC program with the Member Plan in this manner allowed the Rancheria get the maximum cost benefit from the PRC program's ability to pay provider claims at MLR.

The IHS refused to process any of the *Rancheria's* requests for CHEF reimbursement under this coordination of benefits arrangement. IHS supported this position by asserting that the Payor of Last Resort provision in § 2901(b) of the Affordable Care Act (ACA), 25 U.S.C. § 1623(b), did not make an exception for tribal member health plans and thus the Rancheria's Member Plan is an alternate resource to PRC and CHEF. This is a radical departure from long-standing IHS policy under the Payor of Last Resort regulation at 42 C.F.R. § 136.61, which does not include tribal health plans in its definition of alternate resources. It also is contrary to the definition of alternate resources in § 1621a(d)(5) of the IHCIA establishing the CHEF.
The IHS, simultaneously with the Redding litigation, published a Notice of Proposed Rulemaking, 81 Fed. Reg. 4239 (Jan. 26, 2016) proposing to make tribal health plans an alternate resource to CHEF. Due to objections by tribes, this regulation is on hold.

The oral argument did not go well for the IHS. The argument opened with the judge indicating that the definition of a "tribal health plan" in the IHCIA included the Rancheria's Member Plan. Thus, the Rancheria's Member Plan was encompassed within the ACA Payor of Last Resort provision. In other words, the ACA Payor of Last Resort provision encompassed both the PRC program and the Rancheria's Member Plan. The Member Plan was thus not an alternate resource to the Rancheria's compacted PRC program.

Having apparently lost her central argument, the Government's attorney then shifted to arguing that nevertheless, the Rancheria was not following CHEF administrative procedures in the IHS Manual, and thus could not access CHEF funds. The judge was not impressed with this argument either, indicating that the IHS Manual is not a legally binding regulation and there was no law against the Rancheria coordinating the benefits of the PRC program and the Member Plan.

Because questions were raised at the hearing about how the Rancheria's coordination of benefits process actually worked, and how it had been changed over time in an attempt to respond to IHS' concerns, the judge asked the Rancheria's attorneys to file a detailed statement addressing these questions. The Government would then have a chance to respond. So the case is not yet ready for the judge to issue an opinion, but the oral argument was very favorable to the Rancheria.

IHS Actively Negotiating New Lease Proposals Under Section 105(l) of the Indian Self-Determination Act

In a set of lawsuits that finally wrapped up in the fall of 2016, the United States District Court for the District of Columbia established in two major rulings that Section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA) and its implementing regulations require the Indian Health Service (IHS) to enter into a fully-compensated lease with a tribe or tribal organization with an ownership, leasehold, or trust interest in a facility used by the tribe or tribal organization for the administration and delivery of services under its ISDEAA contract or compact. The implementing regulations (codified at 25 C.F.R. Part

900, subpart H) set out specific options and elements for lease compensation, and the district court ruled that those options and elements are binding on the IHS—permitting tribes and tribal organizations to negotiate under one of those options for full facility funding. Though the lawsuits were brought against the IHS, the statute and regulations apply equally to the Bureau of Indian Affairs.

The IHS has begun accepting and negotiating new Section 105(l) lease proposals from tribes and tribal organizations that meet the statutory criteria for a lease. Thus far, new proposals have been submitted mainly in Alaska (where the lawsuits originated). There is a steep learning curve for both the IHS and the tribes with respect to implementing the Section 105(l) leasing authority, which until now has been all but ignored. However, the precedent set by these lawsuits and the leases finalized thus far has the potential to dramatically impact the level of facilities funding available for tribal health clinics, hospitals, and other facilities used by tribes and tribal organizations to carry out the ISDEAA, particularly if the IHS effectively leverages its new legal obligations in seeking additional funding from Congress in the upcoming years.

Contract Support Cost Developments

Contract support cost (CSC) issues continue to percolate. After a brief pause during the transition in administrations, IHS has resumed settling past-year CSC claims, with payments issuing from the Treasury Department's Judgment Fund. Beginning in FY 2014, Congress lifted the CSC spending "caps" and has required full payment, so litigation of past-year claims should diminish—but will not disappear entirely. IHS's new CSC policy, approved in October 2016, requires the agency to conduct a "reconciliation" process to ensure each tribe and tribal organization was fully paid but not overpaid. IHS is still in the process of reconciling CSC needs and payments going back to FY 2014 for many tribes. In most cases the reconciliation process should be noncontroversial, but disagreements can be expected. In December, IHS published a CSC distribution report listing all ISDEAA contractors and compactors and how much the agency thinks they were underpaid—or overpaid. The report is available at:
https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/CSC_Report.pdf

Two issues dividing the IHS and tribes—what types of funding generate CSC and how to ensure that CSC does not duplicate Secretarial funding—are currently being litigated in the case Navajo Health Foundation – Sage Memorial Hospital, Inc. v. Burwell. On November 3, 2016, the court held that third-party revenues, such as reimbursements tribes and tribal organizations receive from Medicare, Medicaid and third-party insurance, that are used to provide health care services under an ISDEAA agreement, are to be considered "Secretarial funds" that generate CSC to the same extent as IHS funds appropriated by Congress. In the same decision, the court upheld the tribal position on duplication: that a dollar-for-dollar offset should be applied to administrative costs included in the Secretarial amount. The court rejected the IHS position that duplication is prohibited on a categorical basis (e.g., if the Secretarial amount provides even $1.00 for a certain activity, no additional funding for that activity could be provided as CSC). IHS seems strongly committed to this position, which was incorporated into the new CSC policy. And the ruling on CSC for third-party revenues, if it stands, would greatly expand the agency's annual CSC spending. Not surprisingly, counsel for the hospital recently reported that IHS will appeal the Sage Memorial decision to the Tenth Circuit Court of Appeals.

Upcoming Events

APRIL

April 11-22
weRnative Clothing Line Launch
http://www.wernative.org/gear/team-store
Worldwide, Earth

April 23-27
2017 Tribal Self-Governance Annual Consultation Conference
Spokane, WA

April 24 - May 5
10th Anniversary of the UN Declaration on the Rights of Indigenous People
UN HQ, New York

April 27-29
2017 AISES Leadership Summit
Chandler, AZ

MAY

May 2-4
2017 Tribal Interior Budget Council
Washington, DC

May 2-4
6th Annual HIV/HCV Harm Reduction Summit
Mahnomen, MN

May 14-20
SAMHSA National Prevention Week
Washington, DC

May 23-26
ATNI Mid Year Convention 2017
Portland, Oregon

May 23-24
Oregon Health Authority - SB 770 Quarterly Health & Human Services Cluster Meeting
Coquille Tribe, OR

Upcoming Events

JUNE

June 5-6
Tribal Leaders Diabetes Committee Meeting
Anchorage, AK

June 6-8
Western Tribal Diabetes Project - RPMS/DMS training
Portland, OR

June 6-8
NIHB Public Health Summit
Anchorage, AK

June 9-30
Summer Institute (NARCH)
Portland, OR

June 12-15
NCAI Mid Year Conference and Marketplace
Uncasville, CT

June 16-17
National Alaska Native American Indian Nurses Association (NANAINA) Conference
St Paul, MN

June 26-30
7th Annual THRIVE Conference
Portland, OR

JULY

July 18-20
NPAIHB - CRIHB Joint Quarterly Board Meeting
Cow Creek, OR

July 25-27
IHS Direct Service Tribes Advisory
Committee Quarterly Meeting
Mashpee, MA

We welcome all comments and Indian health-related
news items. Address to:
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MARCH 2017 RESOLUTIONS

RESOLUTION #17-03-01
Supporting Standing Rock

RESOLUTION #17-03-02
Support of CHAP National Exchange

RESOLUTION #17-03-03
Support Engagement of Youth and Development of Youth Track

RESOLUTION #17-03-04
Support Nomination of Dr. Charles W. Grim for Director of the Indian Health Service