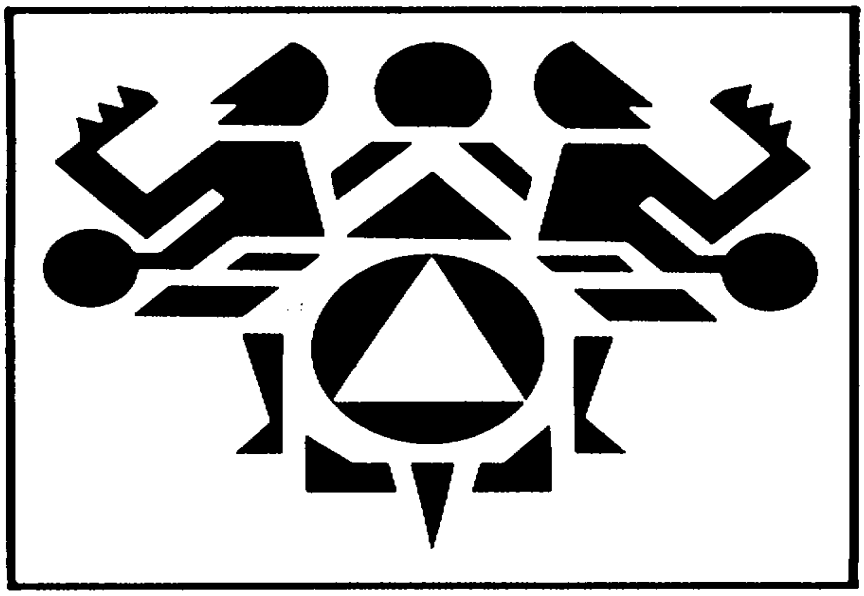
MINUTES

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD



QUARTERLY BOARD MEETING

OCTOBER 10-12, 2017

LEGENDS CASINO – HOTEL
TOPPENISH, WA

Summary of Minutes

Issue	Summary	Action	Follow-Up
TUESDAY, OCTOBER 10, 2017			
WEAVE-NW, Nanette Star, Project Director	*See PowerPoint*		
Diabetes and Hepatitis C Program, Troy Pitney, DIA Partner and Tribal Benefit Specialist, The Mahoney Group	*See PowerPoint*		
NPAIHB Executive Director Report, Joe Finkbonner	*See PowerPoint*		
Northwest Tribal Epidemiology Center, Victoria Warren-Mears, EpiCenter Director	*See PowerPoint*		
Yakama's Maternal Child Health (MCH), Regina Brown, Yakama Nation	*See PowerPoint*		

Summary of Minutes

MCH Manager & Immunization Coordinator			
Oregon Prevention Research Center for Healthy Communities at OHSU Program/Project Updates (Native STAND, SRI, etc) Rana Najjar, School of Nursing Native Diversity Program & Michelle Singer, Center for Health Communities	*See PowerPoint*		
Legislative Update, Laura Platero, NPAIHB Governmental Affairs/Policy Director	**Report Overview** 1. Status of IHS Budgets 2. Current & Pending Policy Issues 3. Legislation in 115th Congress 4. National & Regional Meetings **Status of IHS Budgets** **FY 2018 IHS Budget** • Congress passed a continuing resolution (CR) for FY 2018 budget which funds the government through December 8, 2017. • President's budget proposes a 5.2% decrease below FY 2017 enacted level for services and facilities.		

Summary of Minutes

- House bill proposes a 4.2% increase above FY 2017 enacted level for services and facilities.
  - However, reallocates funds to IHCIF; so minimal increases across all line items
  - Hill visits advocacy per our FY 2018 analysis
- Senate Appropriations Interior Environment and Related Agencies Subcommittee markup of Indian Health Service Budget week of October 16.

FY 2019/2020 IHS Budgets

- National Tribal Budget Formulation Workgroup's Recommendations to IHS for FY 2019
  - Available at: http://www.nihb.org/legislative/budget_formulation.php
- FY 2020 Portland Area Budget Formulation Meeting
  - November 30, 2017 in Portland, OR

Current & Pending Policy Issues

HHS Draft Strategic Plan for FY 2018-2022

- HHS is seeking public comment on its draft Strategic Plan for Fiscal Years 2018-2022
  -Comments due 10/26/17.
- Strategic Plan highlights how the Department will achieve its mission through 5 strategic goals
  1. Reform, strengthen, and modernize the Nation's health care system;
  2. Protect the health of Americans where they live, learn, work, and play;
  3. Strengthen the economic and social well-being of Americans across the lifespan;
  4. Foster sound, sustained advances in sciences; and
  5. Promote effective and efficient management and stewardship.

CMS Policies

- Medicare Diabetes Prevention Program Proposed Rule
  - NPAIHB submitted comments on 9/11/17.
- New Medicare Card Project

Summary of Minutes

- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
  - Compliance is required by 11/15/17

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.
- CMS FAQ released January 18, 2017.
- *Deadlines*:
  - January 18, 2018: Tribe must notify state of intent to change provider status – clinical provider to FQHC.
  - January 30, 2021: Effective date

CMS New Direction for Innovation Center

- CMS is seeking comment on new direction for the CMS Innovation Center

- Comments due 11/20/17.

- CMS is interested in testing models in the following areas:
  1. Increased participation in Advanced Alternative Payment Models (APMs);
  2. Consumer-Directed Care & Market-Based Innovation Models;
  3. Physician Specialty Models;
  4. Prescription Drug Models;
  5. Medicare Advantage (MA) Innovation Models;

Summary of Minutes

6. State-Based and Local Innovation, including Medicaid-focused Models;
7. Mental and Behavioral Health Models; and
8. Program Integrity.

IHS Policies

- **IHS Contract Support Costs**
- **IHS Listening Sessions on RPMS and EHR**
  - DTLL on 6/26/17; listening sessions held in July and August.
  - Response to VA moving to VistA and impact on IHS RPMS EHR.
  - NPAIHB submitted comments on 8/30/17.
- **Other IHS Announcements:**
  - DTLL on 8/25: IHS is accepting applications for the Small Ambulatory Program; due 12/1/17.
  - New wait time standards policy: 28 days or less for primary care and 24 hours or less for urgent care.
  - Creation of a search committee to fill key Area Director positions.
- **IHS Strategic Plan 2018-2022 Tribal Consultation and Urban Confer**
  - DTLL on 9/15/17
  - Listening session held in September
  - Next listening session scheduled for October 18
  - Comments due 10/31/17
- **3 Strategic Plan Goals**
  - To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/ANs;
  - Promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and
  - Strengthen IHS program management and operations.

Summary of Minutes

Legislation in 115th Congress

- Appropriations for FY 2018
- Disaster Tax Relief and Airport and Airway Extension Act of 2017- Extends the SDPI (H.R. 3823)
- KIDS Act of 2017 (S.1827)
- Native Health and Wellness Act of 2017 (H.R. 3706)
- Native Health Access Improvement Act of 2017 (H.R. 3704)
- Restoring Accountability in the Indian Health Service Act of 2017 (S.1250)
- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545)
- Independent Outside Audit of the Indian Health Service Act of 2017 (S.465)
- Drug Free Indian Health Service Act of 2017 (H.R. 3096)
- Tribal Veterans Health Care Enhancement Act (S.304)
- IHS Advanced Appropriations Act of 2017 (H.R. 235)

Indian Legislative Bills in 115th Congress

- Appropriations for FY 2018
  - Indian Health Service Budget
    - Senate Appropriations Subcommittee for Interior, Environment and Related Agencies to Markup Indian Health Service Budget week of October 16.
    - House bill (discussed in earlier slide).
  - Secretary's Minority AIDS Initiative Fund (SMAIF)
    - Senate Appropriations Committee for Labor HHS Education and Related Agencies included $53.9 million for SMAIF.
    - No funding in House Appropriations Committee bill.
    - $3.6 million to IHS; over $1m to NPAIHB in FY 2017.
  - Public Health Training Centers
    - Senate Appropriations Committee for Labor HHS Education and Related Agencies included level funding

Summary of Minutes

- No funding in House Appropriations Committee bill.
- $50k to NPAIHB in FY 2017 through NWPHTC.

- Disaster Tax Relief and Airport and Airway Extension Act of 2017 (H.R. 3823)
  - Introduced by Rep. Kevin Brady (R-TX-8) on 9/25/2017
  - Extends several public health programs including SDPI.
  - Includes $37,500,000 for SDPI for the first quarter of FY 2018 – extends SDPI to 12/31/17.
  - Referred to the House Ways and Means Committee, the Committees on Transportation and Infrastructure, the Energy and Commerce Committee, the Financial Services Committee, and the Budget Committee on 9/25/2017.
  - 9/28/17: Passed in the House and passed in the Senate with an amendment; House agreed to amendment without action.
  - 9/29/17: Signed into law by the President.

- KIDS Act of 2017 (S.1827)
  - Introduced by Sen. Orrin Hatch (R-UT) on 9/18/2017
  - 5 year funding extension for CHIP (2022).
  - Referred to the Senate Committee on Finance on 9/18/2017
  - Committee hearing on October 4, 2017

- Native Health and Wellness Act of 2017 (H.R. 3706)
  - Introduced by Rep. Raul Ruiz (D-CA-36) and co-sponsored by Rep. Frank Pallone Jr. (D-NJ-6) on 9/07/2017
  - Creates a tribal health block grant.
  - Creates a grant program to recruit and mentor AI/AN youth and young adults.
  - Referred to the House Energy and Commerce Committee on 9/07/2017

Summary of Minutes

- Native Health Access Improvement Act of 2017 (H.R. 3704)
  - Introduced by Rep. Frank Pallone, Jr. (D-NJ-6) and co-sponsored by Rep. Raul Ruiz (D-CA-36) on 9/07/2017.
  - Establishes a grant program similar to the SDPI to increase access to substance abuse prevention and behavioral health services for Tribes and Urban Indians.
  - Referred to the Energy and Commerce Committee as well as to the Committee on Natural Resources and Ways and Means Committee on 9/07/2017.
  - Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs within the Committee on Natural Resources on 9/13/2017

- Native American Suicide Prevention Act of 2017 (H.R. 3473)
  - Introduced by Rep. Raul Grijalva (D-AZ-3) on 7/27/2017.
  - Requires States and their designees receiving grants for development and implementation of statewide suicide and early intervention and prevention strategies to collaborate with Tribes.
  - Referred to the House Energy and Commerce Committee on 7/27/2017.
  - Referred to the Subcommittee on Health under the Energy and Commerce Committee on 7/28/2017.
- Drug-Free Indian Health Service Act of 2017 (H.R. 3096)
  - Introduced by Rep. Kristi Noem (R-SD) on 6/28/17; no other co-sponsors.
  - To implement a mandatory random drug testing program for certain employees of the Indian Health Service, and for other purposes.
  - 6/28/17: Referred to Committee on Natural Resources and Committee on Energy and Commerce.

- Restoring Accountability in the Indian Health Service Act of 2017 (S. 1250 & H.R. 2662)
  - Senate and House bills Introduced by Sen. John Barasso (R-WY) and Rep. Kristi Noem (R-SD)

Summary of Minutes

on 5/25/17, respectively.
- This bill attempts to address quality of care issues occurring at some IHS-operated hospitals in the Great Plains Area and elsewhere.
- 5/25/17: Referred to House Senate and House Committees.
- S. 1250- 6/13/17: Senate hearings were held.
- H.R. 2662- 6/21/17: House Subcommittee hearing was held; Chairman Andy Joseph, Jr. testified.

- Trauma Informed Care for Children and Families Act of 2017 (S. 774 & H.R. 1757)
  - Senate and House bills introduced by Sen. Heitkamp (D-ND) on 3/29/17 and by Rep. Davis (D-IL) on 3/28/17, respectively.
  - 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:
      - 3/28/17- Referred to House Committees on Education and the Workforce, Energy and Commerce Subcommittee on Health, and Ways and Means; and
      - 4/12/17- Referred to Subcommittee on Crime, Terrorism, Homeland Security, and Investigations.

- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545
  - Senate bill introduced by Sen. Tom Udall (D-NM) on 3/28/17; and House bill introduced by Rep. Norma Torres (D-CA) on 5/18/17 and has 13 co-sponsors.
  - $150 million for FY 2018; and

Summary of Minutes

- Reauthorizes the Special Diabetes Program for Indians (SDPI) for FY 2018 at $150m; and
- FY 2019-FY 2024 increase annually using medical inflation rate.
- S. 747 - 3/28/17: Referred to Committee on Health, Education, Labor and Pensions.
- H.R. 2545 - 5/19/17: Referred to House Energy and Commerce on Health.

- Independent Outside Audit of the Indian Health Service Act of 2017 (S. 465)
  - 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
- **Separate Note**: Rep. Greg Walden (R-OR) has created 14 member Bipartisan IHS Task Force.

- Tribal Veterans Health Care Enhancement Act (S. 304)
  - 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.
  - 6/15/17: Committee recommended that bill pass.
  - 6/15/17: Committee created a report to accompany S.304.

National & Regional Meetings

HHS Secretary's Tribal Advisory Committee (STAC)

- Last meeting was on September 21-22, 2017 in the Cherokee Nation; and December STAC meeting is cancelled.

Summary of Minutes

- The next meeting will be January 17-18, 2018.
- Annual Tribal Budget Consultation proposed date is March 8-9, 2018.
- At September meeting, several requests were made to Secretary Price:
  - Honor Tribal Consultation and Government-to-Government relationship and hold all HHS agencies accountable to HHS Consultation policy.
  - Importance of Tribal Advisory Committees (TACs) and tribal/federal workgroups
  - Opioid crisis in Indian Country: need for a federal/tribal workgroup to track funding and resources from states to tribes
  - Provide Continued Support for Special Diabetes Program for Indians
  - Improving the healthcare workforce recruitment and retention in Indian Country.
  - Maintain Medicaid expansion for AI/AN and 100% FMAP
  - Tribal exemption from Medicaid 1115 demonstration waiver work and enrollment requirements
  - Getting Area Directors approved

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) –last face-to-face meeting was on August 22, 2017; last conference call was on July 19;
  - Next conference call is October 10, 2017; and the next face-to-face meeting is on October 31, 2017.
- CMS TTAG – last face-to-face meeting was August 23-24, 2017; last conference call was on June 29;
  - Next conference call is on October 11, 2017; and the next TTAG face-to-face meeting is November 1-2,2017

TTAG Issues

- Medicare Diabetes Prevention Program (MDPP)
- Medicare
- New Medicare Card Project

Summary of Minutes

	• 1115 Demonstration Waivers **MMPC Issues** • VA Roundtable: Reimbursement Agreements • 100% FMAP/4 Walls Issue • Future of RPMS • MACRA Merit-based Incentive Payment System (MIPS) • 1332 demonstration waivers and preservation of Indian cost sharing reductions		
AREA DIRECTOR REPORT, DEAN SEYLER PORTLAND AREA IHS DIRECTOR	❖ **H.R. 601 Continuing Appropriations Act, 2018** ❖ H.R. 601, the "Continuing Appropriations Act, 2018" was signed into law by the President on September 8, 2017. ❖ The continuing resolution provides fiscal year 2018 appropriations through December 8, 2017, for the continuing projects and activities of the Federal Government. ❖ **A.S.A.P Area Pool** ❖ Letter to Tribes seeking comments to discontinue; sent 10-06 with 30 day comment ❖ The number of referrals have declined ❖ Not all tribes who have retained shares with ASAP utilize the funding. ❖ The Affordable Care Act has provided extensive funding for substance use disorder treatment that was not been available in prior years. ❖ Difficulty in increasing the number of substance use disorder treatment facilities as recognized IHS vendors. Facilities would rather negotiate treatment fees per each tribe. ❖ **IHS Awards $16.5 Million in Grants to Support Behavioral Health Programs** ❖ Substance Abuse and Suicide Prevention (SASP) ❖ Cow Creek Band of Umpqua Tribe of Indians ❖ Northwest Portland Area Indian Health Board ❖ Port Gamble S'Klallam Tribe ❖ Seattle Indian Health Board		

Summary of Minutes

- Domestic Violence Prevention Program (DVPP)
  - Confederated Tribes of Siletz Indians
  - Nez Perce Tribe
  - Northwest Portland Indian Health Board
- Behavioral Health Integration Initiative (BH2I)
  - Yellowhawk Tribal Health Center
- Preventing Alcohol-Related Deaths (PARD)
- Here is the link to the full release: https://www.ihs.gov/newsroom/pressreleases/2017pressreleases/ihs-awards-16-5-million-in-grants-to-support-behavioral-health-programs/

- **CDC-IHS Healthcare Infection Control Training**
  - Date: Week of 1/22/18 (Dates TBD)
  - Portland, OR (Hotel TBD)
  - Open to all Portland Area IHS/Tribal/Urban
  - Register thru IHS Environmental Health Support Center
    - https://www.ihs.gov/ehsct/index.cfm?module=classes&catID=4
  - **Who Should Attend:**
    - Clinic Leaders
    - Clinic Medical Directors
    - Clinic Healthcare Providers
    - Infection Control Officers
    - Clinic Risk Management
    - Accreditation Managers
    - Facility Managers
  - **POC:** LCDR Matthew Ellis, MPH REHS
  - matthew.ellis@ihs.gov / (503) 414-7788

Accelerated Model for improvement - Ami™ Waves

Summary of Minutes

- **Colville Service Unit**
  - September 25-27, 2017
    - Billing Errors
    - Procurement Process
    - PRC Referrals
    - PRC Payments
    - **Wellpinit Service Unit**
  - September 27-Oct 2, 2017
    - Infection Control Process
    - Optimizing access of patient care
  - **Yakama Service Unit**
  - October 3-5,2017
    - Referral process (Direct Care)
    - Patient access to follow-up care and patient scheduling
    - Phone access for patients

Accelerated Model for improvement -Ami™ Waves

- **Warm Springs Service Unit**
  - October 17-19, 2017
    - Increase Patient Satisfaction
    - Medical Supply Management
    - **Fort Hall Service Unit**
  - October 25-27 27-Oct 2, 2017
    - Increased Access to Care/Patient Satisfaction
    - Pharmacy Point of Sale (POS) Billing
  - **Western Oregon Service Unit**
  - FY17

Summary of Minutes

- Health Information Management (HIM) Scanning
- Lab Draw/Operations
- Lab Inventory

- **FY17 CHEF**
  - $1,725,099 submitted for Portland Area
  - $650,606 has been returned
  - $24,484,022 current balance (as of September 25, 2017)

- **YRTC – NARA Update**
  - 24 bed license granted on 10-02-2017
  - Combining Services Under One Roof
  - Staffing of facility in process
  - Projected opening date – 10-16-2017
  - 620 NE 2nd St. Gresham Oregon
- **Small Ambulatory Program (SAP)**
  - IHS is Accepting Applications for this Health Facility Construction Funding Opportunity.
  - $5.0M Reserved / Max Award is $2.0M
  - 3-5 Awards Anticipated (Highly Competitive)
  - Applications Due: December 1
  - Download Application Kit: https://www.ihs.gov/dfpc
  - Portland Area IHS Will Provide Two Webinars on Application Process
    - October 31st and November 7th
  - If You Plan to Apply, Please Contact
    - CAPT Jason Lovett - jason.lovett@ihs.gov OR
    - Gene Kompkoff - gene.kompkoff@ihs.gov
    - Available to Answer Questions, Provide Facilities Data, and Webinar Information

Summary of Minutes

- **Annual Combined Space Verification**
  - Will Be Sent to Tribes in Early November
  - Verify the Amount and Location of Facility Space Used for IHS PSFA's
  - Response Due Date: December 31, 2017
  - Please Review the Provided Data and Certify if is Accurate
    - Used to Calculate Share of Equipment and M&I Funds
    - Used to Update and Maintain the CMS Facilities List for Encounter Rate Billing
    - Used to Verify Facility Type and Other Statistical Items
  - If Data is Not Accurate, Please Follow Included Instructions to Update
  - Questions:
    - Jonathan McNamara – Health Facilities Engineering – jonathan.mcnamara.ihs.gov
    - Peggy Ollgaard – Business Office – peggy.ollgaard@ihs.gov
    - Mary Brickell – Statistics – mary.brickell@ihs.gov

- **Portland Area IHS Multi-Conference Series**
- Nov. 13-17, 2017 at Spokane NATIVE Project.
  - **AAAHC Achieving Accreditation Workshop**
    - Nov. 13 (afternoon) - Nov. 14 (all day)
    - Currently all slots are filled
  - **Pain Skills Intensive Seminar** (HOPE Committee and UNM sponsored)
    - Nov. 15 (all day)
    - Medication Assisted Treatment (MAT) DATA waiver training Nov. 16 (morning)
    - Registration link- Access code psi11152017
  - **Portland Area Fall Clinical Director's Meeting**
    - Nov 16 (afternoon) – Nov 17 (morning)

Summary of Minutes

- **Portland Area Opiate Procurement**
  - 4th year of data collection for 6 Federal and 11 Tribal sites utilizing the VA Pharmacy Prime Vendor (PPV)
  - Assesses procurement of 9 commonly prescribed opiates
    - Codeine/acetaminophen, hydrocodone/acetaminophen, oxycodone/acetaminophen, fentanyl, hydromorphone, methadone, morphine, oxycodone, tramadol
  - Also tracking procurement of associated drugs:
    - Naloxone- utilized to reverse opiate overdose
    - Naltrexone, buprenorphine/naloxone- used to treat opiate use disorders
  - Individualized reports with analysis and recommendations for best practices on appropriate and judicious opiate prescribing are provided to each included Federal and Tribal clinic.

- **Key Recommendations:**
  - Utilize a facility policy on chronic opioid therapy (COT)/chronic pain management.
  - Assure policies are congruent with the IHS Chronic Non-Cancer Pain Management policy.
  - Assure all prescribers of Controlled Substances have had training on appropriate pain management.
  - Conduct at least annual peer review among your prescribers to assure compliance with facility policies on COT.
  - Implement a First Responder and Take-Home Naloxone (co-prescribing) program, esp. for those prescribed methadone.
  - Transition as many patients as possible off of methadone.
  - Develop local capacity for Medication-Assisted Therapy for opioid dependence.
  - Follow CDC recommendations to limit acute opiate prescriptions to 3 days, rarely more than 7 days, of therapy.

Obtain a Prescription Drug Monitoring Program (PDMP) report on all new patients receiving controlled

Summary of Minutes

	substances, all patients receiving more than 7 days of medication for acute pain, and at each visit for patients on chronic opioid therapy		
WEDNESDAY OCTOBER 11, 2017			
SUICIDE PREVENTION AT HERITAGE UNIVERSITY, MAXINE JANICE AND CELENA MCCRAY	*See PowerPoint*		
HEALING LODGE, SHARON RANDLE, OUTREACH SPECIALIST	*See PowerPoint*		
BEHAVIORAL HEALTH AID, XIOMARA OWENS MS, DIRECTOR OF BHA PROGRAMS ANTHC	*See PowerPoint*		
Yakama's Nak Nu We Sha, June Adams, MSW, NNWS Program Manager & Laretta Smiscon Social	*See PowerPoint*		

Summary of Minutes

Worker Supervisor			
TRIBAL UPDATES	1. Port Gamble S'Klallam Tribe, Karol Dixon 2. Tulalip Tribes, Jim Steinruck, Health Administrator		
CHAIRMAN'S REPORT, ANDY JOSEPH, JR	*See attached report*		
SUGARY DRINKS AND HEALTH, SARA SOKA, MS *VICE PRESIDENT, POLICY HEALTH FOOD AMERICA*	*See PowerPoint*		
YAKAMA NATION BEHAVIORAL HEALTH, KATHERINE SALUSKIN, MSW, PROGRAM DIRECTOR	*See PowerPoint*		
YOUTH-LED PSA (JULY'S QBM) NEVER A WINNING HAND VIDEO & CONCERNING POST TRAINING VIDEO, STEPHANIE CRAIG-RUSHING, THRIVE & PRT	*See PowerPoint*		

Summary of Minutes

PROJECT DIRECTOR			
THURSDAY, APRIL 23, 2014			
COMMITTEE REPORTS	**Elders Committee – Dan Gleason, Chehalis Tribe** (A copy of the report is attached) **Veterans – Cindy Harris, Sauk-Suiattle Tribe** (A copy of the report is attached) **Public Health – Victoria Warren Mears, NPAIHB EpiCenter Director** (A copy of the report is attached) **Behavioral Health – Nick Lewis, Lummi Nation** (A copy of the report is attached) **Personnel – Jaqueline Left Hand Bull, NPAIHB Administrative Officer** (A copy of the report is attached) **Youth Committee** - **Sharon Stanphill, Cow Creek Tribe** (A copy of the report is attached) **Legislative Committee** - **Laura Platero, NPAIHB Governmental Affairs/Policy Director** (A copy of the report is attached)		
FINANCE REPORT	**Eugen Mostifi, NPAIHB Fund Accounting Manager: MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Kim Thompson, Shoalwater Bay Tribe; MOTION PASSES**	**MOTION**	**PASSED**
MINUTES:	**MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Patrick Anderson, Makah Tribe: MOTION PASSES**	**MOTION**	**PASSED**
RESOLUTIONS:			

Summary of Minutes

	18-01-02 ***"Support for the Tribal Epidemiology Center (TEC) to Apply with Oregon Health & Science University (OHSU) for NIH Science Education Partnership Award (SEPA) Funding PAR-17-339"*** **MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Cassie Sellards-Reck, Cowlitz Tribe: MOTION PASSES**	**MOTION**	**PASSED**
	18-01-04 ***"Urging the American Medical Association to Adopt a Policy Statement on Adverse Childhood Experiences and Toxic Stress"*** **MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Sharon Stanphill, Cow Creek Tribe: MOTION PASSES**	**MOTION**	**PASSED**
	18-01-03 ***"RFA-MH-18-410: Addressing Suicide Research Gaps: Understanding Mortality Outcomes (R01)"*** **MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Sharon Stanphill, Cow Creek Tribe: MOTION PASSES**	**MOTION**	**PASSED**
ADJOURN at 9:31 a.m.			

QUARTERLY BOARD MEETING

Legends Casino – Hotel
580 Fort Road Toppenish, WA 98948
October 10-12, 2017
MINUTES

TUESDAY, OCTOBER 10, 2017

Call to Order: Andy Joseph, Chairman,

Invocation & Welcoming: Chairman JoDe Goudy, Yakama Tribal Council, Davis Washines, General Council Chairman and Frank Mesplie, Health Employment, Welfare & Youth Activities Committee Chairman

Posting of Flags: Brian McCloud, Interim Manager Veteran's Affairs, Yakama Warriors Color Guard

Roll Call: Shawna Gavin, Secretary, called roll:

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

There were 26 delegates present, a quorum is established.

WEAVE-NW, NANETTE STAR, PROJECT DIRECTOR

Technical Assistance for All Tribes

- Data analysis
- Strategic planning
- Health systems change
- Enhancing collaborations
- Evaluations & assessments
- Cultural adaptation of resources
- Survey design, implementation, and analysis
- Tobacco prevention & intervention activities
- Policy development
- Youth lead

Tribally Lead …
Webinars, Trainings, Workshops

Resource Library

- http://www.npaihb.org/

Communication Forum to increase collaboration across Tribes and provide an immediate digital platform for sharing resources.

Direct Funding NOW OPEN!
Application Details

- $1000. - $10,000.
- Rolling basis based on available funding!
- Funds utilized for Prevention (PSE) Activities ONLY:
    - Cardiovascular disease
    - Obesity
    - Type 2 Diabetes
    - All associated risks
- Activities completed by September 30, 2018

WEAVE-NW Team
Principle Investigator
Victoria Warren-Mears
Project Director & Epidemiologist

Nanette Star
(Choctaw Oklahoma Nation)
Project Coordinator
Nora Frank-Buckner
(Nez Perce)

Project Evaluator
Jenine Dankovchik

Tobacco Project Specialist
Ryan Sealy
(Chickasaw)

WEAVE-NW Email: weave@npaihb.org
Phone: 503-228-4185

Diabetes and Hepatitis C Program, Troy Pitney, DIA Partner and Tribal Benefit Specialist, The Mahoney Group

See PowerPoint

BREAK

NPAIHB Executive Director Report, Joe Finkbonner

Personnel

New Hires
On-Call Office Assistants
- Gwen Allen
- Erik Ramone
- Ellee Biery
- Naomi Weiser

Taylor Ellis – CDC Public Health Associate

Promotion

- Nora Frank – WEAVE -Promoted from Project Specialist to Project Coordinator

Temp

- Cathy Ann Ballew – TPTS2Tweens Site Coord.

Separation of Employment

- Collin McCormack, return to school

Recognition

Stephanie Craig-Rushing, PRT Project Director, 15 years of service

Maternal & Child Health (MCH) Conference Calls

- The Tribal EpiCenter plans to start hosting quarterly conference calls in 2018
- The calls will be an opportunity to connect with tribal MCH practitioners in the Northwest, share information and resources, and build knowledge and skills
- Email ideanw@npaihb.org to receive more information

Meetings

AUGUST

- 8/2-8/3 Portland Area 638 Orientation, Portland
- 8/8-8/10 Portland Area Dental Meeting, Oregon Coast
- 8/16 Lunch with Diane Oaks, Arcora Foundation
- 8/30-8/31 Nike Native Fitness, Nike HQ

September

- 9/7-9/8 SAMSHA Meeting on Opioid crisis, Seattle, WA
- 9/11-9/13 Accreditation Meeting & Impact Days, Washington , DC
- 9/14 – 9/16 Arcora Foundation Board Retreat, Seattle, WA
- 9/18 – 9/21 ATNI, Spokane, WA
- 9/25 – 9/28 NIHB Annual Conference, Bellevue, WA

Upcoming Events

OCTOBER

- 10/16 – 10/17 NCAI, Milwaukee, WI

NOVEMBER

- 11/1 – 11/2 PHAB Board meeting
- 11/17 Invitation to speak at Indigenous Faculty Forum

DECEMBER

- 12/1 Arcora Foundation Board meeting & Alumni Lunch, Seattle, WA
- 12/6 – 12/7 PHAB Board meeting, Washington, DC

Other Events

- 8/18 - NPAIHB Staff Picnic, Oak Park, Portland, OR

- 8/25-8/26 - Hood to Coast Running & Walking Team
- 9/22 12th Annual Dancing in the Square Indian Day Celebration
- 10/4-10/6 NPAIHB Staff Retreat, Suquamish, WA
- Office Remodel completed

Northwest Tribal Epidemiology Center, Victoria Warren-Mears, EpiCenter Director

Outline

- Overview of the Tribal Epidemiology Center
- Mission and Vision of Our Tribal Epidemiology Center
- Review of Capacities and Roles
  - New awards received for FY 2018

Celebrating 20 Years

All Tribal Epidemiology Center Web Site
www.tribalepicenters.org

Mission of the TECs

- Our mission is to improve the health status of American Indians and Alaska Natives by identification and understanding of health risks and inequities, strengthening public health capacity, and assisting in disease prevention and control.

TEC Activities

- Collect and disseminate data…
  Provide analysis of health data
- Area/Tribal specific health status reports…
  Community Health Profiles
- Maintain/provide access to surveillance databases
- Conduct epidemiologic studies
- Support public health emergency response
- Assist Tribes in disease control and prevention
- Provide training… Epidemiology, Data Collection, and Public Health

NWTEC Projects

- Immunization
- Improving Data and Enhancing Access
- Northwest Tribal Dental Support Center

- Project Red Talon (including We R Native)
- NW Comprehensive Cancer Prevention Program
- Tots to Tweens
- THRIVE
- WEAVE-NW
- Injury Prevention
- Tribal BRFSS
- Health Priorities Survey
- Public Health Emergency Preparedness Conference
- Environmental Epidemiology Pilot

Native CARS

- Native Children Always Ride Safe
  - NIMHD NIH wants to highlight this project and implement it as a best practice.

Hepatitis C Treatment

- NPAIHB NWTEC is host to a Project ECHO Hub for expert staffing of Hepatitis C cases, including treatment planning.
  - Over 36 I/T/U clinics are participating nationwide
  - 96 patients have been discussed and staffed by the team

IDEA-NW

- IDEA – NW staff have been working on a paper for the CDC MMWR on Opioid Use in the NW, using linkage corrected data.
  - In final stages of writing at this time

New Funding

- CDC expansion funding for the tribal epidemiology center
  - Allow development of statistical core enhancement
    - Quicker data provision
    - Partnership with states for real time surveillance
    - Potential development of data portal

NARCH

- Asthma support and tracking project
  - Dr. Bill Lambert at OHSU

NWTEC 101

- We have been holding data use and grant writing trainings
  - More will be coming

- Please remember we have a non-compete policy with tribes

Support Services for Your Grants

- Data
- Roles within the grant
  - Analysis
  - Evaluation
  - For grants that require a data sharing agreement we have the NW Tribal Data Repository
    - Data stewardship

YAKAMA'S MATERNAL CHILD HEALTH (MCH), REGINA BROWN, YAKAMA NATION MCH MANAGER & IMMUNIZATION COORDINATOR

YN – MCH638 Contracted Program Indian Health Services Master Contract (1971 - 2017)
46 years
M. Smith/Squeochs -1st Manager 1971
R. George - Retired 2016 34+ Yrs (Both Enrolled Yakama)

***MCH Report Outline**:*

1. *YN - MCH Chain of Command*
2. *Portland Area Office (PAO)*
3. *MCH Goals & Objectives*
4. *MCH Program Activities/Clinics*
5. *Injury Prevention Project*
6. *Reports*
7. *Collaborations*
8. *Pending Grants*
9. *MCH Staff*

***MCH Report**:*

MCH Chain of Command

- HEW Committee
- Tribal Director
- Human SVC Deputy Director
- MCH Manager
- MCH Outreach (3)
- Trainee (YN-NWF & PFP)
- Summer Youth (4-8wks)

Portland Area Office (PAO)

- Yakama I.H.S Clinic
  - Federal I.H.S Facility
  - 1 out of 3 I.H.S Facilities in WA State
  - Provides services to **All** federally recognized tribes & descendants
- **PAO =** WA, Oregon & Idaho Tribes
  - Federal: 6
  - Tribal 638 / Compact: 47
  - Urban: 3
- Indian Health Service: 12 Area Offices
  - Alaska - Albuquerque
  - Bemidji - Billings
  - California - Great Plains
  - Nashville - Navajo
  - Oklahoma - Phoenix
  - **Portland** - Tucson
- Federal, Tribal 638/Compact & Urban
- I.H.S Headquarters, Rockville MD
- RPMS Computer System
  - Scheduling & Letters
  - Immunization Register
  - Report System
- Electronic Health Records / EHR (2007)
  - Documentation: Chart Reviews, Phone Calls, Hospital Visits (NB & PP), PN Intakes, Home Visits, Counseling, WCC
- E-Mail, Outlook: IHS.GOV

MCH Goals & Objectives

- Improve Health Care through Immunizations
- Decrease Death Rates: Fetal, Infant, Children & Adolescent, Maternal
- Reduce STD's in Pregnancies
- Encourage Women's Health Care
- Decrease BBTD

WCC, MCH Intake/Referral's, WHC: IHS & Private Care, Injury Prevention

Program Activities & Clinics

Case-Management Program

- Prenatal → Post-Partum

- 1st, 2nd & 3rd Trimester
- Children

-Birth - 6-year Age Groups

I.H.S Eligible/Registered

Please PowerPoint for additional graphics

Area Locations:

- Harrah/Brownstown
- Toppenish/Satus
- Wapato City/Parker
- White Swan/Medicine Valley
  - Off Reservation: Yakima, Union Gap, Selah, Naches, Ellensburg, Cle Elum, Zillah, Granger, Sunnyside, Grandview, Goldendale
- Out of State/Local Area

PN Case-Load: 5 Area's

- Prenatal 1st, 2nd & 3rd Trimester
  - I.H.S Medical Referrals, Daily/Weekly

Self-Referrals (2nd & 3rd Trimester)

- MCH Intakes Daily/Weekly
- OB Referrals → Outside Providers
- Monitored: HV, T/C, Office Visits
- PN Lists Updated monthly (reports)

Not All PN patient's come thru I.H.S/MCH

Please PowerPoint for additional graphics
Hospital Visits: Weekly, MON - FRI

- PN List: Deliveries Monitored
- Weekly Staff Rotation
- Toppenish Community Hospital
- Virginia Mason (YVMH)
- NB Car Seat Delivered
  - PP/Early Deliveries
  - Unknown Pregnancy, Not on PN List

Not all PN's deliver locally (Seattle or Out of State)

Newborns: Divided into 5 Area's

- Newborn PE (within 2 days)

- Activated on MCH Immunization Register weekly/monthly
- Family contact by MCHO {Active/Inactive}
- NB/PP Info entered into E.H.R
- Registration Packets w/I.H. S Registration

Not all NB's register w/I.H. S after delivery

Birth-6 Years Case-Load:

- ACTIVE List: WCC/Immunizations completed @ Yakama I.H.S. PCP @ Yakama I.H.S.
- *INACTIVE List: Private Care for WCC & Immunizations - PCP Outside of Yakama I.H.S. (Dental, Pharmacy, Medical Walk-Ins, PRC, Wic @ Yakama I.H.S)

*Does Not Count on QTRLY Reports

- Out of State/Local Area: Inactive

Case-Load Guidelines Birth - 6 Years:

- Master List beginning of each QTR
- Chart Review: UTD & Target List
- Reminder Due Letters once per month
- Schedule/Monitor WCC Due List
- Phone Call: APPT Reminders
- Home Visit's: Rtn Letters, (Active)
- Transfers: Area to Area, Re-Activate
- Document All Pt Contacts

WA formerly Child-Profile:

- Immunization Information System {WA- IIS }
- HEW Resolution
- Inactive Case-Load Only
- Private Care: WA Providers
  - Does Not Require Release of Information

- EHR Documentation: All Immunization Updates

Well Child Clinics:

- Toppenish Wcc Daily, Appt: 865-1709

-APPT's by I.H.S PCP Team currently

- White Swan WCC: 2 per month

-APPT's by MCH

-MCH Ph: (509)865-2102, X-360/X-312

- Wapato WCC: Closed May 2011
  - No E.H.R Connection, No running water in exam room. Renovation: June 2016-present.

GSA Vehicles:

- GSA Truck
- GSA VAN (traded SUV 5/17)
  - Outreach Clinics
  - Hospital Visits
  - Home Visits
  - Local Trainings/Meetings
- Tribal Permits & WA Driver's License Required

Injury Prevention

- Child Restraints (car seats)
  - Newborn Car Seat Carrier's, on-going
  - Convertible & Booster Seats (dependent upon budget)
  - Paperwork Completed in Advance
  - Documented by PCC & into EHR
  - Must be Up-To-Date with WCC/ Immunizations (Appt's available daily)
- Re-Started: April 2017 with Grant
- Newborn RF Car Seat Carrier: 5-22 lb
  - 2 weeks prior to Due Date/EDC
  - Delivered to hospital, weekly
  - Grant NB Order Rec'd: March 2017
- Convertible Car Seats: 5-65 lb
- High-Back Booster: 4yr - 8yr

- Prior purchases, dependent upon budget
- Current Native CARS Pro

- Native CARS (Children Always Ride Safe) Mini-Grant Award: 1-Yr Project:
  - Dec 19, 2016 - Dec 18, 2017
  - Previous Pilot Project, 6 NW Tribes
  - 6 Project Choices
  - RPMS Referral Patch & Car Seat Distribution Project
  - Funding Doubled: Car Seat TECH Training Project, Travel cost (4 staff)
- Funding Received: February 2017

#1: RPMS Patch & Car Seat Distribution:

- RPMS Patch Installed: JAN 2017 *Trng & Lunch Cost Included, → H.Start
- Car Seat Observation Survey's: 200

*Age Group: NB-8 years

- Includes $4000 order of NB car seats 69 Total Received
- Provided Convertible Car Seats: 100
- Provided High-Back Booster Seats: 50

Car/Booster Seat's Received: Feb 24, 20

Program Reports

- MCH Program & Individual Reports:
  - Weekly Staff Meeting
  - Program Schedule/Clinics/Percentage
  - Total Contacts:
    - Chart Reviews
    - Phone Calls
    - Intakes
    - Hospital Visits (PP/NB)
    - Car Seat/Booster Seat

  Monthly YN Reports
    - - Includes WCC & Audiology Appt #'s
    - - Due last Thursday of Month
    - - Total Number's used for GC Report

  Quarterly Reports: PAO & YN
    - Quarterly 3-27 months
    - Two-YR-Old 19-35 months
    - Adolescent 11-17 years
    - Adult 18 & above
    - Influenza (2 QTR's per YR)

  Quarterly Reports: PAO/YN
    - Due after end of each Quarter:
    - 1st: OCTOBER - DECEMBER
    - 2nd: JANUARY - MARCH
    - 3rd: APRIL - JUNE
    - 4th: JULY - SEPTEMBER

    Percentage Totals entered to I.H.S National data-base each QTR
    - -Total # Included with monthly reports

Collaborations

- WhiteSwan Health Clinic Outreach
  - 2 per month, 24 Clinics per year
  - AM Clinics: 9:00-11:00 March through October
  - PM Winter Clinics: 1:00-3:00 November through February
- MCH: Coordinate, scheduling, reminder letters, phone calls, home visits & arranging transportation
- **YN-White Swan Health Clinic**

80 Bird Song Lane,
White Swan WA 98952
Phone: (509)874-2979
Fax: (509)874-2113

WS Medical Director: Abdulla Shirzad

- 34+ Years Collaboration

-Clinic Totals Reported on monthly/yearly MCH reports

- Audiology
  - PRC Contracted Tribal Program
  - 8 Clinics per month, 2 days per week
  - Appointments: ½ Hour to 1 Hour
  - Appointment's preferred
  - APPT's: 865-1712, 865-1757
- MCH: Scheduling, HA Drop-Off's & HA Pick-Up's, reminder appointment calls, Daily messages

(Sept 2014)

- Audiology, Svc Provided:
  - Hearing Screenings
  - Hearing Aid Checks & Adjustments
  - Referral's
  - Hearing Aide's
  - Batteries
  - All Age Groups (head start, seniors)
- HA payment: PRC, Private Insurance or Private Pay

Audiology

- Office Location: Yakama I.H.S Community Health, Tribal Hallway
- **MCH**/Clinic Reports: Kept & DNKA appointment's
- Clinic Totals included w/MCH report

- **Audiologist**: Linda Simpson, - 1 Person Program
- - Previous I.H.S program

- YN Child-Care Program
  - Total List of Children by Child-Care
  - MCH Review Immunization Records
  - Total List of Children **only** (not by center location)
  - Provide List of Children 'Due' & monitor for future WCC/Immun.
- **New Collaboration**: April 2017
- -Total # will be included in reports

Grants Projects

- Native CARS, NPAIHB FY-2017
- BIA Highway Safety FY-2017
  - Convertible Car Seats & Booster Seats
- BIA Highway Safety FY-2018
  - Newborn Car Seat Carrier's, Convertible Car Seats & Booster Seats
  - Canopy's
  - Folding Tables
  - Latch Manuals
  - Registration Cost, CPS Tech Training

MCH Staff

Enrolled Yakama Members
-3 Regular FT Staff
-1 FT, Native WF
- Enrolled, Other Tribe

-1 Regular FT Staff

NPAIHB Report Completed By:
Regina L. Brown/YN
MCH Mgr & Immunization Coordinator
- 26+ Years with YN-MCH
- 2 Years w/YN prior
- Office Location: Yakama I.H.S Community Health

E-mail: regina.brown@ihs.gov
Hours: Mon-Fri 8a-5p

LUNCH - Committee Meetings *(working lunch)*

Oregon Prevention Research Center for Healthy Communities at OHSU Program/Project Updates (Native STAND, SRI, etc) Rana Najjar, School of Nursing Native Diversity Program & Michelle Singer, Center for Health Communities

Center for healthy communities
www.oregonprc.org

Thomas "Tom" Becker, MD, PhD, Director
William "Bill" Lambert, PhD, Associate Director
Caitlin Donald, MSW (Osage/Ponca), Program Manager
Michelle Singer, BS (Navajo), Native STAND Project Manager
Brittany Morgan, BS, Native STAND Data Manager

Partners in research
Northwest Portland Area Indian Health Board

Research Projects & Training Programs
Summer Research Training Institute 2018
Native STAND

Native STAND Project Core TEAM
OHSU Center for healthy communities
Bill Lambert
Michelle Singer
Brittany Morgan
Caitlin Donald
*Tom Becker
*Kavita Rajani

NPAIHB
Stephanie Craig Rushing
Jessica Leston
**We R Native*
**Native VOICES*
**Healthy Native Youth*
**THRIVE*
**NW NARCH SRI*

**PAIRB Coordinator*

Dissemination, implementation & evaluation Study
5 year CDC-FUNDED project
An effective healthy decision-making curriculum for enhancing and promoting positive Native youth development and well-being.

Disseminate regionally & nationally
(n = 50 tribal communities)
Randomize to two arms:

1. Passive
2. Active technical assistance

Evaluate according to RE-AIM framework
Project evaluation framework

- *Reach*: Proportion and representation of participating educators, teens, and organizations
- *Effectiveness*: Youth outcomes
- *Adoption*: Individuals and organizations that implement the curriculum
- *Implementation:* Fidelity of delivery and cost absorbed by community sites
- *Maintenance:* Curriculum becomes part of routine operations, including budget, staff, and space

Project Update – Into action!
48 AI/AN health educators trained over 3 cohorts:

- Year 1 (12), Year 2 (18), Year 3 (18)
- Summer Educator Training Series Completed.

Y3 cohort getting ready for 1st time implementation.
Collection of info on adoption/adaption of curriculum with Y1 & Y2 cohorts ongoing.

- Some Y1/Y2 sites conducting 2nd or 3rd time implementation.

In 2017, weekly phone interviews with 30 sites.

- Potentially ~ 600 AIAN youth (30 sites x 20 youth each).
- After October 1st, Y3 cohort (18 sites) will be added in as they begin.
- Project 2019 Goal ~ 1250 AIAN youth

Year 4 began September 30, 2017. Year 5 begins September 2018.

Native STAND - Center for Healthy Communities
Facebook Page – Like us!
Stories from the field!

"Native Stand UP!!" on YouTube!
Warm Springs Native STAND program creates music video to reach other Native youth.
https://youtu.be/A4QtHCSbHok
Words of Wisdom (WOW) and more**!**

Native STAND, the Center, and OHSU are grateful for the helpfulness and coordination of supportive resources.

- NPAIHB leadership, staff & use of training rooms
- NW NARCH Summer Research Training Institute
- THRIVE Tribal Youth Conference students
- NPAIHB Delegate & Tribal ongoing support!

Health STEPS 2.0 Advancing Health Equity through Student Empowerment and Professional Success Statewide Program, Amanda Bruegle, MD

Oregon Nursing & Population Demographics

Recent reports by the Office of Oregon Health Policy and Research (2013) and Oregon Healthcare Workforce Committee (2014) indicate that gaps in racial and ethnic representation in the workforce, primarily for the Hispanic population, exist for registered nurses, nurse anesthetists, clinical nurse specialists and nurse practitioners. Oregon Health Authority and the Oregon Department of Human Services (2013) have identified gaps in healthcare workforce diversity as a factor contributing to health inequity in the state.
The Native American population in Oregon is estimated to be about 1.4% and there is less of a gap in the registered nursing workforce in Oregon with approximately 0.7% of Oregon registered nurses identifying as Native American. However, the gap widens for advanced practice nurses with 0% of the nurse anesthetist workforce and 0.2% of nurse practitioners in Oregon identifying as Native American (Oregon Health Authority, 2014).

One School of Nursing – Multiple Campuses
Oregon Health & Science University School of Nursing

Portland, Monmouth, Ashland and La Grande

Advancing **Health E**quity through **St**udent **E**mpowerment & **P**rofessional **S**uccess Model

Outcomes of HealthE STEPS Nursing Workforce Diversity Grant 2013 - 2016

This proposal is based on a currently-funded model*, Advancing Health Equity through Student Empowerment & Professional Success,* which provides evidence of successful recruitment, enrollment, and retention strategies (Noone, Wros, Najjar, Cortez & Magdalleno, 2016).

HealthE STEPS was implemented on two of the campuses of OHSU (Ashland and Monmouth) with excellent results in meeting the SON URM benchmark of 20% (See Figure 3) compared to all campuses. Ashland had a head start in developing recruitment activities as compared to Monmouth campus which represents some of the difference in the findings (although both campuses exceeded the benchmark by the end of the grant period).

Outcomes of HealthE STEPS Nursing Workforce Diversity Grant 2013 - 2016

Tables 3 and 4 outline the results of the previous HealthE STEPS grant. Three of the five goals related to all students were met, with a fourth nearly met by grant end. The fifth goal related to the percentage of URM students was met for the Ashland and Monmouth campuses and is achievable through deployment of HealthE STEPS 2.0.

Outreach Activities

- Exploring increased clinical placements for nursing students in tribal clinics
- Partnering with Dr. Erik Brodt and OHSU On Track to increase recruitment of Native American students into nursing

We are Hiring!

- Diversity Coordinators
  - LaGrande
  - Klamath Falls
  - .5 fte

The ideal candidate has:

- A bachelor's or master's degree in student services or related major;
- Working with disadvantaged or minority college/university students;
- Working with health professions students;
- Experience and/or interest in the health professions.
- Strong ties/relationships with local underrepresented communities

Questions

What is the role of nurses in improving the health of Native Americans in our region? How could it be improved/expanded?

Is it an interest/priority for tribal leaders to increase the number of Native American nurses in the workforce?

If so, how can we partner with Native American groups throughout the state to increase Native American student interest in nursing?

What advice do you have for us?

Thank you

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) Nursing Workforce Diversity Program Grant Number D19HP30850 Advancing Health Equity through Student Empowerment & Professional Success (HealthE STEPS , $1.9 million. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

LEGISLATIVE UPDATE, LAURA PLATERO, NPAIHB GOVERNMENTAL AFFAIRS/POLICY DIRECTOR

Report Overview

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

Status of IHS Budgets

FY 2018 IHS Budget

- Congress passed a continuing resolution (CR) for FY 2018 budget which funds the government through December 8, 2017.
- President's budget proposes a 5.2% decrease below FY 2017 enacted level for services and facilities.
- House bill proposes a 4.2% increase above FY 2017 enacted level for services and facilities.
  - However, reallocates funds to IHCIF; so minimal increases across all line items
  - Hill visits advocacy per our FY 2018 analysis
- Senate Appropriations Interior Environment and Related Agencies Subcommittee markup of Indian Health Service Budget week of October 16.

FY 2019/2020 IHS Budgets

- National Tribal Budget Formulation Workgroup's Recommendations to IHS for FY 2019
  - Available at: http://www.nihb.org/legislative/budget_formulation.php
- FY 2020 Portland Area Budget Formulation Meeting
  - November 30, 2017 in Portland, OR

Current & Pending Policy Issues

HHS Draft Strategic Plan for FY 2018-2022

- HHS is seeking public comment on its draft Strategic Plan for Fiscal Years 2018-2022 -Comments due 10/26/17.
- Strategic Plan highlights how the Department will achieve its mission through 5 strategic goals
    1. Reform, strengthen, and modernize the Nation's health care system;
    2. Protect the health of Americans where they live, learn, work, and play;
    3. Strengthen the economic and social well-being of Americans across the lifespan;
    4. Foster sound, sustained advances in sciences; and
    5. Promote effective and efficient management and stewardship.

CMS Policies

- Medicare Diabetes Prevention Program Proposed Rule
    - NPAIHB submitted comments on 9/11/17.
- New Medicare Card Project
- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
    - Compliance is required by 11/15/17

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.
- CMS FAQ released January 18, 2017.
- *Deadlines*:
    - January 18, 2018: Tribe must notify state of intent to change provider status – clinical provider to FQHC.
    - January 30, 2021: Effective date

CMS New Direction for Innovation Center

- CMS is seeking comment on new direction for the CMS Innovation Center

- Comments due 11/20/17.

- CMS is interested in testing models in the following areas:
    1. Increased participation in Advanced Alternative Payment Models (APMs);
    2. Consumer-Directed Care & Market-Based Innovation Models;
    3. Physician Specialty Models;
    4. Prescription Drug Models;
    5. Medicare Advantage (MA) Innovation Models;
    6. State-Based and Local Innovation, including Medicaid-focused Models;
    7. Mental and Behavioral Health Models; and
    8. Program Integrity.

IHS Policies

- **IHS Contract Support Costs**
- **IHS Listening Sessions on RPMS and EHR**
    - DTLL on 6/26/17; listening sessions held in July and August.
    - Response to VA moving to VistA and impact on IHS RPMS EHR.
    - NPAIHB submitted comments on 8/30/17.
- **Other IHS Announcements:**
    - DTLL on 8/25: IHS is accepting applications for the Small Ambulatory Program; due 12/1/17.
    - New wait time standards policy: 28 days or less for primary care and 24 hours or less for urgent care.
    - Creation of a search committee to fill key Area Director positions.
- **IHS Strategic Plan 2018-2022 Tribal Consultation and Urban Confer**
    - DTLL on 9/15/17
    - Listening session held in September
    - Next listening session scheduled for October 18
    - Comments due 10/31/17
- **3 Strategic Plan Goals**
    - To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/ANs;
    - Promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and
    - Strengthen IHS program management and operations.

Legislation in 115th Congress

- Appropriations for FY 2018
- Disaster Tax Relief and Airport and Airway Extension Act of 2017- Extends the SDPI (H.R. 3823)

- KIDS Act of 2017 (S.1827)
- Native Health and Wellness Act of 2017 (H.R. 3706)
- Native Health Access Improvement Act of 2017 (H.R. 3704)
- Restoring Accountability in the Indian Health Service Act of 2017 (S.1250)
- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545)
- Independent Outside Audit of the Indian Health Service Act of 2017 (S.465)
- Drug Free Indian Health Service Act of 2017 (H.R. 3096)
- Tribal Veterans Health Care Enhancement Act (S.304)
- IHS Advanced Appropriations Act of 2017 (H.R. 235)

Indian Legislative Bills in 115th Congress

- Appropriations for FY 2018
  - Indian Health Service Budget
    - Senate Appropriations Subcommittee for Interior, Environment and Related Agencies to Markup Indian Health Service Budget week of October 16.
    - House bill (discussed in earlier slide).
  - Secretary's Minority AIDS Initiative Fund (SMAIF)
    - Senate Appropriations Committee for Labor HHS Education and Related Agencies included $53.9 million for SMAIF.
    - No funding in House Appropriations Committee bill.
    - $3.6 million to IHS; over $1m to NPAIHB in FY 2017.
  - Public Health Training Centers
    - Senate Appropriations Committee for Labor HHS Education and Related Agencies included level funding
    - No funding in House Appropriations Committee bill.
    - $50k to NPAIHB in FY 2017 through NWPHTC.

- Disaster Tax Relief and Airport and Airway Extension Act of 2017 (H.R. 3823)
  - Introduced by Rep. Kevin Brady (R-TX-8) on 9/25/2017
  - Extends several public health programs including SDPI.
  - Includes $37,500,000 for SDPI for the first quarter of FY 2018 – extends SDPI to 12/31/17.
  - Referred to the House Ways and Means Committee, the Committees on Transportation and Infrastructure, the Energy and Commerce Committee, the Financial Services Committee, and the Budget Committee on 9/25/2017.
  - 9/28/17: Passed in the House and passed in the Senate with an amendment; House agreed to amendment without action.

  - 9/29/17: Signed into law by the President.

- KIDS Act of 2017 (S.1827)
  - Introduced by Sen. Orrin Hatch (R-UT) on 9/18/2017
  - 5 year funding extension for CHIP (2022).
  - Referred to the Senate Committee on Finance on 9/18/2017
  - Committee hearing on October 4, 2017

- Native Health and Wellness Act of 2017 (H.R. 3706)
  - Introduced by Rep. Raul Ruiz (D-CA-36) and co-sponsored by Rep. Frank Pallone Jr. (D-NJ-6) on 9/07/2017
  - Creates a tribal health block grant.
  - Creates a grant program to recruit and mentor AI/AN youth and young adults.
  - Referred to the House Energy and Commerce Committee on 9/07/2017

- Native Health Access Improvement Act of 2017 (H.R. 3704)
  - Introduced by Rep. Frank Pallone, Jr. (D-NJ-6) and co-sponsored by Rep. Raul Ruiz (D-CA-36) on 9/07/2017.
  - Establishes a grant program similar to the SDPI to increase access to substance abuse prevention and behavioral health services for Tribes and Urban Indians.
  - Referred to the Energy and Commerce Committee as well as to the Committee on Natural Resources and Ways and Means Committee on 9/07/2017.
  - Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs within the Committee on Natural Resources on 9/13/2017

- Native American Suicide Prevention Act of 2017 (H.R. 3473)
  - Introduced by Rep. Raul Grijalva (D-AZ-3) on 7/27/2017.
  - Requires States and their designees receiving grants for development and implementation of statewide suicide and early intervention and prevention strategies to collaborate with Tribes.
  - Referred to the House Energy and Commerce Committee on 7/27/2017.
  - Referred to the Subcommittee on Health under the Energy and Commerce Committee on 7/28/2017.
- Drug-Free Indian Health Service Act of 2017 (H.R. 3096)
  - Introduced by Rep. Kristi Noem (R-SD) on 6/28/17; no other co-sponsors.
  - To implement a mandatory random drug testing program for certain employees of the Indian Health Service, and for other purposes.

- 6/28/17: Referred to Committee on Natural Resources and Committee on Energy and Commerce.

- Restoring Accountability in the Indian Health Service Act of 2017 (S. 1250 & H.R. 2662)
  - Senate and House bills Introduced by Sen. John Barasso (R-WY) and Rep. Kristi Noem (R-SD) on 5/25/17, respectively.
  - This bill attempts to address quality of care issues occurring at some IHS-operated hospitals in the Great Plains Area and elsewhere.
  - 5/25/17: Referred to House Senate and House Committees.
  - S. 1250- 6/13/17: Senate hearings were held.
  - H.R. 2662- 6/21/17: House Subcommittee hearing was held; Chairman Andy Joseph, Jr. testified.

- Trauma Informed Care for Children and Families Act of 2017 (S. 774 & H.R. 1757)
  - Senate and House bills introduced by Sen. Heitkamp (D-ND) on 3/29/17 and by Rep. Davis (D-IL) on 3/28/17, respectively.
  - 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:
      - 3/28/17- Referred to House Committees on Education and the Workforce, Energy and Commerce Subcommittee on Health, and Ways and Means; and
      - 4/12/17- Referred to Subcommittee on Crime, Terrorism, Homeland Security, and Investigations.

- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545
  - Senate bill introduced by Sen. Tom Udall (D-NM) on 3/28/17; and House bill introduced by Rep. Norma Torres (D-CA) on 5/18/17 and has 13 co-sponsors.
  - $150 million for FY 2018; and
  - Reauthorizes the Special Diabetes Program for Indians (SDPI) for FY 2018 at $150m; and
  - FY 2019-FY 2024 increase annually using medical inflation rate.

  - S. 747 - 3/28/17: Referred to Committee on Health, Education, Labor and Pensions.
  - H.R. 2545 - 5/19/17: Referred to House Energy and Commerce on Health.

- Independent Outside Audit of the Indian Health Service Act of 2017 (S. 465)
  - 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
- **Separate Note**: Rep. Greg Walden (R-OR) has created 14 member Bipartisan IHS Task Force.

- Tribal Veterans Health Care Enhancement Act (S. 304)
  - 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.
  - 6/15/17: Committee recommended that bill pass.
  - 6/15/17: Committee created a report to accompany S.304.

National & Regional Meetings

HHS Secretary's Tribal Advisory Committee (STAC)

- Last meeting was on September 21-22, 2017 in the Cherokee Nation; and December STAC meeting is cancelled.
- The next meeting will be January 17-18, 2018.
- Annual Tribal Budget Consultation proposed date is March 8-9, 2018.
- At September meeting, several requests were made to Secretary Price:
  - Honor Tribal Consultation and Government-to-Government relationship and hold all HHS agencies accountable to HHS Consultation policy.
  - Importance of Tribal Advisory Committees (TACs) and tribal/federal workgroups
  - Opioid crisis in Indian Country: need for a federal/tribal workgroup to track funding and resources from states to tribes
  - Provide Continued Support for Special Diabetes Program for Indians

- Improving the healthcare workforce recruitment and retention in Indian Country.
- Maintain Medicaid expansion for AI/AN and 100% FMAP
- Tribal exemption from Medicaid 1115 demonstration waiver work and enrollment requirements
- Getting Area Directors approved

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) –last face-to-face meeting was on August 22, 2017; last conference call was on July 19;
  - Next conference call is October 10, 2017; and the next face-to-face meeting is on October 31, 2017.
- CMS TTAG – last face-to-face meeting was August 23-24, 2017; last conference call was on June 29;
  - Next conference call is on October 11, 2017; and the next TTAG face-to-face meeting is November 1-2,2017

TTAG Issues

- Medicare Diabetes Prevention Program (MDPP)
- Medicare
- New Medicare Card Project
- 1115 Demonstration Waivers

MMPC Issues

- VA Roundtable: Reimbursement Agreements
- 100% FMAP/4 Walls Issue
- Future of RPMS
- MACRA Merit-based Incentive Payment System (MIPS)
- 1332 demonstration waivers and preservation of Indian cost sharing reductions

AREA DIRECTOR REPORT, DEAN SEYLER PORTLAND AREA IHS DIRECTOR

- **H.R. 601 Continuing Appropriations Act, 2018**
  - H.R. 601, the "Continuing Appropriations Act, 2018" was signed into law by the President on September 8, 2017.
  - The continuing resolution provides fiscal year 2018 appropriations through December 8, 2017, for the continuing projects and activities of the Federal Government.
- **A.S.A.P Area Pool**

- Letter to Tribes seeking comments to discontinue; sent 10-06 with 30 day comment
- The number of referrals have declined
- Not all tribes who have retained shares with ASAP utilize the funding.
- The Affordable Care Act has provided extensive funding for substance use disorder treatment that was not been available in prior years.
- Difficulty in increasing the number of substance use disorder treatment facilities as recognized IHS vendors. Facilities would rather negotiate treatment fees per each tribe.

- **IHS Awards $16.5 Million in Grants to Support Behavioral Health Programs**
  - Substance Abuse and Suicide Prevention (SASP)
    - Cow Creek Band of Umpqua Tribe of Indians
    - Northwest Portland Area Indian Health Board
    - Port Gamble S'Klallam Tribe
    - Seattle Indian Health Board
  - Domestic Violence Prevention Program (DVPP)
    - Confederated Tribes of Siletz Indians
    - Nez Perce Tribe
    - Northwest Portland Indian Health Board
  - Behavioral Health Integration Initiative (BH2I)
    - Yellowhawk Tribal Health Center
  - Preventing Alcohol-Related Deaths (PARD)
  - Here is the link to the full release: https://www.ihs.gov/newsroom/pressreleases/2017pressreleases/ihs-awards-16-5-million-in-grants-to-support-behavioral-health-programs/
- **CDC-IHS Healthcare Infection Control Training**
  - Date: Week of 1/22/18 (Dates TBD)
  - Portland, OR (Hotel TBD)
  - Open to all Portland Area IHS/Tribal/Urban
  - Register thru IHS Environmental Health Support Center
    - https://www.ihs.gov/ehsct/index.cfm?module=classes&catID=4
  - **Who Should Attend:**
    - Clinic Leaders
    - Clinic Medical Directors
    - Clinic Healthcare Providers
    - Infection Control Officers
    - Clinic Risk Management
    - Accreditation Managers

- Facility Managers
- **POC:** LCDR Matthew Ellis, MPH REHS
- matthew.ellis@ihs.gov / (503) 414-7788

Accelerated Model for improvement - Ami™ Waves

- **Colville Service Unit**
  - September 25-27, 2017
    - Billing Errors
    - Procurement Process
    - PRC Referrals
    - PRC Payments
    - **Wellpinit Service Unit**
  - September 27-Oct 2, 2017
    - Infection Control Process
    - Optimizing access of patient care
  - **Yakama Service Unit**
  - October 3-5,2017
    - Referral process (Direct Care)
    - Patient access to follow-up care and patient scheduling
    - Phone access for patients

Accelerated Model for improvement -Ami™ Waves

- **Warm Springs Service Unit**
  - October 17-19, 2017
    - Increase Patient Satisfaction
    - Medical Supply Management
    - **Fort Hall Service Unit**
  - October 25-27 27-Oct 2, 2017
    - Increased Access to Care/Patient Satisfaction
    - Pharmacy Point of Sale (POS) Billing
  - **Western Oregon Service Unit**
  - FY17
    - Health Information Management (HIM) Scanning
    - Lab Draw/Operations
    - Lab Inventory
- **FY17 CHEF**
  - $1,725,099 submitted for Portland Area
  - $650,606 has been returned

- $24,484,022 current balance (as of September 25, 2017)

- **YRTC – NARA Update**
  - 24 bed license granted on 10-02-2017
  - Combining Services Under One Roof
  - Staffing of facility in process
  - Projected opening date – 10-16-2017
  - 620 NE 2nd St. Gresham Oregon
- **Small Ambulatory Program (SAP)**
  - IHS is Accepting Applications for this Health Facility Construction Funding Opportunity.
  - $5.0M Reserved / Max Award is $2.0M
  - 3-5 Awards Anticipated (Highly Competitive)
  - Applications Due: December 1
  - Download Application Kit: https://www.ihs.gov/dfpc
  - Portland Area IHS Will Provide Two Webinars on Application Process
    - October 31st and November 7th
  - If You Plan to Apply, Please Contact
    - CAPT Jason Lovett - jason.lovett@ihs.gov OR
    - Gene Kompkoff - gene.kompkoff@ihs.gov
    - Available to Answer Questions, Provide Facilities Data, and Webinar Information

- **Annual Combined Space Verification**
  - Will Be Sent to Tribes in Early November
  - Verify the Amount and Location of Facility Space Used for IHS PSFA's
  - Response Due Date: December 31, 2017
  - Please Review the Provided Data and Certify if is Accurate
    - Used to Calculate Share of Equipment and M&I Funds
    - Used to Update and Maintain the CMS Facilities List for Encounter Rate Billing
    - Used to Verify Facility Type and Other Statistical Items
  - If Data is Not Accurate, Please Follow Included Instructions to Update
  - Questions:
    - Jonathan McNamara – Health Facilities Engineering – jonathan.mcnamara.ihs.gov
    - Peggy Ollgaard – Business Office – peggy.ollgaard@ihs.gov
    - Mary Brickell – Statistics – mary.brickell@ihs.gov

- **Portland Area IHS Multi-Conference Series**
- Nov. 13-17, 2017 at Spokane NATIVE Project.
  - **AAAHC Achieving Accreditation Workshop**
    - Nov. 13 (afternoon) - Nov. 14 (all day)
    - Currently all slots are filled
  - **Pain Skills Intensive Seminar** (HOPE Committee and UNM sponsored)
    - Nov. 15 (all day)
    - Medication Assisted Treatment (MAT) DATA waiver training Nov. 16 (morning)
    - Registration link- Access code psi11152017
  - **Portland Area Fall Clinical Director's Meeting**
    - Nov 16 (afternoon) – Nov 17 (morning)

- **Portland Area Opiate Procurement**
  - 4th year of data collection for 6 Federal and 11 Tribal sites utilizing the VA Pharmacy Prime Vendor (PPV)
  - Assesses procurement of 9 commonly prescribed opiates
    - Codeine/acetaminophen, hydrocodone/acetaminophen, oxycodone/acetaminophen, fentanyl, hydromorphone, methadone, morphine, oxycodone, tramadol
  - Also tracking procurement of associated drugs:
    - Naloxone- utilized to reverse opiate overdose
    - Naltrexone, buprenorphine/naloxone- used to treat opiate use disorders
  - Individualized reports with analysis and recommendations for best practices on appropriate and judicious opiate prescribing are provided to each included Federal and Tribal clinic.

- **Key Recommendations:**
  - Utilize a facility policy on chronic opioid therapy (COT)/chronic pain management.
  - Assure policies are congruent with the IHS Chronic Non-Cancer Pain Management policy.
  - Assure all prescribers of Controlled Substances have had training on appropriate pain management.
  - Conduct at least annual peer review among your prescribers to assure compliance with facility policies on COT.

- ❖ Implement a First Responder and Take-Home Naloxone (co-prescribing) program, esp. for those prescribed methadone.
- ❖ Transition as many patients as possible off of methadone.
- ❖ Develop local capacity for Medication-Assisted Therapy for opioid dependence.
- ❖ Follow CDC recommendations to limit acute opiate prescriptions to 3 days, rarely more than 7 days, of therapy.

Obtain a Prescription Drug Monitoring Program (PDMP) report on all new patients receiving controlled substances, all patients receiving more than 7 days of medication for acute pain, and at each visit for patients on chronic opioid therapy

Executive Session

Recess

WEDNESDAY OCTOBER 11, 2017

Call to Order, Andy Joseph, Chairman

Invocation, Janice Clements, Warm Springs

SUICIDE PREVENTION AT HERITAGE UNIVERSITY, MAXINE JANICE AND CELENA MCCRAY

Náx̲shsim Natash Wa (We Are One) Project
Náx̲shsim Natash Wa (pronounced like Nahhh-ka-shh-him Nahhh-Tahh-shh-Wa) is the Ichishkíin Sinwit language phrase that translates as
"We are one."

THRIVE Suicide Prevention Project

- Through the GLS funding streams, THRIVE is able to provide funding each year for Heritage to coordinate and implement suicide early intervention and prevention strategies targeting their students, faculty, and AI/AN youth in their local community (Yakama Nation).
- SP Training and Technical Assistance
- SP Resources:
    - Educational Materials
    - Media Campaigns
        - Lived Experience Videos

Heritage University (HU)Suicide Prevention

- Strength- based approaches
- Cultural Protective Factors
- Cultural Responsiveness
- HU Initiatives

Strength-Based approaches

Cultural Protective Factors

HU- Culturally Responsive

Advisory Board

HU Suicide Prevention Initiatives

- Question, Persuade, Refer (QPR) Gatekeeper Training
- Applied Suicide Intervention Skills (ASIST) Training
- Internships
- Crisis Response Plan
- Campus-Community Collaborations
- Tepee/Lodge – Cross-Cultural Learning space, Talking Circle
- Native American Heritage Month
- All Nations Powwow – Stand Strong Special
- Wellness Through Laughter Comedy Show
- Gun Lock Safety event
- Comfort Care packages

HEALING LODGE, SHARON RANDLE, OUTREACH SPECIALIST

SEVEN TRIBAL NATIONS CAME TOGETHER

- ❖ Vision and Foresight of Tribal leaders.
- ❖ Spokane, Kalispel, Colville, Nez Perce, Kootenai, Coeur D'Alene and Umatilla Tribe.
- ❖ Addressed concern of sending "our children" to faraway places for help.
- ❖ Central site was selected (Spokane)
- ❖ Created through Public Law 93.638.
  Evolved, continued to grow and dream facility was opened in 1996.

See PowerPoint for additional photos of facility

OVERALL COMPLIANCE STANDARDS

- Washington State Administrative Code (WAC): 203
- Department of Health (DOH): 593
- Indian Health Service (Food Service): 45
- USDA (Food Service): 300 pages of standards
- CARF International: 1200
- FIRE MARSHALS (state and local)
- FINANCIAL OMB A-133: Federal Single Audit Act
- Spokane Public Schools Contract
- Behavioral Health Organizations (BHO)
- OSHA Audit

RESIDENT PROFILE

- Average number of residents served/yr: 190+
- Serve youth ages 13-17 years old
- Serve approximately 70% native youth, serve all.
- We serve more males than females
- We have 45 beds: 29 males and 16 female
- Top three drugs of choice: 1) Marijuana, 2) Alcohol, and 3) Amphetamines
- Top three mental health diagnosis: 1) ADHD, 2) Depression/Anxiety and PTSD

HOLISTIC AND THERAPEUTIC COMMUNITY

- Voluntary Program (not lock down)
- Hands-Off Facility
- Multi-Disciplinary Team Approach
- Treating Youth with Respect and Dignity at all times.
- Create a Safe Place

PROGRAM COMPONENTS

Chemical Dependency Treatment
- Social Justice CD Curriculum
- CD Education (group/1:1)

- Expressive Arts/ Music
- Sports, Weight Lifting and Running

Cultural Program - Root Digging - Rights of Passage - Guest Speakers, Dancers, Drummers - Sweat Lodge Ceremonies - Cultural Projects -Groups

Education Program - GEDs - High school credit - High school credit retrieval

Mental Health
Mental Health Counselors
•1 on 1's
•Groups

Food Service
•3 meals per day with 3 snacks per day.
•Sugar-free Diet
• Caffeine-free Diet

Recreation
•Basketball
•Softball
•Running
•Hiking
•Volley Ball
•Weight lifting
•Disc Golf

CULTURAL PROJECTS
ANIMAL TEACHINGS
Teachings through stories Teachings through skits Discussing Traits Bring self-awareness
RITES OF PASSAGE

MUSIC PROGRAM
The Music Program records hundreds of songs by our young residents. Many of those songs have been selected to be on a featured album. The Music Program has become a core therapeutic tool for the clinical team in addressing trauma and addiction**.**

CALENDAR PROJECT
- ❖ Recovery
- ❖ Hope

BEHAVIORAL HEALTH AID, XIOMARA OWENS MS, DIRECTOR OF BHA PROGRAMS ANTHC

Behavioral Health Aides: A Grassroots Approach to Rural Behavioral Healthcare

Objectives
- **Describe key elements of BHA program**
  - Context
  - Certification program
- **Describe BHA scope of work**
  - Across the continuum of care
- **Identify factors related to program implementation and sustainability**

Overview

- **Context**
  - History & current events
  - Stakeholders and partners
- **AK Health Aides Programs**
  - Certification Board
  - Standards & Procedures
- **Behavioral Health in Alaska**
  - BHA scope of practice
  - BHA billing & reimbursement
- **BHA Training & Resources**
  - Behavioral Health Aide Manual

Program Context: Geography, Culture, State Population Demographics

- Alaska's area: **570,641 miles^2**
- Total Alaska population: **737, 354**
  - Alaska Native/American Indian population: **143,367**
  - Median age: **26.8 years**
- Diverse Alaska Native cultural groups
  - **11** distinct cultures
  - **11** different languages, **22** different dialects

Alaskan Context

- Geography
- Weather
- Seasons
  - Hrs. of daylight
- Culture
- Natural resources
  - Subsistence
- Community

Alaska's Tribal Health System

To meet the healthcare needs of our state, we have a system of care that divides the state into regions

Generally speaking, each region has tribes and tribal councils who oversee and inform their regional Tribal Health Organization

All Health Aides are employed by their regional Tribal Health Organization

A Statewide System

- **Village-based services**
  - Small village clinics, Community Health Aides, Behavioral Health Aides, Dental Health Aides, home health/ personal care attendants
- **Subregional services**
  - Mid-level practitioner serving several villages
- **Regional services**
  - Referral hospital or physician health center
- **Statewide services**
  - Alaska Native Medical Center
- **Contract health services**
  - External or private sector referrals

Referral Patterns

The Alaska Native Health Care System Referral Pattern same scale comparison – Alaska area to Lower 48

Partners and Partnership

- Indian Health Services
- Alaska Native Tribal Health Consortium
  - Community Health Aide Program
  - Dental Health Aide Program
  - Behavioral Health Department
- Community Health Aide Certification Board (CHAPCB)
- Tribal Health Organizations
  - Tribal Behavioral Health Directors
- State of Alaska, Dept. of Behavioral Health
- Alaska Behavioral Health Association
- Local, regional, and statewide providers
- Training partners

Key Contextual Factors

- Alaska is REALLY big (and extreme)
- Alaska is like a village
- Tribal Sovereignty and the Tribal Health System
  - Coordinated access to higher levels of care

- Cultural identities and practices
- $$$
  - Funding, cost of living, travel, billing/revenue
- Autonomy and Partnership

Who are YOU serving?

- **Demographics**
- **Cultural identity & practices**
- **Where are they located?**
  - Rural, remote, urban
- **Issues related to access?**
  - Including stigma and/or familiarity with MI/SA
- **Are you investing in prevention and early intervention?**

Who are YOUR partners?

- **Similarities and differences between communities, regions, organizations?**
  - Where is the common ground?
- **What systems need to be in place/ coordinated?**
  - Levels of care and provider types
  - Billing systems and sources of revenue
- **What is your vision for integrating BHAs?**
  - In your healthcare system? Communities?
  - Who needs to have a seat at the table?

Program History: Healthcare Close to Home

CHAP History

1950s Chemotherapy Aides (Volunteers) Direct Observed Therapy for TB patients
1960s Formal Training/Federal Funding 1968
1976 Indian Health Care Improvement Act (IHCIA) (PL 94-437)
1992 IHCIA amended to add § 119 that provided for the Alaska Community Health Aide Program under authority of the 25 U.S.C. § 13 and required a Certification Board (PL 102-573)

Health Aide History

1998 Alaska Area Director appoints a CHAP Certification Board (CHAPCB)
2002 Standards amended to address Dental Health Aides and Therapists (DHA/T)
2005 First DHA/Ts Certified
2008 Standards amended to address Behavioral Health Aides and Practitioners (BHA/P)
2009 First BHA/Ps Certified

Certification Board Members

- Standards & Procedures
- Summary of Certification requirements
- Application Forms
- **www. akchap.org**

  - Training Center Regions (4)
  - CHA Training Centers (1)
  - CHAP Directors' Association (1)
  - CHA Association (1)
  - Medical Director (1)
  - Federal [Alaska Area Native Health Service] (1)
  - State of Alaska (1)
  - Dental Health (1)
  - Behavioral Health (1)

Standards and Procedures

- Certification requirements
- Program oversight
- Supervision requirements
- Scope of practice
- Competencies *(Knowledge & Skills Checklist)*
- Training & related curriculum
- Practicum
- Continuing education
- Approved training sponsors

CHAPCB Program Operations

- Ongoing review of applications & granting certification
- Maintain database and applicant files
- Facilitate 3 Board meetings per year
- Travel and support for Board Members
- Billing, budget projection & reconciliation
- Correspondence, newsletter & website

Why Certification?

- Quality services
- Standards of care
- Recognized provider type

Individuals who are certified as a BHA/P…

- Completed Board-specified training and work requirements
- Have knowledge and skills specific to their scope of practice
- Stay updated on best practices (Continuing Education)

How will YOUR BHAs get certified?

- **Why certification?**
  - What is it? Why is it important? What does it represent?
- **Structure for certification**
  - Interdisciplinary Certification Board
    - Committed, detail oriented, collaborative, informed
  - Board staff
  - Staff at organization
    - Commitment to model, supervision, integration of BHAs into service model
- **Standards and Procedures**
  - Establish requirements to meet and maintain a standard
  - Designed to honor context and culture
  - Scope of work
- **Consider and/or align with other systems**
  - Other providers' scope of practice
  - Local and regional resources

Behavioral Health: Scope of Practice
Behavioral Health in Alaska

- Adverse Childhood Events
  - Historical trauma
- Unintentional injury
- Suicide
- Substance abuse
  - Binge drinking
  - Alcohol abuse mortality
- Domestic violence

Standards and Procedures: Behavioral Health Aide Program

- Employed by tribe or tribal organization
- Administrative oversight (*Licensed*)
- Clinical supervision (*Licensed or unlicensed*)
- Four levels of certification
  - BHA-I, BHA-II, BHA-III, BHP
- Scope of practice
  - Culturally-informed, community-based, clinical services
  - Behavioral health prevention, intervention, aftercare, and postvention
- Certification requirements
  - Training
  - Practicum
  - # of work hours
  - 40 CEUs every 2 years

BHA Scope of Practice

BHA-I

- Screening
- Initial intake process
- Case management
- Community education, prevention, early intervention

BHA-II

- Substance abuse assessment & treatment

BHA-III

- Rehabilitative services Quality assurance case reviews

BHP

- Team leadership
- Mentor/support BHA-I, II, and III

Aligning systems CHAPCB / State of Alaska

Clinical Associate

- Behavioral health screening/ client status review
- Short-term crisis stabilization
- Case management
- Peer support services
- Screening and brief intervention

- Comprehensive community support services *(adults)*
- Individual & Group
- Therapeutic behavioral health services *(children)*
- Individual & Group
- Family (with & without patient)

Substance Abuse Counselor

- Assessments
- Treatment

Who do BHAs Serve?

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

BHAs Serve Their Communities

- Meetings (building community partnerships, meeting coordination and logistics, facilitation, identify elders and presenters)
- Activities (drum making, berry picking, walks/runs, health fair, craft events, exercise groups, family fun nights)
- Psychoeducation (information about different topics, how they affect health and well-being, reviving traditional knowledge and practices to address modern-day issues)

Domestic Violence: Prevention & Intervention

- Domestic violence prevention and intervention (healthy relationships and healthy communication presentations, resource development and identification, community campaigns)

Substance Abuse: Prevention and Intervention

- Substance abuse prevention and treatment (presentations, groups, sober activities, welfare checks, case management)
- Tobacco cessation (psychoeducation, referrals, counseling)

Suicide, Grief, and Loss: Prevention, Intervention, Postvention

- Suicide prevention and intervention (crisis stabilization, case management, on-call)
- Grief and loss (crisis response, community support, support groups)

Defining Your BHA Scope

- **What is your vision for the BHA program?**
  - In your healthcare system? Communities?
- **Prevalence of behavioral health problems**
- **Current providers and scope**
  - Within behavioral health
  - Interdisciplinary team
- **Clear distinction between certification levels**
  - Scope of practice
  - Competencies

Behavioral Health Aide: Training towards certification

- THO Employment
- Supervised by Master's level clinician

- Work experience hours
- Training curriculum
- 100-hour Practicum

- Competency evaluation
- Employee development plans

BHA Training

- **Related to scope of work**
  - Specific to cert. level
- **Specific courses and curriculum (CHAPCB)**
  - Curriculum builds upon itself
- **Two pathways to certification**
  - Non-academic *(Specialized)*
  - Academic *(Alternative)*
- **Must be CHAPCB approved**

BHA Training: Two Pathways

Specialized

- Based on CHAPCB curriculum

- Blended delivery
  - Online LMS
  - Distance and OJT
  - In-person
    - Intensives
    - Annual BHA Forum

Alternative

- Industry certificate/ degree
  - Not be specific to CHAPCB curriculum
    - Add'l courses required to meet cert. requirements
  - Pipeline to career

BHA-I Courses

- General Orientation (28)
- Orientation to Village-based BH Services (8)
- Ethics & Consent (6)
- Confidentiality & Privacy (6)
- Intro to Behavioral Health (24)
- Intro to Counseling (12)
- Intro to Documentation (12)
- Survey of Community Resources & Case Mngmt (8)
- Working with Diverse Populations (12)
- Intro to Group Counseling (8)
- Crisis Intervention (16)
- HIV/AIDS & Blood-Borne Pathogens (8)
- Community Approach to Promoting BH (8)
- Family Systems I (16)
- Recovery, Health, Wellness, & Balance (8)

BHA-II Courses

- Psycho-physiology & Behavioral Health (16)
- Intro to Co-Occurring Disorders (8)
- Tobacco Dependency Treatment (8)
- DSM Practice Application (12)
- Advance Interviewing Skills (16)
- ASAM Practice Application (12)
- Case Studies & Clinical Case Management (8)
- Traditional Health Based Practices (8)
- Intermediate Therapeutic Groups Counseling (16)

- Applied Crisis Management (8)
- Community Development Approach to Prevention (12)
- Family Systems II (16)

BHA-III Courses

- Treatment of Co-Occurring Disorders (12)
- Advanced Behavioral Health Clinical Care (40)
- Documentation & Quality Assurance (16)
- Intro to Case Management Supervision (16)
- Applied Case Studies in Alaska Native Culture Based Issues (8)
- Behavioral Health Clinical Team Building (12)
- Intro to Supervision (8)

BHP Courses

- Issues In Village-Based BH Care (40)
- Special Issues in BH Services (16)
- Competencies for Village-Based Supervision (16)
- Principals & Practice of Clinical Supervision (40)

BHA Training: Resources

- CHAP and DHAT training programs
- Existing training partners
  - In-house
  - Online Learning Management System
  - Local substance abuse counselor training program
  - University certificate and degree programs
- Developing model of training delivery
  - Blended delivery
  - Maximize distance-delivery
  - Course blocks
  - Find a partner who honors/prioritizes YOUR curriculum

BHA Training: Current Events

Training includes:

- Course work
- Practical application
- Integrating current events into training
- OJT with supervision

- Evaluation of competencies

Training should:

- Be thoughtful
- Prepare skilled providers
- Offer career opportunities
- AAS Degree Program at Iḷisaġvik College
  - Meets BHA-I and BHA-II cert. reqs
  - Certificate (yr. 1), AAS (yr. 2)
- Registered Apprenticeship (RA)
  - Model for workforce training and development
  - Recognized nationally, earn and learn, wage increases
  - Meets BHA-I and BHA-II cert. reqs
- Billing/revenue
  - BHA State Plan Amendment
    - Certified BHAs as a billable provider
    - Encounter rate for specific services
    - Reduced documentation requirements

Behavioral Health Aide Manual eBHAM

The BHAM was created exclusively for the BHA program. Due to our funding source, this first edition of the BHAM has an emphasis on working with children and adolescents, though the majority of its contents can be used to support clients of any age.

The BHAM is grounded in Alaska Native ways of knowing and recommends culturally and clinically appropriate services based on best practices adapted specifically for Alaska. It is intended to compliment BHA training and often defers to Organization's unique Policies and Procedures and/or clinical supervisors for guidance. It is not intended to be a general medical reference or self-teaching tool. It is a practice manual that is intended to reinforce BHA training and guide them to practice within their scope of training and certification.

Based on the recommendations of the Statewide committee, the BHAM includes 5 primary section:

BHA Knowledge & Skills *(Competencies)*

- Working with Others
- Screening and Assessment

- Planning Services
- Providing Services
- Linking to Community Resources
- Community Education and Advocacy
- Cultural Competency and Individualizing Care
- Documenting
- Professional and Ethical Practice
- Professional Development

How Will You Train YOUR BHAs?
Standards and Procedures

- **What is their scope of practice?**
- **Knowledge, skills, abilities (competencies)**
  - BHAs
  - BHA supervisors
  - Process for evaluation
- **Curriculum and training tied to competencies**
  - Teamwork: BHAs, Supervisors, Instructors

Key Factors to Grow a BHA Program

- **Partnerships and resources**
  - Certification Board
  - Training
- **Consistency / fidelity**
- **Integration**
  - Into BH system
  - Included in tx plan
  - Train other providers how to work with BHAs
- **Sustainability**
  - Training
  - Billing systems and revenue potential

ANTHC: www.anthc.org
CHAPCB: www.akchap.org
BHA program
email: behavioralhealth@anthc.org
web: anthc.org/behavioral-health-aide-program/

BREAK

Yakama's Nak Nu We Sha, June Adams, MSW, NNWS Program Manager & Laretta Smiscon Social Worker Supervisor

Nak Nu We Sha Staff

- Program Manager
- SW Supervisor
- 12 Social Workers
- 2 Office Asst.
- 1 Bookkeeper
- 1 Foster Care Licensor

Nak Nu We Sha Mission and Vision Statement

- **Vision Statement**—Nak Nu We Sha envisions children raised within their community, culture and tradition, protected by exercising Yakama Nation Sovereignty.
- Mission Statement—The mission of the Yakama Nation Nak Nu We Sha Program is;
  - **the prevention of the disintegration of our Indian Families;**
  - **Through early intervention and remediation services.**

What Nak Nu We Sha does for children

Equality~Equity

What does Nak Nu We Sha do?

- Child Abuse Prevention Activities (Tule Gathering, Pow Wow) One-time emergency assistance, clothing donations, car seats
- Independent Living Classes (cooking classes)
- Kinship Services-Respite, gas vouchers, electricity, vouchers, Food, Clothing, Personal Hygiene, diapers, etc.
- Foster Care Licensing
- Child Placement Agency-Places dependent children, Basic and Intensive Case Management for Dependent Children (transportation, visits, referrals, family reunification)

Who Nak Nu We Sha Services

Enrolled Yakama Children and Indian Children Living on the Yakama Reservation under 21
Dependent Children of Nak Nu We Sha are victims of child abuse or neglect
Nak Nu We Sha receives notice of Approx. 35 Child Abuse and Neglect Intakes
Title IVB Population 5,605 (3,419 Yakama)

Serves 209 to 225 Dependent Children
Serves 197 Kinship Children (Children living with relatives)

Historical trauma *is the collective emotional wounding across generations that results from massive cataclysmic events – Historically Traumatic Events (HTE)**

- The trauma is held personally and transmitted over generations. Thus, even family members who have not directly experienced the trauma can feel the effects of the event generations later

Inter-Generational Basis for Chronic Disease Disparities Among American Indians and Alaska Natives
See graphics

Funding Sources and Contracts

1. Title IV B- Part I-Child Welfare Services
2. Title IV B-Part II –Promoting Safe and Stable Families
3. BIA ICWA Federal Funding
4. State Foster Child Placing Agency
5. State ICWA
6. Independent Living Services
7. Kinship Services-Tribal
8. Kinship Services-State

Behavioral Health Referrals

- NNWS will do a Mental Health CAN Screen on all dependent children they case manage.
- Initial referral will be sent to Yakama Nation Behavioral Health until client resides out of area or has exceptional circumstances.
- Immediate Suicidal Clients will be referred to Comprehensive Mental Health 575-4200 or taken to the Hospital for immediate treatment.

Case Closures (1 Year as 7/17)

- 50 Case Closures (19% of cases closed last year)
- 40% of the cases Children Returned back to parents
- 40% of the cases Children went into Guardianship (non-Indian or Indian)
- 16% of the cases Aged Out
- 4% of the case child deceased
- 89% (186 cases) Need Permanency

Future Directions
Prevention

- Intervene before a child is abused or neglected
- Reduce Riske Factors-Parenting Skills
- Embrace Traditions

"To be yourself in world that is constant trying to make you something different"

80 Percent of Nak Nu We Sha's Resource are focused on Tertiary Prevention

Blackfeet Saying
A child is sacred. And when that child comes into the home, the family must welcome it. And if the child is happy and feels the want, he will come into this world very, very strong. And not to know this is to know nothing.

LUNCH

TRIBAL UPDATES

1. Port Gamble S'Klallam Tribe, Karol Dixon
2. Tulalip Tribes, Jim Steinruck, Health Administrator

CHAIRMAN'S REPORT, ANDY JOSEPH, JR

I attended several meetings this quarter:

On August 9th and 10th, I attended the Portland Area FAAB meeting in Seattle, Washington.

On August 15th, I attended the IHS behavioral health listening session; then on the 16th, I attended the IHS Contract Support Costs workgroup meeting in Tulsa, Oklahoma. At the listening session I talked about the importance of programs like We R Native for our youth. Since the CSC policy was finalized, the workgroup reviewed the CSC worksheets, implementation of the CSC policy, and discussed CSC appropriations for FY 2018.

On August 30th and 31st, I attended the Nike Native Fitness event at Nike Headquarters in Beaverton. This is a great partnership and fun event.

On September 18th through 21st, I attended the ATNI annual meeting in Spokane, Washington. I

had the opportunity to take the PULS Cardiac Test while I was at the conference. This test detects a person's risk for a heart attack because even healthy people with good cholesterol levels may be at risk.

On September 25th through the 28th, I attended the NIHB Tribal Health Conference in Bellevue, Washington. The conference was well attended with over 600 people in attendance. There were some good speakers in the plenary sessions like Mark Trahant and Gov. Jay Inslee. Chairman Cladoosby from Swinomish talked about their new Opioid treatment center and asked IHS employees to stand and make a commitment to incorporate DHATs into the IHS system.

SUGARY DRINKS AND HEALTH, SARA SOKA, MS *VICE PRESIDENT, POLICY*
HEALTH FOOD AMERICA
Strategies to Reduce Diabetes > Sugary Drinks

Our Mission: *Healthy Food America acts on science to drive change in policy and industry practice so that all people can live in places where nutritious food is easy to obtain and exposure to unhealthy products is limited. We collaborate with other advocates to knock added sugar back to healthful levels.*

Epidemics of diabetes and obesity
1 out of 3 children born in the year 2000 will develop diabetes

See PowerPoint for additional graphics

The rate of diagnosed diabetes varied by region from 6.0% among Alaska Natives to 24.1% among American Indians in southern Arizona.

Almost half of added sugars comes from sugary drinks

- Among youth, 2-18, 60% of total added sugar calories come from beverages
- Americans gulp 150 calories per day from sugary drinks

Why focus on sugary drinks?

- Primary source of added sugar in U.S. diet
- Major source of added calories fueling the obesity epidemic
- Heavily marketed (youth and communities of color targeted by drink industry, like commercial tobacco)

- Consumption higher among communities of color and people with lower incomes
- Cause obesity, diabetes, dental decay, liver, and heart disease
- Do not affect appetite
- No nutritional benefits

Sugary drinks cause chronic diseases

1 soda/day:

Risk of overweight/obesity by 55% (children).
Risk of diabetes by 26%.
Risk of dying from heart disease by almost 1/3.
Risk of stroke by 22%.
Risk of tooth decay by 30% with daily consumption (adults).

What to do about it?

"Food can either empower us and make us strong, or it can kill us."
- Denisa Livingston, Diné Community Advocacy Alliance Organizer, MPH
DenisaWorldwide@gmail.com

Healthy Diné Nation Initiatives

- Eliminate 5% sales tax on healthy, cultural foods
- Place 2% sales tax on unhealthy foods, effective April 2015 (Healthy Diné Nation Act of 2014)
  - $1.8 M per year
  - $3.5 million to date
- Community Wellness Development Projects
  - Community-based and directed health and wellness projects to create healthier physical and social community environments

Community Wellness Projects

- Wellness and exercise equipment, supplies
- Trails and recreation facilities
- Health classes, workshops and coaching
- Food system: farming and vegetable gardens, greenhouses, farmers' markets, agricultural projects, equine therapy, healthy food preparation classes, food processing and storage facilities, health food initiatives, community food cooperatives
- Recreational, health, and youth clubs
- Library, health education materials
- Healthy convenience store improvements

- Clean water initiatives, clean community's initiatives, recycling initiatives
- Emergency preparedness
- Other community-based wellness projects

Taxed foods and beverages

- Beverages
  - Artificially sweetened, naturally sweetened, or sugar-sweetened drinks
- Sweets
  - Candy, frozen desserts, pastries, pudding, gelatin based desserts, or fried or baked goods.
- Chips and Crisps
  - Crispy type snack foods that are fried, baked, or toasted, such as potato chips, to rtilla chips, pita chips, or cheese puffs.
- Fast Food
  - Ready to eat, quickly served foods, including any canned, precooked, or potted meats.
- Flavor enhancers
  - Salt, sugar, and sweeteners.

Preparing the ground: Diné Community Advocacy Alliance (DCAA)

- Grassroots community health advocates raise awareness and mobilize community to combat obesity and diabetes
- Community advocacy trainings: how to advocate, making policy change in Navajo Nation, and the diabetes and obesity epidemics on the Navajo Nation

Funding

- Self-financed
- Donation from American Heart Association for media

What to expect from industry

- Hired Navajo lobbyist to oppose efforts at Council meetings
- Met with President just before he vetoed initial bills

What to do about it?

We the people, the grassroots people, have the solutions to our own problems in our hands. We have to create a space and opportunity to allow our tribal citizens to get involved. We have been the first community-led referendum in the U.S. to succeed at this level.

As volunteers, we are operating from passion and compassion to defeat our epidemics because we see so much suffering in our communities.

Philadelphia Mayor, Jim Kenney

"What we're looking to do is to take some of that profit, to put it back into the neighborhoods that have been their biggest customers, to improve the lives and opportunities for the people who live there."

Notah Begay III Foundation
nb3foundation.org/our-work/native-strong/

What to do about it?
At every level we are still advocating to ensure these laws and policies are implemented and enforced.
As we are facing challenges, we are also moving forward in monumental steps working with the Navajo Nation Executive Branch and Office of Navajo Tax Commission to create a formal partnership with the grassroots people, our organization, to provide guidance and assistance. I am signing some documents that will create another successful step and will be an example for other tribal governments.

Acceptability & Appeal
Include health information at point of purchase
Consumers lack information on the health effects of sugary drinks.
- Require health warnings on sugary drinks
- Post health information signs on shelves where sugary drinks are sold

- Media campaigns
- Tradition educates the community

Availability
Kids meals
A third of all US children and adolescents aged 2–19 consumed fast food on a given day.
- Ban soda as default beverage option or ban completely.
- Nutritional standards for kids meals.

Healthy retail
- Replace sugary drinks with healthier products
- Endcaps and displays
- Shelf location
- Checkout aisles
- Promote healthier beverages
- Sell healthier beverages
- Offer incentives like tax credits

- Small-scale healthy food stores that are appropriate to the constrained infrastructures existing in tribal communities

Procurement
- Vending
- Cafeterias
- Government programs
    - Parks and Recreation Sites.
    - Child care and before/after school programs.
    - Meetings
- Government contracts

Community Centers
Schools
No sugary drinks at school
- USDA bans full sugar drinks during class hours for elementary and middle schools
- Allows drinks with <40 cal/8 oz in high schools
- Eliminated from cafeterias
- Permitted off hours, special events, trips, and fundraisers
- Work remains:
    - Assure implementation
    - Seek total elimination from schools
    - Address in-school marketing

Child care
- No sugary drinks at child care.
- Availability can be reduced through:
    - Distributing information about nutrition.
    - Licensing and regulation.
    - Offering technical assistance to implement healthy practices and policies.
- CA AB 2084 (2010) – no sweetened beverages allowed

Hospitals and health care
- In 2006, 99% of hospital cafeterias sold SSBs
- **Partnership for a Healthier America**:
  150 hospitals now serve healthier drinks
- **Healthier Hospitals**:
  500 hospitals committed to healthier foods

- **University of California, San Francisco**
  Eliminated sale of sugary drinks in 2015

Increase water availability

Affordability
Sugary drink tax

- Reduces consumption
- Reduces disease
  - Diabetes: 2.6% decrease in new cases over 10 years
  - Obesity:
  - 1% decrease (adults)
  - 1.4% decrease (children)
- Increases awareness about adverse health effects
- Generates revenue to support community health and well-being
- Reduces US health care costs by $23 billion over 10 years

Sugary Drink Taxes

Taxes decrease sugary drink consumption
Impact of taxes in Berkeley and Mexico

Other impacts
Berkeley

- Based on retail scanner data:
  - **Store revenue**: no decrease in Berkeley relative to comparison cities
  - **Grocery bills**: No increase for consumers
- Based on data from Berkeley's Office of Economic Development:
  - **Food jobs**: increased by 7%
  - **Food sector revenue**: increased by 15%

Building the base for change
"Establishment of Tribal food policy councils has been one of the central actions that embeds and encourages a broader array of follow-on actions that improve food and nutrition. "

- Muskogee Creek Nation -
  The first Tribe to pass a tribal government resolution establishing a 'food and fitness policy council" in 2010

- The Mvskoke people launched its Food Sovereignty Initiative in 2009
- Tribal Health and Wellness Committees
- Resolution supporting increased availability of healthy traditional foods
- Youth committee developing policies to present to schools and tribal college
- Marketing campaigns promoting healthy foods and drinks

Sugary drinks - not part of healthy eating

[We] used to have a healthy, sacred relationship with food and with each other. [We] literally ate out of one bowl. That was a healthy best practice.
We need to figure out how to restore this. Underlying all this is to return to the values. Our elderly blessed themselves with the foods they ate. They asked for good health, strength, and asked that the food nourish their bodies and mind.
Now in this day and age, we have gone away from that practice.

Contact us!

- Get answers to your questions
- Technical assistance and support
- Tools and resources
- Media and communications help

healthyfoodamerica.org
ssoka@hfamerica.org

YAKAMA NATION BEHAVIORAL HEALTH, KATHERINE SALUSKIN, MSW, PROGRAM DIRECTOR

YNBHS Program Description

- The Yakama Nation Behavioral Health Program will provide limited range of high quality professional Mental Health and confidential services. Our focus is to serve children, teens, adults, elders, veterans and families to reflect the unique social cultural and traditional experience of our clients in strengthening the family system. If you suffer from: 1) Depression/Stress; 2) Anxiety; 3) Trauma; 4) Anger; 5) Family Conflict; 6) Thoughts of Self Harm; 7) Work related Issues, YNBHS will provide a response in a timely manner to ensure quality service delivery.

Services Include

1) Individual, Family, Support Group Therapy, and Couples Counseling- YNBHS provides counseling and therapy to eligible individuals on a referral and voluntary basis.
2) Outreach and consultation to local school districts- Yakama Nation Tribal school, Mount Adams School District, Wapato School District, Toppenish School District and Granger School District clinical counseling, and support services for Native students- Therapists go into the schools to provide therapy to eligible students, whose mental health needs are more significant than a "Academic School Counselor" can provide. This is completed on a referral basis.
3) Crisis Management/ Outpatient Services- For individuals who are experiencing crisis and want immediate mental health care. If patient's mental health needs exceed the capacity of suicidal ideations or self-harm to self or others, a Designated Mental Health Professional from Comprehensive Mental Health is called or local law enforcement to detain individual for their safety.
4) Victim Resource Program- Yakama Nation Behavioral Health Services (YNBHS) partnered with other Tribal Agencies and non-Tribal organizations developed a Wellness Center that facilitates Crime Victims on the Yakama Reservation that is inclusive to victims of sexual assault, physical abuse, date rape, elder abuse, and other crime association to victims. It is our intentions to pursue a wellness center from a Social Work prospective. The Social work method provides a comprehensive approach to help to enhance the wellbeing of individual people achieve changes in their lives, for the better, in turn making a difference in our communities and wider society. VRP also provides victims of crime Advocacy and Case Management for victims of domestic violence, sexual assault, date rape, and human trafficking.
5) Community Support and Education Services- Wellness/ Historical Trauma Training, groups and counseling- Training provided to community by request. Our Special Projects Unit also does outreach and education to schools, community events, and local fairs.
6) Trauma Evaluation (TBD)- Including the Adverse Childhood Experience assessment to Intake process.
7) Bio/Social/Psycho Assessment Services- Provided by Therapist I at initial time of face-to-face with patient to determine patient's diagnosis.
8) Address suicide prevention/ intervention/ postvention services that is included to community outreach, training, and counseling services- Special Projects Unit provides Question, Persuade and Refer trainings to community, schools, and other Tribal departments on request.
9) Domestic Violence Perpetrator Program- Domestic Violence Perpetrator and MRT (Moral Reconation Therapy)- Assessments, Individual and Group therapy- Certified

Therapist provides DV perpetrators an assessment, individual, group therapy by referral, usually by the Tribal Courts and/or individual needing specialized counseling.
10) LICWAC staffing consults'- Clinical Supervisor attends staffing's to provide expert clinical consulting on behalf of YNBHS.
11) Anger Management- Provided by Therapist who is certified to provide Anger Management services.
12) Healing Seasons- YNBHS has partnered with University of Washington Indigenous Wellness Research Institute to provide our Therapists with evidence-based practices (EBP's) therapy techniques, such as CPT (Cognitive Processing Therapy), Narrative Exposure Therapy (NET) and Motivational Interviewing (MI); to work with patients who experienced trauma/grief/loss on a voluntary basis.

Yakama Nation Behavioral Health Services (YNBHS) will partner with other Tribal Agencies and non-Tribal organizations to develop a Wellness Center that will facilitate Crime Victims on the Yakama Reservation. It is our intentions to pursue a wellness center from a Social Work prospective. Social work, help to enhance the wellbeing of individual people achieve changes in their lives, for the better, in turn making a difference in our communities and wider society.

The Yakama Nation Wellness Center will provide support for crime victims through a system of holistic care. Individually care plans created for each victim by a team of care providers, natural helpers will help victims navigate social support. Support includes crisis counseling, individual counseling, family counseling, Domestic Violence Advocacy, Drug and Alcohol outreach, Court Appointed Special Advocate outreach, Medicaid outreach, Anger Management counseling, Suicide Prevention Training, Historical Trauma/ Greif counseling, and sexual assault outreach. The Wellness Center will provide a safety net for victims that have recently became homeless, or in need of safe keeping by referring to homeless shelters, safe houses and or purchasing a motel room, depending on eminent harm or danger status of the victim. The Project Coordinator will provide Administrative and coordination of events.

A **Community Readiness Assessment (CRA)** will also be conducted and Strategic Action Plan to assist with building the foundation of the Wellness Center. This assessment will also set the stage for future grants thru the Department of Justice Office of Victims Crime (DOJ/OVC).

Office of Violence against Women (OVW)- This is a 3 year grant that focuses on the following: Develop a coordinated community response team that will enhance Domestic Violence Revised Yakama Codes (RYC) protocols for domestic violence response.

1. expand and improve services to support victims, YNBHS will hire a victim advocate to work with victims of domestic violence, dating violence, sexual assault, sex trafficking and stalking.

2. Work with the community to create education and prevention campaigns informing the Yakama Reservation about domestic violence, dating violence, sexual assault, sex trafficking, and stalking.

3. provide legal advice and representation of victims of domestic violence, dating violence, sex trafficking, sexual assault, or stalking who need assistance with legal issues that are caused by and/or suffered abuse.

4. Provide services to youth (ages 11-24) who are victims of domestic violence, dating violence, sexual assault, or stalking and the needs of children and youth who are exposed to these crimes, including support for the non-abusing parent or caretaker of the youth or child.

Office of Crime Victims Advocacy (OVCA) serves as a voice within state government for the needs of crime victims in Washington State. The purpose of this funding is to support individuals who have been hurt or harmed; impacted or affected by crime; suffered physical, financial, or emotional harm as a result of the commission of crime regardless if the event has been reported to law enforcement or when the event occurred.

Grants

- DOJ/OVC: Serving Crime Victims- $450,000.00 for the 3 years.
- DOJ/OVW: Office of Violence against Women- $446,445.00 for 3 years.
- OVCA: Office of Crime Victims Advocacy- $547,854.00 for 2 1/5 years.
- OVCA- Cultural Specific- $500,000.00 for 2 1/5 years.

The Project Director is Katherine Saluskin. The OVC Project Specialist is Tucelia Palmer (Yakama member). The OVW Project Specialist is Crystal Esquivel (Yakama member). OVCA Project Coordinator is Ruben Calvario (unenrolled). The Advocates is Jordan Meninick (Yakama member).

Native Connections Grant

The project goals are to reduce the impact of substance abuse, mental illness, and trauma on the Yakama Indian Reservation and within its boundaries, through a public health approach. We will use a holistic approach bringing together Reservation communities, local agencies, and Yakama Nation agencies to support and provide wrap-around-services for Yakama/AI/AN youth and young adults, up to ages 24. We purpose to serve at least 200 Yakama and other AI/AN youth (8-24 years of age) annually. This will be achieved by:

1) Increasing our understanding across the reservation about suicide risk and protective factors, why they exist, and why each risk as well as protective factors must be addressed;

2) Conduct a community assets, needs and readiness assessment from all seven towns across the reservation to bringing community members together to 2a) share how youth suicide and substance use impact the quality of life for everyone across the Yakama Reservation, 2b) to obtain an inventory of the resources currently available that can be leveraged to improve the quality of life for community members 2c) to Identify our community's strengths and weaknesses;
3) Share assessment findings with the community to 3a) engage community members in discussions about needs, assets, and the community's response; 3b) increase key leaders and community members awareness and how they can contribute to the community's assets; 3c) use the information about community needs to assess our service delivery priorities; 3d) use the data for decision making to address community needs and how to use the available assets; and use the data to inform strategic planning, priority setting, program outcomes, and program improvements

Native Connections award is $1,000,000.00 in the span of 5 years.
The Native Connections Project Director is Katherine Saluskin, who is enrolled Yakama. The Native Connections Project Coordinator II is Aryell Adams, who is a descendant of the Yakama Nation and enrolled member of the Cherokee Tribe and Liaison is Jeremy Garcia who is an enrolled member of the Yakama Nation.

Tribal Youth Suicide Prevention Grant (GLS)
There is a high rate of suicides among the Native American communities within the Yakama Reservation. Adolescents and young adults make up the majority of suicides that have taken place. There is also a high rate of alcohol and drug abuse within the Yakama Nation community.
YNBH will track attendance, administer and collect evaluations on all efforts to ensure that outcomes are being improved. Evaluations will be anonymous and will request for population identifiers such as ethnicity, gender identity, age and feedback on the impact of the activity itself. Surveys will also be conducted in local schools, Pow-wows, youth conferences, health fairs and other social events for community feedback on awareness efforts. To further support the impact, data collection and analysis will also be conducted within the juvenile justice system, foster care programs, behavioral and substance use programs to monitor trends throughout the time activities and efforts are being made within the community.
The purpose of the proposed project is to develop and implement tribal youth suicide policies and evidence-based prevention programs that enhances awareness, identification, referral and treatment strategies.
Conduct Suicide Prevention trainings across the Yakama Reservation.

1) Each year provide consistent training opportunities to youth, community members, adults serving youth, and service providers

a) Six 1-hour QPR-Question, Persuade, and Refer trainings per year for community members and parents; (up to 30 per class)

b) Two ½ day SafeTalk for adults in youth serving positions: teachers, school staff, tribal social services, health care providers, and police (up to 30 per class)

c) One 2-day ASIST Applied Suicide Intervention Skills Training for adults directly serving youth: school Therapists, school nurses, foster parents, child welfare staff, juvenile justice staff (up to 30 per class)

d) One 2-day Assessing & Managing Suicide Risk AMSR trainings for Behavioral Health Therapists year 1, 3, and 5 (all Therapists)

2) Train and maintain at least 4 trainers for QPR suicide awareness and prevention for community training opportunities.

The amount awarded for this grant is $8,644,636.00 for the span of 5 years.
The Project Director for this grant is Katherine Saluskin (enrolled Yakama). The Project Coordinator II is Diane Sekaquaptewa (enrolled Yakama). The Therapist I is William Vivette (enrolled other, Yakama descendent) and Camella George (enrolled Yakama). The Natural Helper is Shaniya Gunnier-Shipman (enrolled Yakama).

Circles of Care Grant

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services provided the Yakama Nation with a grant for Planning and Developing Infrastructure to Improve the Mental Health and Wellness of Children, Youth and Families in American Indian/Alaska Natives (AI/AN) Communities (Short Title: Circles of Care VII) grants. The purpose of this program is to provide tribal communities with tools and resources to plan and design a holistic, community-based, coordinated system of care approach to support mental health and wellness for children, youth, and families. These grants are intended to increase the capacity and effectiveness of mental health systems serving AI/AN communities. Circles of Care grantees will focus on the need to reduce the gap between the need for mental health services and the availability and coordination of mental health, substance use, and co-occurring disorders in AI/AN communities for children, youth, and young adults from birth through age 25 and their families.

This grant will employ a Program Specialist, Social Worker III, Youth Engagement Specialist, and a Community Cultural Coordinator.
This grant is in the amount of $403,119.00 for 3 years.

Mental Health Promotion Project (MHPP) (Washington State DSHS/DBHR)
Mental health is a state of well-being in which individuals can realize their own abilities, can cope with the normal stresses of life, can work productively, and are able to make a contribution to his or her community.
Mental health promotion works at three levels:

- strengthening individuals,
- strengthening communities, and
- reducing structural barriers to mental health

Structural barriers to mental health can be reduced through actions to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, health services, and support to those who are vulnerable.

Promotion of mental health can be achieved by working to improve your community in a variety of ways. Here are just a few examples:

- early childhood interventions (e.g. home visiting for pregnant women, pre-school psychosocial interventions, combined nutritional and psychosocial interventions among disadvantaged populations);
- social support to old age populations (e.g. befriending initiatives, community and day centers for the aged);
- programs targeted at vulnerable groups such as minorities, migrants, and people affected by conflicts and disasters
- mental health promotion activities in schools (e.g. programs supporting normal transitions and changes in schools, increasing the atmosphere of child-friendly schools);
- mental health interventions at work (e.g. stress prevention programs);
- housing policies (e.g. housing improvement at a policy level);
- violence and substance abuse prevention programs (e.g. community policing initiatives);

In the past YNBHS hosted camps for families, hosted Conferences, and supported Triple D Basketball camps. This grant is awarded yearly in the amount of $10,000.00 per year.

Healing Seasons
Purpose and overview
The purpose of this project evaluate the effectiveness of culturally adapted Narrative Exposure Therapy (NET) and culturally adapted Motivational Interviewing with Skills Training (MIST) in preventing HIV / STI sexual risk behavior by directly addressing posttraumatic stress disorder symptoms or substance misuse. The program consists of up to six (6) weekly 90-120-minute counseling sessions that are free to the participants as well as four (4) computer surveys for

which the participants' are paid. After completing the first survey, participants are assigned by chance to either NET or MIST.
The counseling is offered in four clinical locations:
1. Yakama Nation Behavior Health (YNBH), Toppenish, WA
2. Comprehensive Healthcare (CompHC), Yakima and Sunnyside, WA
3. Indian Health Services, White Swan, WA – (both YNBH & CompHC counselors)

Additionally, high school student participants can complete their counseling sessions on campus.
Recruitment
The project opened recruitment in July 2017. Please refer to the consort chart in the following pages for further recruitment information.
In order to participate in the project, a person must be
1. American Indian or Alaska men and women and descendants
2. At least 16 years old or older
3. Living on or near the Yakama reservation
4. At least subthreshold Posttraumatic Stress Disorder (PTSD)
5. Some substance use in the previous 12 months
6. Some lifetime sexual activity

Interested callers may not participate if they meet any of the below criteria:
1. Self-harm or suicide attempt in the previous 30 days
2. Homicidal ideation in the previous 3 months
3. Psychiatric medications that have not be stable for at least 2 months**
4. And alcohol dependence diagnosis with severe withdrawal symptoms**
5. Unable to understand the process and provide consent.
** Interested callers are encouraged to call back once medication has stabilized or severe withdrawal symptoms have been resolved.
Any caller for whom this program is not a good fit is referred to alternative programs and services within the community.
Healing Seasons is funded through the University of Washington Indigenous Wellness Research Institute. Project will provide:
- Alternative therapy approaches that is client driven and developed by Yakama Nation members
- Sustainable therapeutic skills that will outlast the life of the grant
- Hire an additional full time counselors at YNBH and Comprehensive Health
- Train additional counselors from YNBH & COMPHC in two different therapies to enhance their skill set

o Counselors will be train in 1 therapy, then toward the end of the grant, train in the second therapy. This is to ensure solid skill development before taking on a new therapy.
- Continuing Education Credits will be available:
o Attend the 2 day training, attend supervision meetings, see clients
- Trained counselors will be provided additional support
o (e.g. therapy for themselves & weekly supervision by clinical psychologists)
- Provide six free therapy sessions at four sites: Toppenish, White Swan, Sunny side, Yakima
o Funds for transportation costs for participants
o Provide treatment engagement support to participants
- Hire up to two research assistants who live in the Yakama area
o Must have at least a bachelor degree and 1-year experience or equivalent.
o Yakama Preference Given
o Job announcement will be posted early summer with possible start date in August
- YNBHS will be reimbursed $298.88 per session.

Conclusion
Yakama Nation Behavioral Health Services has expanded its services in the past 4 years. Staff has increased from 7 employees to 30 with the funding of grants.
The Victims Resource Program was created to assist and serve victims of crime because Yakama Nation did not have a program that provided support or resources for victims of crime. YNBHS took a clinical Social Work approach to work comprehensively with victims to learn coping skills and address the trauma issues that may contribute to victimization.

YNBHS also recovered the Domestic Violence Perpetrator program. This program was originally under Justice Services and funded with Tribal funds. We made a proposal to ascertain the program and sustain it through 3rd Party billing. Also, we wanted to take a comprehensive mental health approach to the Perpetrators. The Therapist who provides DV Perp services is also certified in Anger Management.

YNBHS is planning on becoming a Trauma-Informed Care agency. TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment". This will be implemented through grant funding.

YOUTH-LED PSA (JULY'S QBM) NEVER A WINNING HAND VIDEO & CONCERNING POST TRAINING VIDEO, STEPHANIE CRAIG-RUSHING, THRIVE & PRT PROJECT DIRECTOR

Never a Winning Hand PSA

Long Version:
https://vimeo.com/233006812

Short Version (One Minute):
https://vimeo.com/233006446

30 Second Spot:
https://vimeo.com/233006264

Healthily Native Youth Org
We recognized that, to be effective, health curricula must be age-appropriate, culturally-relevant, and reflect the values and learning styles of the learners being taught. Finding curricula that meet these requirements for American Indian and Alaska Native youth can be really challenging.
Designed a website that could help teachers/educators do just that…
www.HealthyNativeYouth.org is a one-stop-shop for tribal health educators, teachers, and parents**.**

Sexual Health Curricula
From the Curricula tab…
You can click on the program name to learn more about each curriculum, including intended age-group, where it can be implemented, and how much time will be required.

- You can filter your search by age, lgbt inclusivity, program setting, and evidence of effectiveness.
- You can also compare two or more programs to each other… by class size, cost, or program duration.

Once you've selected a program, each has folder tabs that contain lesson plans, handouts, and supplemental materials. Many include recorded videos and webinars to help prepare you to facilitate the program.
We also provide information about how the program was designed or adapted, and evaluated with AI/AN youth.

You can also compare two or more programs to each other… by class size, cost, or program duration.

Once you've selected a program, each has folder tabs that contain lesson plans, handouts, and supplemental materials. Many include recorded videos and webinars to help prepare you to facilitate the program.
We also provide information about how the program was designed or adapted, and evaluated with AI/AN youth.

Responding to Concerning Post on Social Media
The new 1-hour webinar training will prepare adults who work with Native youth to help youth who post or view concerning posts on social media, and connect them to appropriate services.
The training is designed for **adults** who work with Native youth, including: parents, mentors, teachers, coaches, health educators.

What are "Concerning Posts"?
Concerning posts include those that express depression or intent to hurt one's self or others, that have been posted on a social media site, such as Facebook, Instagram, Twitter, or Snapchat.
Emerging research suggests that nearly one-third of AI/AN youth see concerning messages on social media on a daily or weekly basis.
These include posts that express depression, grief, intent to hurt one's self, or intent to hurt others, that have been posted on a social media site, such as Facebook, Instagram, Twitter, or Snapchat.

1. Watch the video training (30 min.)
The one-hour training includes a 30-minute video, that you can share with adults in your community to better understand the issue.

Community Awareness Activity
In the "Resource" tab, we've also created two Community Awareness activity guides that you can use to raise awareness about this topic: one for youth and one for adults.
It can be used just about anywhere: at school events, at a staff meeting, a tribal council meeting, or at tribal gatherings.

Please let us know if you select or use a program on the site. (10 minutes!)

This is what we use to show the reach of the programs available on the site – who is using them and how many youth have been taught.

About the Program
Also, help us grow.
If you have a health program that you'd like to share… Consider housing it here! It will be made available to educators across Indian Country, and you'll receive feedback on program uptake and reach, with the ability to update training materials and lesson plans as needed.

Take the Back-to-School Challenge

- ☐ A 3-month challenge to help students grades 6-12 develop skills for healthy relationships. Earn your class free school supplies!
- ☐ Step 1: Select a curriculum from HNY.
- ☐ Step 2: Implement it with a group of students
- ☐ Step 3: Complete the Feedback Form by Dec 1st: https://www.healthynativeyouth.org/about/feedback

Win Prizes!!!

- ☐ First 10 entries = $250 in School Supplies
- ☐ All Participants = We R Native Promo Kits

Share the site with your community networks: www.HealthyNativeYouth.org

Sign up to receive updates about curricula available on the site (*in the red bar at the bottom of the homepage*)

Follow the site on Facebook (www.facebook.com/HealthyNativeYouth)

This project is funded by the Indian Health Service HIV and behavioral health programs. This work is also supported with funds from the Secretary's Minority AIDS Initiative Fund.

RECESS

THURSDAY, APRIL 23, 2014

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

Invocation: Dan Gleaon, Chehalis Tribe

Committee Reports

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

Veterans – Cindy Harris, Sauk-Suiattle Tribe (A copy of the report is attached)

Public Health – Victoria Warren Mears, NPAIHB EpiCenter Director (A copy of the report is attached)

Behavioral Health – Nick Lewis, Lummi Nation (A copy of the report is attached)

Personnel – Jaqueline Left Hand Bull, NPAIHB Administrative Officer (A copy of the report is attached)

Youth Committee - Sharon Stanphill, Cow Creek Tribe, (A copy of the report is attached)

Legislative Committee - Laura Platero, NPAIHB Governmental Affairs/Policy Director (A copy of the report is attached)

Finance Report – Eugen Mostifi, NPAIHB Fund Accounting Manager: MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Kim Thompson, Shoalwater Bay Tribe; MOTION PASSES

Minutes: July's Minutes; MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Patrick Anderson, Makah Tribe: MOTION PASSES

Resolutions:

18-01-02

"Support for the Tribal Epidemiology Center (TEC) to Apply with Oregon Health & Science University (OHSU) for NIH Science Education Partnership Award (SEPA) Funding PAR-17-339"
MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Cassie Sellards-Reck, Cowlitz Tribe: MOTION PASSES

18-01-04
"Urging the American Medical Association to Adopt a Policy Statement on Adverse Childhood Experiences and Toxic Stress"
MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Sharon Stanphill, Cow Creek Tribe: MOTION PASSES

18-01-03
"RFA-MH-18-410: Addressing Suicide Research Gaps: Understanding Mortality Outcomes (R01)"
MOTION by Shawna Gavin, Confederated Tribes of Umatilla; second by Sharon Stanphill, Cow Creek Tribe: MOTION PASSES

ADJOURN at 9:31 a.m.

_____ _____

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

_____ _____

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

_____ _____

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

QUARTERLY BOARD MEETING

Legends Casino – Hotel
580 Fort Road Toppenish, WA 98948

October 10-12, 2017

AGENDA

MONDAY, OCTOBER 9, 2017 KAMIAKIN ROOM (CASINO HOTEL)

Tribal Health Directors Meeting

TUESDAY, OCTOBER 10, 2017 – (YAKAMA NATION'S CULTURAL CENTER)

7:30 AM	**Executive Committee Meeting**	
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call	Andy Joseph, Chairman Chairman JoDeGoudy, Yakama Tribal Council, Davis Washines, General Council Chairman, and Frank Mesplie, Health, Employment, Welfare & Youth Activities Committee Chairman Brian McCloud, Interim Manager Veteran's Affairs, Yakama Warriors Color Guard Shawna Gavin, Treasurer
9:15 AM	WEAVE-NW **(1)**	Nanette Star, Project Director
9:45 AM	Diabetes and Hepatitis C Program **(2)**	Troy Pitney, DIA, Partner and Tribal Benefit Specialist, The Mahoney Group
10:15 AM	**Break**	
10:30 AM	NPAIHB Executive Director Report (16)	Joe Finkbonner, Executive Director
11:00 AM	Northwest Tribal Epidemiology Center **(17)**	Victoria Warren-Mears, EpiCenter Director
11:30 AM	Yakama's Maternal Child Health (MCH) **(4)**	Regina Brown, Yakama Nation MCH Manager & Immunization Coordinator

QUARTERLY BOARD MEETING

Legends Casino – Hotel
580 Fort Road Toppenish, WA 98948

October 10-12, 2017

AGENDA

12:00 PM	**LUNCH** Committee Meetings *(working lunch)* 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution 7. Youth	Staff: Clarice Charging Staff: Don Head Staff: Victoria Warren-Mears Staff: Stephanie Craig Staff: Andra Wagner Staff: Laura Platero Staff: Nanette Star
1:30 PM	Oregon Prevention Research Center for Healthy Communities at OHSU Program/Project Updates (Native STAND, SRI, etc) **(5)**	Rana Najjar, School of Nursing Native Diversity Program & Michelle Singer, Center for Health Communities
2:00 PM	Northwest Native American Center of Excellence (NNACOE) at OHSU **(6)**	Amanda Bruegl, MD, & Dove Spector, Northwest Native American Center of Excellence
2:30 PM	Legislative Update **(7)**	Laura Platero, Government Affairs/Policy Director
3:00 PM	**BREAK**	
3:30 PM	Area Director Report **(8)**	Dean Seyler, Portland Area IHS Director
4:30 PM	Executive Session	

QUARTERLY BOARD MEETING

Legends Casino – Hotel
580 Fort Road Toppenish, WA 98948

October 10-12, 2017

AGENDA

WEDNESDAY OCTOBER 11, 2017 - (YAKAMA NATION'S CULTURAL CENTER)

9:00 AM	Call to Order Invocation	Andy Joseph, Chairman
9:15 AM	Suicide Prevention at Heritage University **(9)**	HU and THRIVE Staff
9:30 AM	Healing Lodge **(10)**	Sharon Randle, Outreach Specialist
10:00 AM	Behavioral Health Aid **(11)**	Xiomara Owens MS, Director of BHA Programs ANTHC
10:45 AM	**BREAK**	
11:00	Behavioral Health Aid **(11)**	Xiomara Owens MS, Director of BHA Programs ANTHC
11:30 AM	Yakama's Nak Nu We Sha **(12)**	June Adams, MSW, NNWS Program Manager & Laretta Smiscon Social Worker Supervisor
12:00 PM	**LUNCH**	
1:30 PM	**Tribal Updates** 1. Nooksack Tribe 2. Port Gamble S'Klallam Tribe 3. Tulalip Tribes	
2:15 PM	Sugary Drinks and Health **(13)**	SARA SOKA, MS *Vice President, Policy Health Food America*
3:15 PM	**BREAK**	
3:45 PM	Yakama Nation Behavioral Health **(14)**	Katherine Saluskin, MSW, Program Director

QUARTERLY BOARD MEETING

Legends Casino – Hotel
580 Fort Road Toppenish, WA 98948

October 10-12, 2017

AGENDA

4:15 PM	Youth-led PSA (July's QBM) Never A Winning Hand Video & Concerning Post Training Video **(15)**	Stephanie Craig-Rushing, THRIVE & PRT Project Director

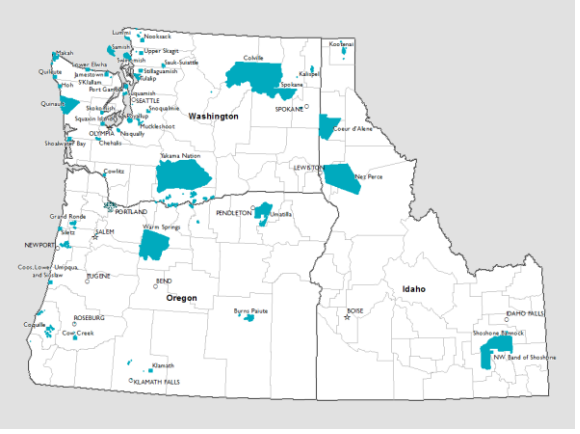
THURSDAY, OCTOBER 12, 2017 - (YAKAMA NATION'S CULTURAL CENTER)

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. Finance Report 2. Approval of Minutes • July 2017 3. Resolutions 4. Future Board Meeting Sites: • *January 2018 – Portland, OR* • *April 2018 - Pendleton, OR (hosting Umatilla)* • *July 2018 – Bellingham, WA (hosting Lummi)*	Eugene Mostifi, Fund Accounting Manager

12:00 PM Adjourn

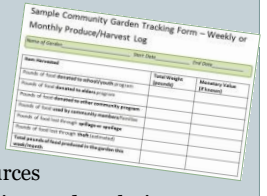
Wellness for Every American Indian to Achieve and View Health Equity WEAVE-NW

OCTOBER 10, 2017
GOOD HEALTH & WELLNESS IN INDIAN COUNTRY INITIATIVE



Technical Assistance for All Tribes

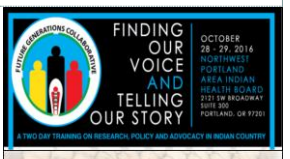
- Data analysis
- Strategic planning
- Health systems change
- Enhancing collaborations
- Evaluations & assessments
- Cultural adaptation of resources
- Survey design, implementation, and analysis
- Tobacco prevention & intervention activities
- Policy development
- Youth lead


Sample Community Garden Tracking Form – Weekly or Monthly Produce/Harvest Log

Northwest Portland Area Indian Health Board

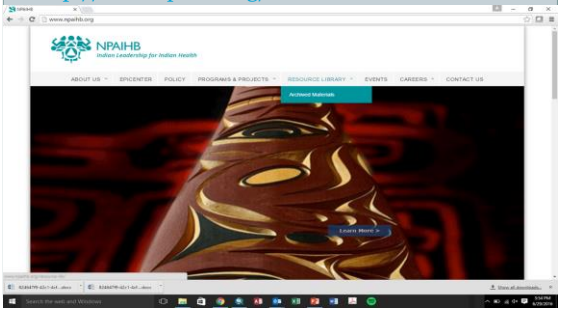
Tribally Lead …

Webinars, Trainings, Workshops



Resource Library

- http://www.npaihb.org/



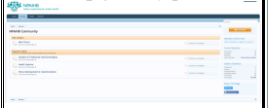
Communication Forum to increase collaboration across Tribes and provide an immediate digital platform for sharing resources.

You are invited to try the LIVE NPAIHB Community Message Board!!!!

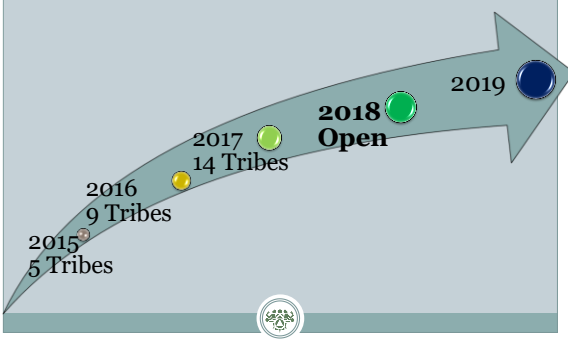
This discussion forum is a space for tribal communities to share thoughts, ideas, pose questions, provide tips, and resources on:

- ✓ Land Use
- ✓ Tribal Policy
- ✓ Gardening & traditional foods
- ✓ Health Care topics including Health Systems
- ✓ Policy development & implementation
- ✓ Other topics important to your community

http://www.npaihb.org/Community/index.php



Direct Funding NOW OPEN!



Application Details

- $1000. - $10,000.
- Rolling basis based on available funding!
- Funds utilized for Prevention (PSE) Activities ONLY:
  - Cardiovascular disease
  - Obesity
  - Type 2 Diabetes
  - All associated risks
- Activities completed by September 30, 2018

WEAVE-NW Team

Principle Investigator
Victoria Warren-Mears

Project Director & Epidemiologist
Nanette Star
(Choctaw Oklahoma Nation)

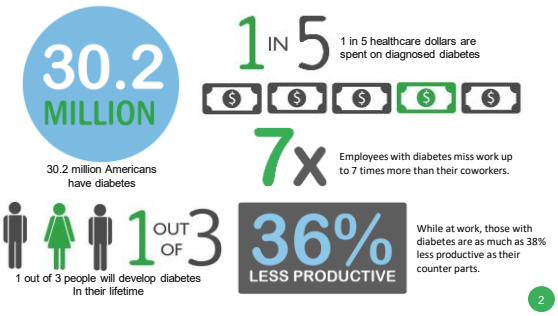
Project Coordinator
Nora Frank-Buckner
(Nez Perce)

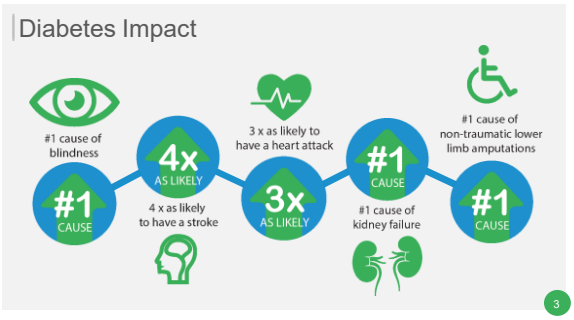
Project Evaluator
Jenine Dankovchik

Tobacco Project Specialist
Ryan Sealy
(Chickasaw)

WEAVE-NW Email:
weave@npaihb.org
Phone: 503-228-4185

THE MAHONEY GROUP TMG Diabetes & Rewards Program



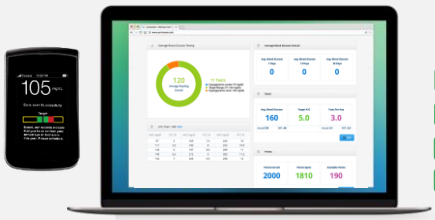


Blood Glucose Monitoring

- Blood glucose monitoring forms the backbone of a diabetes management plan
- Knowing your blood glucose levels in different situations keep your levels in a healthy range
- Blood glucose readings help you understand how your body responds to different situations

4

TMG Diabetes & Rewards Program

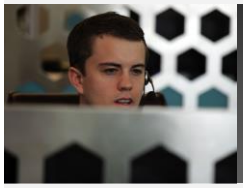


- Free Supplies
- View Trends
- Set Alerts
- Create Goals
- Share Readings

No Logbooks | 100% Accuracy and Visibly | Simplifies Management

5

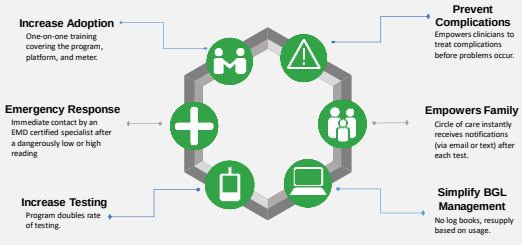
CareCenter



- 24/7/365
- Emergency dispatch accredited
- Educate – how to test – benefits of testing
- Encourage – help cultivate healthy habits
- Incentive – Rewards Program

6

Program Benefits



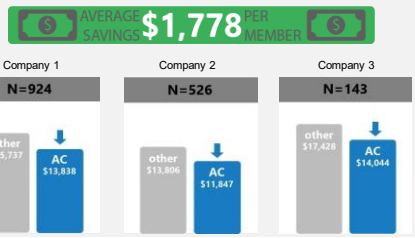
7

Member Experience

"This program has changed my life!"

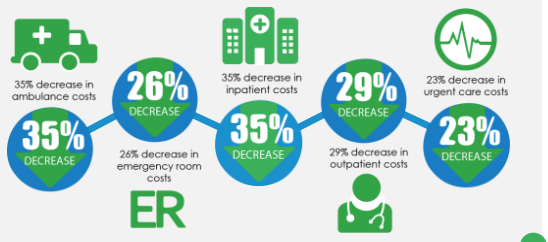
8

Overall Customer Savings



9

Source of Savings



10

Summary

TMG Program provides **real-time visibility**

allowing for **active monitoring & care**

creating **improved outcomes**

5 years *of data compilation.*

Has serviced over **35,000 members**

With over **1,300 healthcare plans**

$1,778 *average savings.*

YAKAMA Nation 2017

October

Northwest Portland Area Indian Health Board Quarterly Board Meeting

Toppenish WA 98948

YN MCH

YN Maternal Child Health (MCH)

Yakama Nation Maternal Child Health (MCH) Program

Program Location:

Yakama Indian Health Clinic
401 Buster Road
Toppenish WA 98948
Ph: (509)865-1757 / 1712
Fax: (509)865-6514
Hours: 7:00am – 5:00pm M-F

YN Maternal Child Health (MCH)

YN Maternal Child Health (MCH)

YN – MCH
638 Contracted Program
Indian Health Services
Master Contract
(1971 - 2017)
46 years

M. Smith/Squeochs - 1st Manager 1971

R. George - Retired 2016
34+ Yrs
(Both Enrolled Yakama)

MCH Report Outline:

1. YN - MCH Chain of Command
2. Portland Area Office (PAO)
3. MCH Goals & Objectives
4. MCH Program Activities/Clinics
5. Injury Prevention Project
6. Reports
7. Collaborations
8. Pending Grants
9. MCH Staff

MCH Report:

MCH

Chain of

Command

MCH Chain of Command:

- HEW Committee
- Tribal Director
- Human SVC Deputy Director
- MCH Manager
- MCH Outreach (3)
- Trainee (YN-NWF & PFP)
- Summer Youth (4-8wks)

YN Maternal Child Health (MCH)

MCH Report:

Portland
Area
Office
(PAO)

YN Maternal Child Health (MCH)

Portland Area Office:

- Yakama I.H.S Clinic
  - Federal I.H.S Facility
  - 1 out of 3 I.H.S Facilities in WA State
  - Provides services to **All** federally recognized tribes & descendants
- **PAO** = WA, Oregon & Idaho Tribes
  - Federal: 6
  - Tribal 638 / Compact: 47
  - Urban: 3

YN Maternal Child Health (MCH)

Portland Area Office:

- Indian Health Service: 12 Area Offices
  - Alaska - Albuquerque
  - Bemidji - Billings
  - California - Great Plains
  - Nashville - Navajo
  - Oklahoma - Phoenix
  - **Portland** - Tucson
- Federal, Tribal 638/Compact & Urban
- I.H.S Headquarters, Rockville MD

YN Maternal Child Health (MCH)

Portland Area Office:

- RPMS Computer System
  - Scheduling & Letters
  - Immunization Register
  - Report System
- Electronic Health Records / EHR (2007)
  - **Documentation**: Chart Reviews, Phone Calls, Hospital Visits (NB & PP), PN Intakes, Home Visits, Counseling, WCC
- E-Mail, Outlook: IHS.GOV

YN Maternal Child Health (MCH)

MCH Report:

- MCH

GOALS
&
Objectives

YN Maternal Child Health (MCH)

Goals & Objectives:

- Improve Health Care through Immunizations
- Decrease Death Rates: Fetal, Infant, Children & Adolescent, Maternal
- Reduce STD's in Pregnancies
- Encourage Women's Health Care
- Decrease BBTD

WCC, MCH Intake/Referral's, WHC: IHS & Private Care, Injury Prevention

YN Maternal Child Health (MCH)

MCH Report:

- MCH

Program Activities & Clinics

YN Maternal Child Health (MCH)

Program Activities & Clinics:

Case-Management Program

- Prenatal → Post-Partum
  - 1st, 2nd & 3rd Trimester
- Children
  - -Birth - 6 year Age Groups

I.H.S Eligible/Registered

YN Maternal Child Health (MCH)

GENDER			
YEAR	MALE	FEMALE	TOTAL
1971 (46 y/o)	89	75	164
1981 (36 y/o)	100	113	213
1991 (26 y/o)	143	135	278
2001 (16 y/o)	121	130	251
2011 (6 y/o)	121	143	264
2017 (9 month) JAN - SEPT	75	69	144
TOTAL →	649	665	1314

YN Maternal Child Health (MCH)

GENDER			
10-YR SPAN 1971 - 2017	MALE	FEMALE	TOTAL
37-46 Yr-Olds	862	899	1761
27-36 Yr-Olds	1193	1299	2492
17-26 Yr-Olds	1241	1289	2530
7-16 Yr-Olds	1410	1222	2632
Birth-6 Yr-Olds	672	633	1305
TOTAL →	5378	5342	10,720

YN Maternal Child Health (MCH)

Program Activities & Clinics:

Area Locations:

- Harrah/Brownstown
- Toppenish/Satus
- Wapato City/Parker
- White Swan/Medicine Valley
- Off Reservation: Yakima, Union Gap, Selah, Naches, Ellensburg, Cle Elum, Zillah, Granger, Sunnyside, Grandview, Goldendale
- Out of State/Local Area

YN Maternal Child Health (MCH)

YN Maternal Child Health (MCH)

Program Activities & Clinics:

PN Case-Load: 5 Area's

- Prenatal 1st, 2nd & 3rd Trimester
  - I.H.S Medical Referrals, Daily/Weekly
    Self Referrals (2nd & 3rd Trimester)
  - MCH Intakes Daily/Weekly
  - OB Referrals → Outside Providers
  - Monitored: HV, T/C, Office Visits
  - PN Lists Updated monthly (reports)

Not All PN patient's come thru I.H.S/MCH

YN Maternal Child Health (MCH)

	TRIMESTER			
AREA	1ST	2ND	3RD	TOTAL
HARRAH/B.town	10	3	0	13
Toppenish	4	5	1	10
Wapato City	3	5	0	8
White Swan	9	0	0	9
Off Rez	3	2	0	5
TOTAL →	29	15	1	45

MCH PRENATAL CASE-LOAD

YN Maternal Child Health (MCH)

YEAR SPAN	SCHED.APPT	DROP-IN	OVER-BOOK	NO-SHOW	TOTAL # Pt SEEN
JAN 2012-DEC 2015	346	64	19	200	429
JAN 2002-DEC 2011	1433	229	33	544	1695
JAN 1992-DEC 2001	3119	132	6	112	3257
MAY 1989-DEC 1991	601	2	0	2	603
TOTAL →	5499	427	58	858	5984

Previous OB Intake Clinic Total

YN Maternal Child Health (MCH)

Program Activities & Clinics:

Hospital Visits: Weekly, MON - FRI

- PN List: Deliveries Monitored
- Weekly Staff Rotation
- Toppenish Community Hospital
- Virginia Mason (YVMH)
- NB Car Seat Delivered
  - PP/Early Deliveries
  - Unknown Pregnancy, Not on PN List

Not all PN's deliver locally (Seattle or Out of State)

YN Maternal Child Health (MCH)

Program Activities & Clinics:

Newborns: Divided into 5 Area's

- Newborn PE (within 2 days)
  - Activated on MCH Immunization Register weekly/monthly
  - Family contact by MCHO {Active/Inactive}
  - NB/PP Info entered into E.H.R
  - Registration Packets w/I.H.S Registration

Not all NB's register w/I.H.S after delivery

YN Maternal Child Health (MCH)

FY-17	TCH		YVMH		OTHER *(WA)		OUT OF *STATE		TOTAL Gender		TOTAL NEWBORNS
QTR	M	F	M	F	M	F	M	F	M	F	Both
1ST	10	8	13	15	0	1	1	1	24	25	49
2ND	8	6	16	17	2	1	2	1	28	25	53
3RD	4	7	9	13	1	2	2	0	16	22	38
4TH	7	6	13	16	0	1	0	0	20	23	43
TOTAL →	29	27	51	61	3	5	5	2	88	95	183

*2M, 1 F = Sunnyside. 1M, 1 F= Seattle. 1M, 1 F = Spokane. 1M = Richland.
1 F= Hood River, OR. 1 F= Grand Forks, ND. 1 F= The Dalles, OR. 2 F= Madras, OR.
1 M= Phoenix, AZ. 1M= Lewiston, ID. M = Male. F = Female.

FY-2017 Newborn Deliveries

YN Maternal Child Health (MCH)

Program Activities & Clinics:

Birth-6 Years Case-Load:

- **ACTIVE List**: WCC/Immunizations completed @ Yakama I.H.S. PCP @ Yakama I.H.S.
- ***INACTIVE List**: Private Care for WCC & Immunizations - PCP Outside of Yakama I.H.S. (Dental, Pharmacy, Medical Walk-Ins, PRC, Wic @ Yakama I.H.S)

  *Does Not Count on QTRLY Reports

- **Out of State/Local Area: Inactive**

YN Maternal Child Health (MCH)

Program Activities & Clinics:

Case-Load Guidelines Birth - 6 Years:

- Master List beginning of each QTR
- Chart Review: UTD & Target List
- Reminder Due Letters once per month
- Schedule/Monitor WCC Due List
- Phone Call: APPT Reminders
- Home Visit's: Rtn Letters, (Active)
- Transfers: Area to Area, Re-Activate
- Document All Pt Contacts

YN Maternal Child Health (MCH)

Program Activities & Clinics:

WA formerly Child-Profile:

- Immunization Information System { WA- IIS }
- HEW Resolution
- Inactive Case-Load Only
- Private Care: WA Providers
  - Does Not Require Release of Information
- **EHR Documentation: All Immunization Updates**

YN Maternal Child Health (MCH)

AREA	Active	Inactive	TOTAL
HARRAH/B.town	208	140	348
Toppenish	124	106	230
Wapato City	87	82	169
White Swan	118	50	168
Off Rez	86	229	315
TOTAL →	623	607	1,230

FY-2018,1st QTR- Active/Inactive

YN Maternal Child Health (MCH)

Program Activities & Clinics:

Well Child Clinics:

- Toppenish Wcc Daily, Appt: 865-1709
  - -APPT's by I.H.S PCP Team currently
- White Swan WCC: 2 per month
  - -APPT's by MCH
  - -MCH Ph: (509)865-2102, X-360/X-312
- Wapato WCC: Closed May 2011
  - No E.H.R Connection, No running water in exam room. Renovation: June 2016- present.

YN Maternal Child Health (MCH)

YEAR SPAN	SCHED. APPT	DROP-IN	OVER-BOOK	NO-SHOW	TOTAL # Pt SEEN
JAN 2002 – NOV 2006	9507	1128	330	3163	10,965
JAN 1992-DEC 2001	26,173	3262	3	2593	29,438
JAN 1981-OCT 1989	5518	239	2	510	5759
TOTAL →	41,640	4629	335	9647	46,604

Previous TOPP WCC Clinic

YN Maternal Child Health (MCH)

MCH Activities & Other:

GSA Vehicles:

- GSA Truck
- GSA VAN (traded SUV 5/17)
  - Outreach Clinics
  - Hospital Visits
  - Home Visits
  - Local Trainings/Meetings
- Tribal Permits & WA Drivers License Required

YN Maternal Child Health (MCH)

MCH Report:

- Injury

Prevention

YN Maternal Child Health (MCH)

Injury Prevention:

- Child Restraints (car seats)
  - Newborn Car Seat Carrier's, on-going
  - Convertible & Booster Seats (dependent upon budget)
  - Paperwork Completed in Advance
  - Documented by PCC & into EHR
  - Must be Up-To-Date with WCC/ Immunizations (Appt's available daily)
- Re-Started: April 2017 with Grant

YN Maternal Child Health (MCH)

Injury Prevention:

- Newborn RF Car Seat Carrier: 5-22 lb
  - 2 weeks prior to Due Date/EDC
  - Delivered to hospital, weekly
  - Grant NB Order Rec'd: March 2017
- Convertible Car Seats: 5-65 lb
- High-Back Booster: **4yr - 8yr**
  - Prior purchases, dependent upon budget
  - Current Native CARS Project

YN Maternal Child Health (MCH)

Injury Prevention:

- **Native CARS** (Children Always Ride Safe)Mini-Grant **Award: 1-Yr Project**:
  - Dec 19, 2016 - Dec 18, 2017
  - Previous Pilot Project, 6 NW Tribes
  - 6 Project Choices
  - RPMS Referral Patch & Car Seat Distribution Project
  - **Funding Doubled**: Car Seat TECH Training Project, Travel cost (4 staff)
- Funding Received: February 2017

YN Maternal Child Health (MCH)

Injury Prevention:

#1: RPMS Patch & Car Seat Distribution:

- RPMS Patch Installed: JAN 2017
  ***Trng & Lunch Cost Included, → H.Start**
- Car Seat Observation Survey's: 200
  ***Age Group: NB-8 years**
- Includes $4000 order of NB car seats
  69 Total Received
- Provided Convertible Car Seats: 100
- Provided High-Back Booster Seats: 50

- **Car/Booster Seat's Received: Feb 24, 2017**

YN Maternal Child Health (MCH)

MCH Report:

- MCH

Program

Reports

YN Maternal Child Health (MCH)

MCH Report:

- MCH Program & Individual Reports:
  - Weekly Staff Meeting
  - Program Schedule/Clinics/Percentage
  - Total Contacts:
    - Chart Reviews
    - Phone Calls
    - Intakes
    - Hospital Visits (PP/NB)
    - Car Seat/Booster Seat

YN Maternal Child Health (MCH)

MCH Report:

- Monthly YN Reports
  - Includes WCC & Audiology Appt #'s
  - Due last Thursday of Month
  - Total Number's used for GC Report
- Quarterly Reports: PAO & YN
  - Quarterly 3-27 months
  - Two-YR-Old 19-35 months
  - Adolescent 11-17 years
  - Adult 18 & above
  - Influenza (2 QTR's per YR)

YN Maternal Child Health (MCH)

MCH Report:

- Quarterly Reports: PAO/YN
  - Due after end of each Quarter:
    - 1st: OCTOBER - DECEMBER
    - 2nd: JANUARY - MARCH
    - 3rd: APRIL - JUNE
    - 4th: JULY - SEPTEMBER

- Percentage Totals entered to I.H.S National data-base each QTR

-Total # Included with monthly reports

YN Maternal Child Health (MCH)

AREA	UTD	DUE	TOTAL	%
Harrah	27	16	43	63%
TOPP	34	5	39	87%
WAP.C	16	3	19	84%
WS	20	4	24	83%
Off Rez	15	1	16	94%
Total →	112	29	141	79%

FY-2017, 4th QTR, Qtrly Rpt

YN Maternal Child Health (MCH)

MCH Report:

- MCH

Collaborations

Collaborations:

- WhiteSwan Health Clinic Outreach
  - 2 per month, 24 Clinics per year
  - AM Clinics: 9:00-11:00 March through October
  - PM Winter Clinics: 1:00-3:00 November through February
- MCH: Coordinate, scheduling, reminder letters, phone calls, home visits & arranging transportation

Collaborations:

- YN-White Swan Health Clinic
  80 Bird Song Lane
  White Swan WA 98952
  Phone: (509)874-2979
  Fax: (509)874-2113
- WS Medical Director: Abdulla Shirzad
- 34+ Years Collaboration

-Clinic Totals Reported on monthly/yearly MCH reports

YEAR SPAN	SCHED.APPT	DROP-IN	OVER-BOOK	NO-SHOW	TOTAL # Pt SEEN
JAN 2012-SEP 2017	912	192	43	1633	1147
JAN 2002-DEC 2011	2650	302	360	3213	3312
JAN 1992-DEC 2001	6538	42	225	307	6805
OCT 1989-DEC 1991	1200	0	4	79	1204
TOTAL →	11,300	536	632	3545	12,468

WS WCC, AM/PM Clinic Total's

YN Maternal Child Health (MCH)

YEAR SPAN	SCHED. APPT	DROP-IN	OVER-BOOK	NO-SHOW	TOTAL # Pt SEEN
JAN 2012-DEC 2013	0	0	0	0	0
JAN 2002-DEC 2011	1093	68	149	2834	1310
TOTAL →	1160	68	149	2834	1377

Wapato WCC, Clinic Total's

YN Maternal Child Health (MCH)

CLINIC	YEAR SPAN	SCHED. APPT	DROP-IN	OVER-BOOK	NO-SHOW	TOTAL # Pt SEEN
TOPP	JAN 1981-NOV 2006	41,198	4629	335	9647	46,162
WAP	JAN 2002-APR 2011	1093	68	149	2834	1310
WS	OCT 1989-SEP 2017	11,300	536	632	3545	12,468
TOTAL →	JAN 1981-SEP 2017	53,591	5233	1116	9647	59,940

Topp, Wap, WS Clinic's Combined

YN Maternal Child Health (MCH)

Collaborations:

- Audiology
  - PRC Contracted Tribal Program
  - 8 Clinics **per month**, 2 days per week
  - Appointments: ½ Hour to 1 Hour
  - **Appointment's preferred**
  - APPT's: **865-1712, 865-1757**
- **MCH**: Scheduling, HA Drop-Off's & HA Pick-Up's, reminder appointment calls, Daily messages (Sept 2014)

YN Maternal Child Health (MCH)

Collaborations:

- Audiology, Svc Provided:
  - **Hearing Screenings**
  - **Hearing Aid Checks & Adjustments**
  - **Referral's**
  - **Hearing Aide's**
  - **Batteries**
  - **All Age Groups (head start, seniors)**
- **HA payment**: PRC, Private Insurance or Private Pay

YN Maternal Child Health (MCH)

Collaborations:

- Audiology
  - Office Location: Yakama I.H.S Community Health, Tribal Hallway
  - **MCH**/Clinic Reports: Kept & DNKA appointment's
  - Clinic Totals included w/MCH report
- **Audiologist**: Linda Simpson,
  - 1 Person Program
  - Previous I.H.S program

YN Maternal Child Health (MCH)

YEAR	SCHED.APPT	DROP-IN	OVER-BOOK	NO-SHOW	TOTAL # Pt SEEN
FY-2015	487	2	63	128	552
FY-2016	577	2	51	75	630
FY-2017	480	0	75	87	555
TOTAL →	1544	4	189	290	1737

Audiology Clinic, 3 Year Totals

YN Maternal Child Health (MCH)

Collaborations:

- YN Child-Care Program
  - Total List of Children by Child-Care
  - MCH Review Immunization Records
  - Total List of Children **only** (not by center location)
  - Provide List of Children 'Due' & monitor for future WCC/Immun.
- **New Collaboration**: April 2017

  -Total # will be included in reports

YN Maternal Child Health (MCH)

MCH Report:

Grants

Projects

YN Maternal Child Health (MCH)

Completed Grant App's:

- Native CARS, NPAIHB FY-2017
- BIA Highway Safety FY-2017
  - Convertible Car Seats & Booster Seats
- BIA Highway Safety FY-2018
  - Newborn Car Seat Carrier's, Convertible Car Seats & Booster Seats
  - Canopy's
  - Folding Tables
  - Latch Manuals
  - Registration Cost, CPS Tech Training

YN Maternal Child Health (MCH)

MCH Report:

MCH

STAFF

YN Maternal Child Health (MCH)

MCH Staff (5):

- Enrolled Yakama Members
  - -3 Regular FT Staff
  - -1 FT, Native WF
- Enrolled, Other Tribe
  - -1 Regular FT Staff

YN Maternal Child Health (MCH)

MCH Staff:

- NPAIHB Report Completed By:

Regina L. Brown/YN
MCH Mgr & Immunization Coordinator
- 26+ Years with YN-MCH
- 2 Years w/YN prior

- Office Location: Yakama I.H.S Community Health

-E-mail: regina.brown@ihs.gov

-Hours: Mon-Fri 8a-5p

YN Maternal Child Health (MCH)

Thank You !

- Be Wise-Immunize

- Buckle-Up

YN Maternal Child Health (MCH)

OREGON Prevention Research Center

OREGON HEALTH & SCIENCE UNIVERSITY OHSU

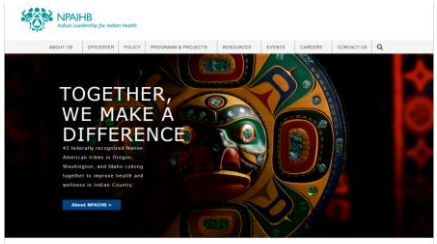
CENTER FOR HEALTHY COMMUNITIES
RESEARCH PROJECTS & TRAINING UPDATE

CENTER FOR HEALTHY COMMUNITIES
WWW.OREGONPRC.ORG

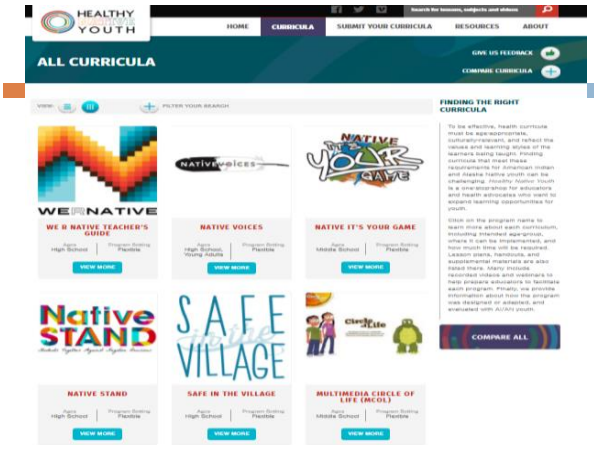
This activity is funded by the CDC Prevention Research Center and the NIH's Northwest Native American Research Center for Health (NW NARCH) as part of the efforts to eliminate health disparities for tribal youth.

Thomas "Tom" Becker, MD, PhD	Director
William "Bill" Lambert, PhD	Associate Director
Caitlin Donald, MSW (Osage/Ponca)	Program Manager
Michelle Singer, BS (Navajo)	Native STAND Project Manager
Brittany Morgan, BS	Native STAND Data Manager

PARTNERS IN RESEARCH
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD



RESEARCH PROJECTS & TRAINING PROGRAMS



Native STAND

CORE RESEARCH PROJECT

NATIVE STAND

NATIVE STAND PROJECT CORE TEAM

OHSU CENTER FOR HEALTHY COMMUNITIES

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

NPAIHB

Stephanie Craig Rushing
Jessica Leston

*We R Native
*Native VOICES
*Healthy Native Youth
*THRIVE
*NW NARCH SRI
*PAIRB Coordinator

OREGON Prevention Research Center

DISSEMINATION, IMPLEMENTATION & EVALUATION STUDY
5 YEAR CDC-FUNDED PROJECT

An effective healthy decision-making curriculum for enhancing and promoting positive Native youth development and well-being.

Disseminate regionally & nationally
(n = 50 tribal communities)

Randomize to two arms:

1. Passive
2. Active technical assistance

Evaluate according to RE-AIM framework

PROJECT EVALUATION FRAMEWORK

- ***Reach***: Proportion and representation of participating educators, teens, and organizations
- ***Effectiveness***: Youth outcomes
- ***Adoption:*** Individuals and organizations that implement the curriculum
- ***Implementation:*** Fidelity of delivery and cost absorbed by community sites
- ***Maintenance:*** Curriculum becomes part of routine operations, including budget, staff, and space

PROJECT UPDATE – INTO ACTION!

48 AI/AN health educators trained over 3 cohorts:

- Year 1 (12), Year 2 (18), Year 3 (18)
- Summer Educator Training Series Completed.

Y3 cohort getting ready for 1st time implementation.

Collection of info on adoption/adaption of curriculum with Y1 & Y2 cohorts ongoing.

- Some Y1/Y2 sites conducting 2nd or 3rd time implementation.

In 2017, weekly phone interviews with 30 sites.

- Potentially ~ 600 AIAN youth (30 sites x 20 youth each).
- After October 1st, Y3 cohort (18 sites) will be added in as they begin.
- Project 2019 Goal ~ 1250 AIAN youth

Year 4 began September 30, 2017. Year 5 begins September 2018.

NATIVE STAND - CENTER FOR HEALTHY COMMUNITIES FACEBOOK PAGE – LIKE US!

Stories from the field!

"Native Stand UP!!" on YouTube!

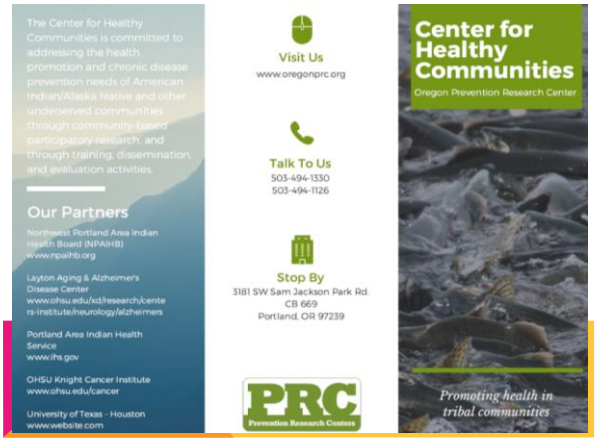
Warm Springs Native STAND program creates music video to reach other Native youth.

https://youtu.be/A4QtHCSbHok

Words of Wisdom (WOW) and more!

Native STAND, the Center, and OHSU are grateful for the helpfulness and coordination of supportive resources.

- NPAIHB leadership, staff & use of training rooms
- NW NARCH Summer Research Training Institute
- THRIVE Tribal Youth Conference students
- NPAIHB Delegate & Tribal ongoing support!



Questions & Discussion

HealthE STEPS 2.0

Advancing Health Equity through Student Empowerment and Professional Success Statewide Program

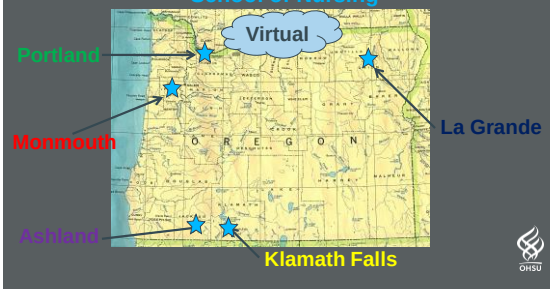
October 10th, 2017
Rana Halabi Najjar, PhD, RN, CPNP

Oregon Nursing & Population Demographics

	Hispanic/ Latino	Non-Hispanic/ Latino	Asian	Native American/ Alaskan Native	Black/ African American	Native Hawaiian/ Pacific Islander	Other Race	Two or more races
RN	2.5%	86.1%	3.3%	0.7%	0.7%	0.2%	1.2%	2.0%
NPs	3.1%	89.1%	3%	0.2%	0.4%	0.3%	0.8%	2.1%
CRNAs	1.8%	80.9%	4%	0%	0.4%	0%	0.7%	1.1%
CNSs	1.6%	89.1%	1.8%	0.8%	0.8%	0%	0%	0.8%
OR Pop	11.7%	88.1%	3.7%	1.4%	1.8%	0.4%	3.8%	3.7%

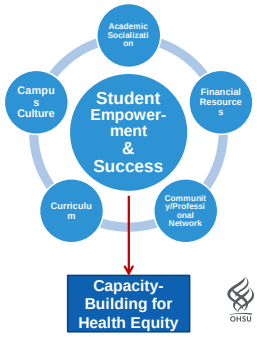
One School of Nursing – Multiple Campuses

Oregon Health & Science University
School of Nursing



Advancing **Health** Equity through **St**udent **E**mpowerment & **P**rofessional **S**uccess Model

Social Determinant	Strategy
Educational opportunity	Academic socialization
Economic stability	Financial resources
Socioeconomic opportunity	Community & Professional Network
Social inclusion	Campus Culture
Health equity	Curriculum Development



HealthE STEPS 2.0 Team


Joanne Noone
Project Director (PI)


Peggy Wros
Diversity Liaison


Rana Halabi Najjar
Project Manager &
Faculty Coordinator
Monmouth Campus


David Cortez
Diversity Coordinator
Mentor


Layla Garrigues
Faculty Coordinator
Portland Campus

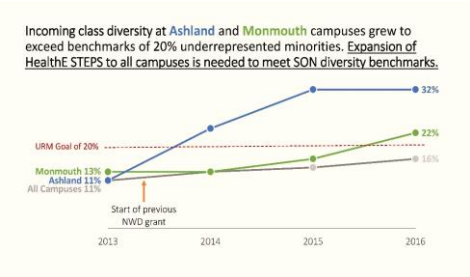

Trish Kohen
Faculty Coordinator
Ashland Campus


Diana Siltanen
Faculty Coordinator
LaGrande Campus


Marilyn Gran-Moravec
Faculty Coordinator
Klamath Falls Campus

*** Four Diversity Coordinators to be hired this fall

Outcomes of HealthE STEPS Nursing Workforce Diversity Grant 2013 - 2016



Outcomes of HealthE STEPS Nursing Workforce Diversity Grant 2013 - 2016

	Baseline	Year One	Year Two	Year Three	Target
Disadvantaged students enrolled in pre-nursing programs at two university campus sites	38%	53%	51%	61%	44% Met
Disadvantaged pre-nursing students transitioned from two university campus sites into nursing Program	5%	26%	32%	32%	20% Met
Number of students transitioning from community college programs to the RN to BSN program	55	136	83	71	70 Met
Graduation rates of underrepresented minority students from university baccalaureate program (all five sites)	78%	93%	82%	89%	90% Nearly Met
Overall percentage of URM students enrolled in the OHSU SON undergraduate baccalaureate programs	11%	13%	12%	14%	19% Not Met

OHSU

Outreach Activities

- Exploring increased clinical placements for nursing students in tribal clinics
- Partnering with Dr. Erik Brodt and OHSU On Track to increase recruitment of Native American students into nursing

OHSU

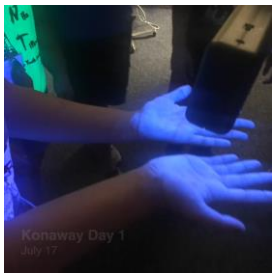
Pipeline Activities

Konaway Nika Tillicum Camp, Trish Kohan

"I want to be a doctor so being in this class helps me learn new skills and how to talk to patients."

2015 Konaway Participant

Pipeline Activities



We are Hiring!

- Diversity Coordinators
  - LaGrande
  - Klamath Falls
  - .5 fte

The ideal candidate has:

- A bachelor's or master's degree in student services or related major;
- Working with disadvantaged or minority college/university students;
- Working with health professions students;
- Experience and/or interest in the health professions.
- Strong ties/relationships with local underrepresented communities

Questions

What is the role of nurses in improving the health of Native Americans in our region? How could it be improved/expanded?

Is it an interest/priority for tribal leaders to increase the number of Native American nurses in the workforce?

If so, how can we partner with Native American groups throughout the state to increase Native American student interest in nursing?

What advice do you have for us?

Thank you

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) Nursing Workforce Diversity Program Grant Number D19HP30850 Advancing Health Equity through Student Empowerment & Professional Success (HealthE STEPS , $1.9 million. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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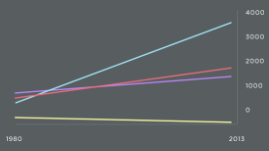
PATHWAYS INTO HEALTH:

NORTHWEST NATIVE AMERICAN CENTER OF EXCELLENCE

NPAIHB DELEGATES MTNG: OCTOBER, 2017 PRESENTED BY: Erik R. Brodt & Amanda Bruegl

U.S. MEDICAL SCHOOL MATRICULANTS 1980-2013



AFRICAN AMERICAN +125%

ASIAN +550%

HISPANIC LATINO +225%

NATIVE AMERICAN -32%

AAMC Data Warehouse: Applicant and Matriculant File as of 10/14/2014

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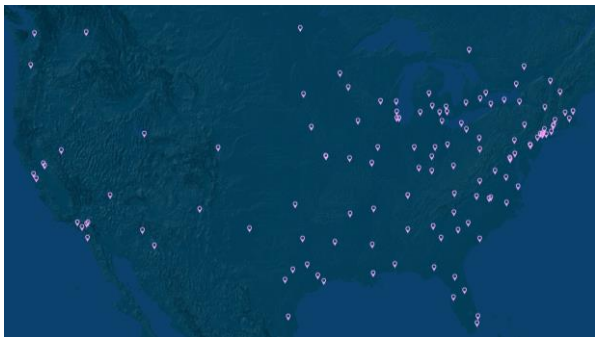
AI/AN APPLICANTS & ACCEPTEES 1996 - 2015

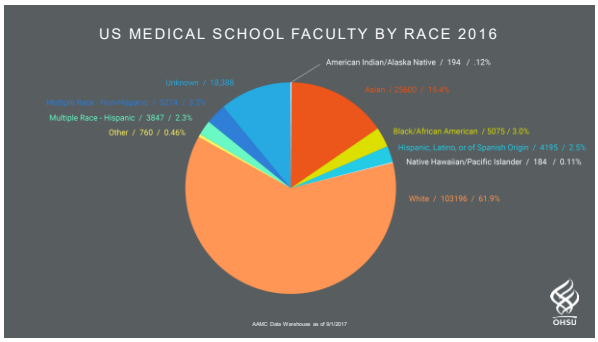
-70% REDUCTION IN AIAN APPLICANTS

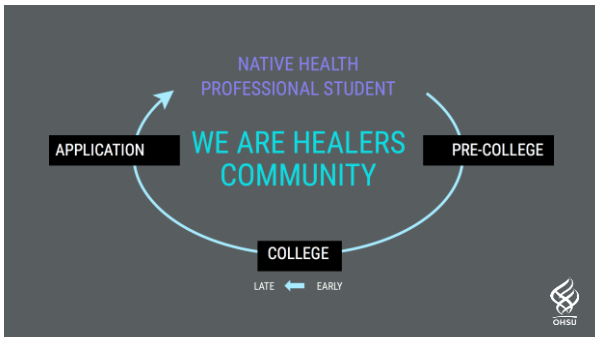
-63% REDUCTION IN AIAN ACCEPTEES

AAMC Data Warehouse: Applicant and Matriculant File as of 12/15/2016

OHSU




US MEDICAL SCHOOL FACULTY BY RACE 2016
American Indian/Alaska Native / 194 / .12%
Unknown / 18,388
Asian / 25600 / 15.4%
Multiple Race - Non-Hispanic / 5274 / 3.2%
Multiple Race - Hispanic / 3847 / 2.3%
Other / 760 / 0.46%
Black/African American / 5075 / 3.0%
Hispanic, Latino, or of Spanish Origin / 4195 / 2.5%
Native Hawaiian/Pacific Islander / 184 / 0.11%
White / 103196 / 61.9%
AAMC Data Warehouse as of 9/1/2017
OHSU


NATIVE HEALTH
PROFESSIONAL STUDENT
APPLICATION
WE ARE HEALERS
COMMUNITY
PRE-COLLEGE
COLLEGE
LATE
EARLY
OHSU


NORTHWEST NATIVE AMERICAN CENTER OF EXCELLENCE
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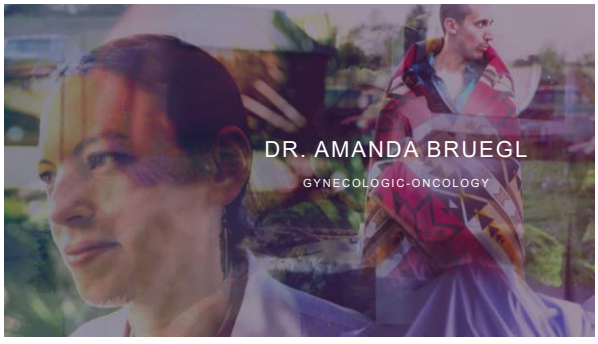
NPAIHB
Indian Leadership for Indian Health
TRIBAL
VOICE
Portland State
UNIVERSITY
8
OHSU

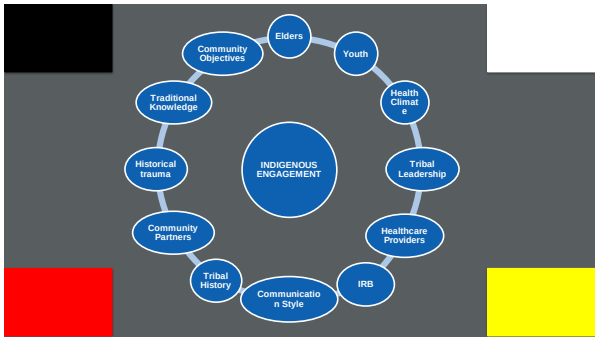

OHSU
OHSU.edu/NativeHeallth
brodt@ohsu.edu
bruegl@ohsu.edu


TRISHA PATTON
DENTAL HEALTH AID THERAPIST


DR. ARNE VAINIO
FAMILY MEDICINE


DR. AMANDA BRUEGL
GYNECOLOGIC-ONCOLOGY


LAKITA MAULSON
MEDICAL STUDENT, CLASS OF 2020


INDIGENOUS ENGAGEMENT
Elders
Youth
Health Climat e
Tribal Leadership
Healthcare Providers
IRB
Communicatio n Style
Tribal History
Community Partners
Historical trauma
Traditional Knowledge
Community Objectives

Policy & Legislative Update

NW Portland Area Indian Health Board
Quarterly Board Meeting
Hosted by The Yakama Nation
October 10, 2017

Report Overview

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

Status of IHS Budgets

3

FY 2018 IHS Budget

- Congress passed a continuing resolution (CR) for FY 2018 budget which funds the government through December 8, 2017.
- President's budget proposes a 5.2% decrease below FY 2017 enacted level for services and facilities.
- House bill proposes a 4.2% increase above FY 2017 enacted level for services and facilities.
  - However, reallocates funds to IHCIF; so minimal increases across all line items
  - Hill visits advocacy per our FY 2018 analysis
- Senate Appropriations Interior Environment and Related Agencies Subcommittee markup of Indian Health Service Budget week of October 16.

FY 2019/2020 IHS Budgets

- National Tribal Budget Formulation Workgroup's Recommendations to IHS for FY 2019
  - Available at: http://www.nihb.org/legislative/budget_formulation.php
- FY 2020 Portland Area Budget Formulation Meeting
  - November 30, 2017 in Portland, OR

Current & Pending Policy Issues

6

HHS Draft Strategic Plan for FY 2018-2022

- HHS is seeking public comment on its draft Strategic Plan for Fiscal Years 2018-2022

  -Comments due 10/26/17.
- Strategic Plan highlights how the Department will achieve its mission through 5 strategic goals
  1. Reform, strengthen, and modernize the Nation's health care system;
  2. Protect the health of Americans where they live, learn, work, and play;
  3. Strengthen the economic and social well-being of Americans across the lifespan;
  4. Foster sound, sustained advances in sciences; and
  5. Promote effective and efficient management and stewardship.

CMS Policies

- **Medicare Diabetes Prevention Program Proposed Rule**
  - NPAIHB submitted comments on 9/11/17.
- **New Medicare Card Project**
- **Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers**
  - Compliance is required by 11/15/17

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.
- CMS FAQ released January 18, 2017.
- *Deadlines*:
  - January 18, 2018: Tribe must notify state of intent to change provider status – clinical provider to FQHC.
  - January 30, 2021: Effective date

CMS New Direction for Innovation Center

- CMS is seeking comment on new direction for the CMS Innovation Center
  - Comments due 11/20/17.
- CMS is interested in testing models in the following areas:
  1. Increased participation in Advanced Alternative Payment Models (APMs);
  2. Consumer-Directed Care & Market-Based Innovation Models;
  3. Physician Specialty Models;
  4. Prescription Drug Models;
  5. Medicare Advantage (MA) Innovation Models;
  6. State-Based and Local Innovation, including Medicaid-focused Models;
  7. Mental and Behavioral Health Models; and
  8. Program Integrity.

IHS Policies

- **IHS Contract Support Costs**
- **IHS Listening Sessions on RPMS and EHR**
  - DTLL on 6/26/17; listening sessions held in July and August.
  - Response to VA moving to VistA and impact on IHS RPMS EHR.
  - NPAIHB submitted comments on 8/30/17.
- **Other IHS Announcements:**
  - DTLL on 8/25: IHS is accepting applications for the Small Ambulatory Program; due 12/1/17.
  - New wait time standards policy: 28 days or less for primary care and 24 hours or less for urgent care.
  - Creation of a search committee to fill key Area Director positions.

IHS Policies

- **IHS Strategic Plan 2018-2022 Tribal Consultation and Urban Confer**
  - DTLL on 9/15/17
  - Listening session held in September
  - Next listening session scheduled for October 18
  - Comments due 10/31/17
- **3 Strategic Plan Goals**
  1. To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/ANs;
  2. Promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and
  3. Strengthen IHS program management and operations.

Legislation in 115th Congress

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Legislation in 115th Congress

- Appropriations for FY 2018
- Disaster Tax Relief and Airport and Airway Extension Act of 2017- Extends the SDPI (H.R. 3823)
- KIDS Act of 2017 (S.1827)
- Native Health and Wellness Act of 2017 (H.R. 3706)
- Native Health Access Improvement Act of 2017 (H.R. 3704)
- Restoring Accountability in the Indian Health Service Act of 2017 (S.1250)
- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545)
- Independent Outside Audit of the Indian Health Service Act of 2017 (S.465)
- Drug Free Indian Health Service Act of 2017 (H.R. 3096)
- Tribal Veterans Health Care Enhancement Act (S.304)
- IHS Advanced Appropriations Act of 2017 (H.R. 235)

Indian Legislative Bills in 115th Congress

- Appropriations for FY 2018
  - Indian Health Service Budget
    - Senate Appropriations Subcommittee for Interior, Environment and Related Agencies to Markup Indian Health Service Budget week of October 16.
    - House bill (discussed in earlier slide).
  - Secretary's Minority AIDS Initiative Fund (SMAIF)
    - Senate Appropriations Committee for Labor HHS Education and Related Agencies included $53.9 million for SMAIF.
    - No funding in House Appropriations Committee bill.
    - $3.6 million to IHS; over $1m to NPAIHB in FY 2017.
  - Public Health Training Centers
    - Senate Appropriations Committee for Labor HHS Education and Related Agencies included level funding
    - No funding in House Appropriations Committee bill.
    - $50k to NPAIHB in FY 2017 through NWPHTC.

Indian Legislative Bills in 115th Congress

- Disaster Tax Relief and Airport and Airway Extension Act of 2017 (H.R. 3823)
  - Introduced by Rep. Kevin Brady (R-TX-8) on 9/25/2017
  - Extends several public health programs including SDPI.
  - Includes $37,500,000 for SDPI for the first quarter of FY 2018 – extends SDPI to 12/31/17.
  - Referred to the House Ways and Means Committee, the Committees on Transportation and Infrastructure, the Energy and Commerce Committee, the Financial Services Committee, and the Budget Committee on 9/25/2017.
  - 9/28/17: Passed in the House and passed in the Senate with an amendment; House agreed to amendment without action.
  - 9/29/17: Signed into law by the President.

Indian Legislative Bills in 115th Congress

- KIDS Act of 2017 (S.1827)
  - Introduced by Sen. Orrin Hatch (R-UT) on 9/18/2017
  - 5 year funding extension for CHIP (2022).
  - Referred to the Senate Committee on Finance on 9/18/2017
  - Committee hearing on October 4, 2017.

Indian Legislative Bills in 115th Congress

- Native Health and Wellness Act of 2017 (H.R. 3706)
  - Introduced by Rep. Raul Ruiz (D-CA-36) and co-sponsored by Rep. Frank Pallone Jr. (D-NJ-6) on 9/07/2017
  - Creates a tribal health block grant.
  - Creates a grant program to recruit and mentor AI/AN youth and young adults.
  - Referred to the House Energy and Commerce Committee on 9/07/2017

Indian Legislative Bills in 115th Congress

- Native Health Access Improvement Act of 2017 (H.R. 3704)
  - Introduced by Rep. Frank Pallone, Jr. (D-NJ-6) and co-sponsored by Rep. Raul Ruiz (D-CA-36) on 9/07/2017.
  - Establishes a grant program similar to the SDPI to increase access to substance abuse prevention and behavioral heath services for Tribes and Urban Indians.
  - Referred to the Energy and Commerce Committee as well as to the Committee on Natural Resources and Ways and Means Committee on 9/07/2017.
  - Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs within the Committee on Natural Resources on 9/13/2017

Indian Legislative Bills in 115th Congress

- Native American Suicide Prevention Act of 2017 (H.R. 3473)
  - Introduced by Rep. Raul Grijalva (D-AZ-3) on 7/27/2017.
  - Requires States and their designees receiving grants for development and implementation of statewide suicide and early intervention and prevention strategies to collaborate with Tribes.
  - Referred to the House Energy and Commerce Committee on 7/27/2017.
  - Referred to the Subcommittee on Health under the Energy and Commerce Committee on 7/28/2017.

Indian Legislative Bills in 115th Congress

- Drug-Free Indian Health Service Act of 2017 (H.R. 3096)
  - Introduced by Rep. Kristi Noem (R-SD) on 6/28/17; no other co-sponsors.
  - To implement a mandatory random drug testing program for certain employees of the Indian Health Service, and for other purposes.
  - 6/28/17: Referred to Committee on Natural Resources and Committee on Energy and Commerce.

Indian Legislative Bills in 115th Congress

- Restoring Accountability in the Indian Health Service Act of 2017 (S. 1250 & H.R. 2662)
  - Senate and House bills Introduced by Sen. John Barasso (R-WY) and Rep. Kristi Noem (R-SD) on 5/25/17, respectively.
  - This bill attempts to address quality of care issues occurring at some IHS-operated hospitals in the Great Plains Area and elsewhere.
  - 5/25/17: Referred to House Senate and House Committees.
  - S. 1250- 6/13/17: Senate hearings were held.
  - H.R. 2662- 6/21/17: House Subcommittee hearing was held; Chairman Andy Joseph, Jr. testified.

Indian Legislative Bills in 115th Congress

- Trauma Informed Care for Children and Families Act of 2017 (S. 774 & H.R. 1757)
  - Senate and House bills introduced by Sen. Heitkamp (D-ND) on 3/29/17 and by Rep. Davis (D-IL) on 3/28/17, respectively.
  - 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:
      - 3/28/17- Referred to House Committees on Education and the Workforce, Energy and Commerce Subcommittee on Health, and Ways and Means; and
      - 4/12/17- Referred to Subcommittee on Crime, Terrorism, Homeland Security, and Investigations.

Indian Legislative Bills in 115th Congress

- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545
  - Senate bill introduced by Sen. Tom Udall (D-NM) on 3/28/17; and House bill introduced by Rep. Norma Torres (D-CA) on 5/18/17 and has 13 co-sponsors.
  - $150 million for FY 2018; and
  - Reauthorizes the Special Diabetes Program for Indians (SDPI) for FY 2018 at $150m; and
  - FY 2019-FY 2024 increase annually using medical inflation rate.
  - S. 747 - 3/28/17: Referred to Committee on Health, Education, Labor and Pensions.
  - H.R. 2545 - 5/19/17: Referred to House Energy and Commerce on Health.

Indian Legislative Bills in 115th Congress

- Independent Outside Audit of the Indian Health Service Act of 2017 (S. 465)
  - 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
- **Separate Note**: Rep. Greg Walden (R-OR) has created 14 member Bipartisan IHS Task Force.

Indian Legislative Bills in 115th Congress

- Tribal Veterans Health Care Enhancement Act (S. 304)
  - 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.
  - 6/15/17: Committee recommended that bill pass.
  - 6/15/17: Committee created a report to accompany S.304.

National & Regional Meetings

27

HHS Secretary's Tribal Advisory Committee (STAC)

- Last meeting was on September 21-22, 2017 in the Cherokee Nation; and December STAC meeting is cancelled.
- The next meeting will be January 17-18, 2018.
- Annual Tribal Budget Consultation proposed date is March 8-9, 2018.
- At September meeting, several requests were made to Secretary Price:
  - Honor Tribal Consultation and Government-to-Government relationship and hold all HHS agencies accountable to HHS Consultation policy.
  - Importance of Tribal Advisory Committees (TACs) and tribal/federal workgroups
  - Opioid crisis in Indian Country: need for a federal/tribal workgroup to track funding and resources from states to tribes
  - Provide Continued Support for Special Diabetes Program for Indians
  - Improving the healthcare workforce recruitment and retention in Indian Country.
  - Maintain Medicaid expansion for AI/AN and 100% FMAP
  - Tribal exemption from Medicaid 1115 demonstration waiver work and enrollment requirements
  - Getting Area Directors approved

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) –last face-to-face meeting was on August 22, 2017; last conference call was on July 19;
  - Next conference call is October 10, 2017; and the next face-to-face meeting is on October 31, 2017.
- CMS TTAG – last face-to-face meeting was August 23-24, 2017; last conference call was on June 29;
  - Next conference call is on October 11, 2017; and the next TTAG face-to-face meeting is November 1-2,2017

TTAG Issues

- Medicare Diabetes Prevention Program (MDPP)
- Medicare
- New Medicare Card Project
- 1115 Demonstration Waivers

MMPC Issues

- VA Roundtable: Reimbursement Agreements
- 100% FMAP/4 Walls Issue
- Future of RPMS
- MACRA Merit-based Incentive Payment System (MIPS)
- 1332 demonstration waivers and preservation of Indian cost sharing reductions

Discussion?

NPAIHB Roster of Pending Federal Healthcare Regulations, Legislation, and Submitted Comments
10/2/2017

Title/Agency Action/Regulation Link	Agency release date; due date for comments	Agency's Summary of Action	Notes:
PRIORITY REGULATIONS			
340B Drug Pricing Program Ceiling Price and Manufacturer Civil Monetary Penalties Regulation **AGENCY: HRSA** **Final rule; further delay of effective date**	Published: 9/29/2017 **Effective: 7/1/2018**	The Health Resources and Services Administration (HRSA) administers section 340B of the Public Health Service Act (PHSA), known as the ''340B Drug Pricing Program'' or the ''340B Program.'' HRSA published a final rule on January 5, 2017, that set forth the calculation of the ceiling price and application of civil monetary penalties. The final rule applied to all drug manufacturers that are required to make their drugs available to covered entities under the 340B Program. On August 21, 2017, HHS solicited comments on further delaying the effective date of the January 5, 2017, final rule to July 1, 2018 (82 FR 39553). HHS proposed this action to allow a more deliberate process of considering alternative and supplemental regulatory provisions and to allow for sufficient time for additional rulemaking. After consideration of the comments received on the proposed rule, HHS is delaying the effective date of the January 5, 2017, final rule, to July 1, 2018.	
HHS Draft Department Strategic Plan for FY 2018-2022 **AGENCY: HHS** https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-20613.pdf	Published: 9/27/2017 **Due Date: 10/26/2017**	The Department of Health and Human Services (HHS) is seeking public comment on its draft Strategic Plan for Fiscal Years 2018–2022. This document articulates how the Department will achieve its mission through five strategic goals. These five strategic goals are (1) Reform, Strengthen, and Modernize the Nation's Health Care System, (2) Protect the Health of Americans Where They Live, Learn, Work, and Play, (3) Strengthen the Economic and Social Well-Being of Americans across the Lifespan, (4) Foster Sound, Sustained Advances in Sciences, and (5) Promote Effective and Efficient Management and Stewardship. Each goal is supported by objectives and strategies. https://www.hhs.gov/ about/strategic-plan/index.html	 hhs-draft-strategic-plan-fy2018-2022.pc
Request for Public Comment: 60 Day Notice for Extension of Fast Track Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery: IHS Customer Service Satisfaction and Similar	Published: 9/27/2017 **Due Date: 11/27/2017**	Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery: IHS Customer Service Satisfaction and Similar Surveys. Type of Information Collection Request: Three year extension approval of this information collection.	

Surveys **AGENCY: IHS** **Request for Comments and Request for Extension of Approval** https://www.gpo.gov/fdsys/pkg/FR-2017-09-27/pdf/2017-20606.pdf		The proposed information collection activity provides a means to garner qualitative customer and stakeholder feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving service delivery. Qualitative feedback is information that provides useful insights on perceptions and opinions, but is not statistical surveys that yield quantitative results that can be generalized to the population of study. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. These collections will allow for ongoing, collaborative and actionable communications between the Agency and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management. The solicitation of feedback will target areas such as: Timeliness, appropriateness, accuracy of information, courtesy, efficiency of service delivery, and resolution of issues with service delivery. Responses will be assessed to plan and inform efforts to improve or maintain the quality of service offered to the public. If this information is not collected, vital feedback from customers and stakeholders on the agency's services will be unavailable.	
CMS Innovation Center New Direction Request for Information (RFI) **AGENCY: CMS** https://innovation.cms.gov/initiatives/direction/ https://innovation.cms.gov/Files/x/newdirection-rfi.pdf	Published: 9/20/2017 **Due Date: 11/20/2017**	One of the most important goals at CMS is fostering an affordable, accessible healthcare system that puts patients first. Through this informal Request for Information (RFI) the CMS Innovation Center (Innovation Center) is seeking your feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The Innovation Center welcomes stakeholder input on the ideas included here, on additional ideas and concepts, and on the future direction of the Innovation Center. While existing partnerships with healthcare providers, clinicians, states, payers and stakeholders have generated important value and lessons, CMS is setting a new direction for the Innovation Center. We will carefully evaluate how models developed consistent with the new directions can complement what we are learning from the existing	Submit comments online: https://survey.max.gov/429625 Email comments: CMMI_NewDirection@cms.hhs.gov

		initiatives. In particular, the Innovation Center is interested in testing models in the following eight focus areas: 1. Increased participation in Advanced Alternative Payment Models (APMs); 2. Consumer-Directed Care & Market-Based Innovation Models; 3. Physician Specialty Models; 4. Prescription Drug Models; 5. Medicare Advantage (MA) Innovation Models; 6. State-Based and Local Innovation, including Medicaid-focused Models; 7. Mental and Behavioral Health Models; and 8. Program Integrity. However, the Innovation Center may also test models in other areas.	
Notice of Availability of Final Policy Document **AGENCY: HRSA** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-20/pdf/2017-19938.pdf	Published: 9/20/2017 **Effective: 8/28/2017**	The Health Center Program Compliance Manual (Compliance Manual) has been developed as a comprehensive, significantly streamlined, and web-based guidance document to assist health centers in understanding and demonstrating compliance with Health Center Program requirements. As such, this guidance document will reduce burden for current and prospective health centers and look-alikes and further strengthen HRSA's oversight of the Health Center and Health Center Federal Tort Claims Act (FTCA) Programs. It also responds to recommendations contained within the Government Accountability Office report, Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements, GAO–12–546, for increased transparency, clarity, and consistency in Health Center Program oversight. The Bureau of Primary Health Care (BPHC) released a draft Compliance Manual on August 23, 2016, for a 90-day public comment period. Individuals and groups submitted over 700 comments regarding the draft Compliance Manual. After thorough review and consideration of all comments received, HRSA made a substantial number of updates to the Compliance Manual to incorporate suggestions and requests for further clarification. HRSA Health Center Program Compliance Manual	
Proposed Data Collection Submitted for	Published:	This notice invites comment on a proposed information collection	

Public Comment and Recommendations; Effective Communication in Public Health Emergencies- Developing Community-Centered Tools for People with Special Health Care Needs **Docket No. CDC-2017-0071** **AGENCY: CDC** **Notice with comment period** https://www.gpo.gov/fdsys/pkg/FR-2017-09-20/pdf/2017-19959.pdf	9/20/2017 **Due Date: 11/20/2017**	project titled "Effective Communication in Public Health Emergencies—Developing Community-Centered Tools for People with Special Health Care Needs" Office of Public Health Preparedness and Response (OPHPR), Centers for Disease Control and Prevention (CDC). The data resulting from this study will be used to develop specific tools, protocols, and message templates that can be used for communicating during emergencies and disasters with families with CYSHCN and ASD. CDC plans to begin the information collection one month after OMB approval and continue for twenty two months.	
Solicitation of Nominations for Appointment to the Healthcare Infection Control Practices Advisory Committee (HICPAC) **AGENCY: CDC** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-18/pdf/2017-19743.pdf	Published: 9/18/2017 **Due Date: 11/30/2017**	The Centers for Disease Control and Prevention (CDC) is seeking nominations for membership on the HICPAC. The HICPAC consists of 14 experts in fields including but not limited to, infectious diseases, infection prevention, healthcare epidemiology, nursing, clinical microbiology, surgery, hospitalist medicine, internal medicine, epidemiology, health policy, health services research, public health, and related medical fields. Nominations are being sought for individuals who have expertise and qualifications necessary to contribute to the accomplishments of the committee's objectives. Nominees will be selected based on expertise in the fields of infectious diseases, infection prevention, healthcare epidemiology, nursing, environmental and clinical microbiology, surgery, internal medicine, epidemiology, health policy, health services research, and public health. Federal employees will not be considered for membership. Members may be invited to serve for four-year terms.	
Agency Information Collection: State Medicaid HIT Plan and Limitations on Provider Related Donations and Health Care Related Taxes. **AGENCY: CMS** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-18/pdf/2017-19787.pdf	Published: 9/18/2017 **Due Date: 10/18/2017**	1. Extension of a currently approved collection; Title of Information Collection: State Medicaid HIT Plan, Planning Advance Planning Document, and Implementation Advance Planning Document for Section 4201 of the Recovery Act; Use: To assess the appropriateness of state requests for the administrative Federal financial participation for expenditures under their Medicaid Electronic Health Record Incentive Program related to health information exchange, our staff will review the submitted information and documentation to make an approval determination of the state advance planning document. Form Number: CMS–	

		10292 2. Extension of a currently approved collection; Title of Information Collection: Limitations on Provider Related Donations and Health Care Related Taxes; Limitation on Payment to Disproportionate Share Hospitals; Medicaid and Supporting Regulations; Use: States may request a waiver of the broad based and uniformity tax program requirements. Each state must demonstrate that its tax program(s) do not violate the hold harmless provision. Additionally, state Medicaid agencies must report (quarterly) on health care related taxes collected and the source of provider related donations received by the state or unit of local government. Each state must maintain, in readily reviewable form, supporting documentation that provides a detailed description of each donation and tax program being reported, as well as the source and use of all donations received and collected. Without this information, the amount of Federal financial participation payable to a state cannot be determined; Form Number: CMS–R–148.	
Agency Information Collection: CMS-437 Psychiatric Unit Criteria Work Sheet and CMS-10515 Payment Collections Operations Contingency Plan **AGENCY: CMS** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-18/pdf/2017-19795.pdf	Published: 9/18/2017 **Due Date: 11/17/2017**	1. Reinstatement with Change of a currently approved collection; Title of Information Collection: Psychiatric Unit Criteria Work Sheet; Use: Certain specialty hospitals and hospital specialty distinct-part units may be excluded from the Inpatient Medicare Prospective Payment System (IPPS) and be paid at a different rate. These specialty hospitals and distinct-part units of hospitals include Inpatient Rehabilitation Facilities (IRFs) units, Inpatient Rehabilitation Facilities (IRFs) hospitals and Inpatient Psychiatric Facilities (IPFs). 2. Extension of a currently approved collection; Title of Information Collection: Payment Collections Operations Contingency Plan; Use: Section 1402 of the PPACA provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange, and section 1412 of the PPACA provides for the advance payment of these reductions to issuers. The data collection will be used by HHS to make payments or collect charges from SBE issuers under the following programs: advance payments of the premium tax credit, advanced cost-sharing reductions, and Exchange user fees. The workbook template was used to make payments in January 2014 and will continue through December 2020, as may be	

		required based on HHS's operational progress. Form Number: CMS–10515	
Social Security Ruling, SSR 17-3pl Titles II and XVI: Evaluating Cases Involving Sickle Cell Disease (SCD) **AGENCY: Social Security Administration** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-15/pdf/2017-19551.pdf	Published: 9/15/2017 **Effective: 9/15/2017**	We consider all medical evidence when we evaluate a claim for disability benefits. The following information is in a question and answer format that provides guidance about SCD and how to consider evidence regarding this impairment. Questions 1 and 2 provide basic background information about SCD and its variants. Question 3 clarifies that sickle cell trait is not a variant of SCD. Question 4 discusses the complications and symptoms of SCD.	
Agency Information Collection; Medicare Geographic Classification Review Board Procedures and Disclosure Requirement for the IN-Office Ancillary Services Exception **AGENCY: CMS** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-15/pdf/2017-19521.pdf	Published: 9/15/2017 **Due Date: 10/16/2017**	1. Extension of a currently approved collection; Title of Information Collection: Medicare Geographic Classification Review Board Procedures and Criteria; Use: During the first few years of IPPS, hospitals were paid strictly based on their physical geographic location concerning the wage index (Metropolitan Statistical Areas (MSAs)) and the standardized amount (rural, other urban, or large urban). However, a growing number of hospitals became concerned that their payment rates were not providing accurate compensation. The hospitals argued that they were not competing with the hospitals in their own geographic area, but instead that they were competing with hospitals in neighboring geographic areas. At that point, Congress enacted Section 1886(d)(10) of the Act which enabled hospitals to apply to be considered part of neighboring geographic areas for payment purposes based on certain criteria. The application and decision process is administered by the MGCRB which is not a part of CMS so that CMS could not be accused of any untoward action. However, CMS needs to remain apprised of any potential payment changes. 2. Extension of a currently approved collection; Title of Information Collection: Disclosure Requirement for the In-Office Ancillary Services Exception; Use: Section 6003 of the ACA established a disclosure requirement for the in-office ancillary services exception to the prohibition of physician self-referral for certain imaging services. This section of the ACA amended section 1877(b)(2) of the Social Security Act by adding a requirement that the referring	

		physician informs the patient, at the time of the referral and in writing, that the patient may receive the imaging service from another supplier.	
Agency Information Collection; Project: Biannual Infrastructure Development Measures for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination Implementation (SYT–I) and Adolescent and Transitional Aged Youth Treatment Implementation **AGENCY: SAMHSA** https://www.gpo.gov/fdsys/pkg/FR-2017-09-12/pdf/2017-19251.pdf	Published: 9/12/2017 **Due Date: 10/12/2017**	The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment has developed a set of infrastructure development measures in which recipients of cooperative agreements will report on various benchmarks on a semi-annual basis. The infrastructure development measures are designed to collect information at the state-level and site-level. The projects were previously named State Adolescent Treatment Enhancement and Dissemination (SAT– ED) and State Youth Treatment Enhancement and Dissemination (SYT– ED) Programs and are now called State Adolescent And Transitional Aged Youth Treatment Enhancement and Dissemination Implementation (SYT–I) and Adolescent and Transitional Aged Youth Treatment Implementation (YT–I) Programs. No changes have been made to the Biannual Infrastructure Development Measures Report. The only revision to the biannual progress report is due to the decrease in the number of respondents. The infrastructure development measures are based on the programmatic requirements. The purpose of this program is to provide funding to States/Territories/ Tribes to improve treatment for adolescents and transitional age youth through the development of a learning laboratory with collaborating local community-based treatment provider sites.	
Medicare Program; Recognition of Revised NAIC Model Standards for Regulation of Medicare Supplemental Insurance **AGENCY: CMS** https://www.gpo.gov/fdsys/pkg/FR-2017-09-01/pdf/2017-18605.pdf	Published: 9/1/2017 **Effective: 1/1/2020**	This notice announces the changes made by the Medicare Access and CHIP Reauthorization of 2015 (MACRA) to section 1882 of the Social Security Act (the Act), which governs Medicare supplemental insurance. This notice also recognizes that the Model Regulation adopted by the National Association of Insurance Commissioners (NAIC) on August 29, 2016, is considered to be the applicable NAIC Model Regulation for purposes of section 1882 of the Act, subject to our clarifications that are set forth in this notice.	
Cost-Based and Inter-Agency Billing Rates for Medical Care or Services Provided by the VA	Published: 8/29/2017	Updates the Cost-Based and Inter-Agency billing rates for medical care or services provided by the Department of Veterans Affairs (VA) that	

AGENCY: VA https://www.gpo.gov/fdsys/pkg/FR-2017-08-29/pdf/2017-18219.pdf	**Effective: 8/29/2017**	apply in certain circumstances. Inter-Agency rates apply to medical care and services that are provided by VA to beneficiaries of the Department of Defense (DoD) or other Federal agencies, when the care or services provided is not covered by an applicable sharing agreement, unless otherwise stated. The calculations for the Cost-Based and Inter-Agency rates are the same with two exceptions. Inter-Agency rates are all-inclusive, and are not broken down into three components (Physician; Ancillary; and Nursing, Room and Board), and Inter-Agency rates do not include standard fringe benefit costs that cover government employee retirement, disability costs, and return on fixed assets. When VA pays for medical care or services from a non-VA source under circumstances in which the Cost-Based or Inter-Agency Rates would apply if the care or services had been provided by VA, the charge for such care or services will be the actual amount paid by VA for the care or services. Inpatient charges will be at the per diem rates shown for the type of bed section or discrete treatment unit providing the care.	
Agency Information Collection; To Advance State, Tribal, Local and Territorial Governmental Agency and System Performance, Capacity, and Program Delivery. CDC is requesting a 3 year approval **AGENCY: CDC** https://www.gpo.gov/fdsys/pkg/FR-2017-08-25/pdf/2017-18035.pdf	Published: 8/25/2017	Information Collections to Advance State, Tribal, Local and Territorial (STLT) Governmental Agency and System Performance, Capacity, and Program Delivery. CDC is requesting a three-year approval for a generic clearance to collect information related to domestic public health issues and services that affect and/or involve state, tribal, local and territorial (STLT) government entities. CDC and HHS seek to accomplish its mission by collaborating with partners throughout the nation and the world to: Monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training	
Eligibility for Supplemental Service-Disabled Veterans' Insurance **AGENCY: VA** **Proposed Rule** https://www.gpo.gov/fdsys/pkg/FR-	Published: 8/23/2017 **Due Date: 10/23/2017**	The Department of Veterans Affairs (VA) proposes to amend its regulations governing the Service Disabled Veterans' Insurance (S–DVI) program in order to explain that a person who was granted S–DVI as of the date of death under is not eligible for supplemental S–DVI because the insured's total disability did not begin after the date of the insured's application for insurance and while the insurance was in force under	

2017-08-23/pdf/2017-17587.pdf		premium paying conditions. Under 38 U.S.C. 1922(a), a veteran ''suffering from a disability or disabilities for which compensation would be payable if 10 per centum or more in degree and except for which such person would be insurable according to the standards of good health'' is eligible for S–DVI up to a maximum of $10,000 upon ''application in writing made within two years from the date service connection of such disability is determined by the Secretary and payment of premiums as provided in this subchapter.'' A grant of supplemental S–DVI is precluded if S– DVI was granted under section 1922(b). This would reflect the Veterans Court's conclusion that the insured cannot qualify for a waiver of premiums under 38 U.S.C. 1912(a) because the insured's total disability did not begin after the date of the insured's application for insurance and while the insurance was in force under premium-paying conditions.	
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices **AGENCY: CMS** **Final Rule** https://www.gpo.gov/fdsys/pkg/FR-	Published: 8/14/2017 **Effective: 10/1/2017**	CMS is revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2018. Some of these changes implement certain statutory provisions contained in the Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013, the Improving Medicare Post-Acute Care Transformation Act of 2014, the Medicare Access and CHIP Reauthorization Act of 2015, the 21st Century Cures Act, and other legislation. CMS is also are making changes relating to the provider-based status of Indian Health Service (IHS) and Tribal facilities and organizations and to the low-volume hospital payment adjustment for hospitals operated by the IHS or a Tribe. In addition, we are providing the market basket update that will apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2018. CMS is updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2018.	 Final Medicare IPPS_FY 2018_Grand It doesn't appear that any of our comments were accepted. But for several comments CMS has stated that they will consider for future rulemaking.

2017-08-14/pdf/2017-16434.pdf			
		DEAR TRIBAL LEADER LETTERS	
IHS Tribal Consultation and Urban Confer on the IHS Strategic Plan https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/58653-1_IHS_StrategicPlan_09152017.pdf	Published: 9/15/2017 **Due Date: 10/31/2017**	IHS is initiating a Tribal Consultation and Urban Confer on the IHS Strategic Plan. IHS is beginning a process for the development of a 5-year IHS Strategic Plan 2018-2022. This coincides with the development of the HHS Strategic Plan for 2018-2022. IHS Strategic Plan Consultation Timeline and Draft Framework for IHS Mission, Goals, and Objectives	Listening Session scheduled for Wednesday, October 18 3:00-4:00PM ET
IHS is Accepting Applications for the Small Ambulatory Program https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/58580-1_DTLL_SAP_OEHE_08252017.pdf	Published: 8/25/2017 **Due Date: 12/1/2017**	The fiscal year (FY) 2017 budget includes $5 million for the Small Ambulatory Program (SAP). The Indian Health Service (IHS) is accepting applications for the SAP. The authorization for the SAP is in Title 25 U.S.C. Section 1636. Under the SAP, American Indian and Alaska Native Tribes or Tribal organizations who are operating an Indian health care facility pursuant to a health care services contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, may competitively obtain funding for the construction, expansion, or modernization of small ambulatory health care facilities. If your Tribe is interested in participating in the FY 2017 SAP, please download and complete the application available online at https://www.ihs.gov/dfpc/ or http://www.fedbizopps.gov by December 1, 2017.	
		FUNDING OPPORTUNITIES	
Native Elder Abuse Innovation Awards 2018 **National Indigenous Elder Justice Initiative**	**Published: 9/15/2017** **Due Date: 11/14/2017**	These grants are intended to provide American Indian Tribes, Alaskan Natives, and Native Hawaiians with funds to focus on awareness, policy development, and infrastructure building for reporting, investigation, and intervention of elder abuse and neglect for Indigenous elders or other innovative elder abuse projects. NIEJI Innovation plans to award	

https://www.nieji.org/innovation-grant/awards	**Award Notification: 1/2/2018**	between 8-12 awards, up to $20,000 to each grantee.	
Zero Suicide Initiative Support **IHS Division of Behavioral Health; Office of Clinical and Preventative Services** https://www.gpo.gov/fdsys/pkg/FR-2017-08-21/pdf/2017-17599.pdf	**Published: 8/21/2017** **Due Date: 10/12/2017** **Start Date: 11/1/2017**	The Indian Health Service (IHS), Office of Clinical and Preventive Service, Division of Behavioral Health (DBH), is accepting applications for cooperative agreements for Zero Suicide Initiative (ZSI)—to develop a comprehensive model of culturally informed suicide care within a system of care framework. This program was first established by the Consolidated Appropriations Act of 2017, Public Law 115–31, 131 Stat. 135 (2017). The purpose of this cooperative agreement is to improve the system of care for those at risk for suicide by implementing a comprehensive, culturally informed, multi-setting approach to suicide prevention in Indian health systems. This award represents a continuation of IHS's efforts to implement the Zero Suicide approach in Indian Country. Existing efforts have focused on training, technical assistance, and consultation for several 'pilot' AI/AN Zero Suicide communities. As a result of these efforts, both the unique opportunities and challenges of implementing Zero Suicide in Indian Country have been identified. The total amount of funding identified for the current fiscal year (FY) 2018 is approximately $2,000,000. Individual award amounts are anticipated to be approximately $400,000. The amount of funding available for non-competing and continuation awards issued under this announcement is subject to the availability of appropriations and budgetary priorities of the Agency. IHS is under no obligation to make awards that are selected for funding under this announcement. Approximately five (5) awards will be issued under this program announcement. Project Period The project period is for three years and will run consecutively from November 1, 2017, to October 31, 2020.	

NPAIHB Roster of Pending Federal Healthcare Regulations, Legislation, and Submitted Comments
9/28/2017

		115th CONGRESS LEGISLATION	
H.R. 3823 Disaster Tax Relief and Airport and Airway Extension Act Sec. 301 Extension of Certain Public Health Programs - SDPI **House Ways and Means Committee** **House Transportation and Infrastructure Committee** **House Energy and Commerce Committee** **House Committee on Financial Services** **House Budget Committee** **Sponsor: Rep. Kevin Brady (R-TX-8)** https://www.congress.gov/bill/115th-congress/house-bill/3823/text?q=%7B%22search%22%3A%5B%22HR+3823%22%5D%7D&r=1	Introduced: 9/25/2017	To amend title 49, United States Code, to extend authorizations for the airport improvement program, to amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, to provide disaster tax relief, and for other purposes. EXTENSION OF SPECIAL DIABETES PROGRAM FOR INDIANS.—Section 330C(c)(2) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)) is amended—	2 cosponsors Not agreed to in House Roll Call: 245-171
S. 1827 KIDS Act of 2017 **Senate Finance Committee** **Sponsor: Sen. Orrin Hatch (R-UT)** https://www.congress.gov/bill/115th-congress/senate-bill/1827/text?q=%7B%22search%22%3A%5B%22S+1827%22%5D%7D&r=1	Introduced 9/18/2017	To extend funding for the Children's Health Insurance Program, and for other purposes. SEC.2. FIVE_YEAR FUNDING EXTENSION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM (21) for fiscal year 2018, $21,500,000,000; "(22) for fiscal year 2019, $22,600,000,000; "(23) for fiscal year 2020, $23,700,000,000; "(24) for fiscal year 2021, $24,800,000,000; and "(25) for fiscal year 2022, for purposes of making 2 semi-annual allotments— "(A) $2,850,000,000 for the period beginning on October 1, 2021, and ending on March 31, 2022; and "(B) $2,850,000,000 for the period beginning on April 1, 2022, and ending on September 30, 2022.".	

S.1804 Medicare For All **Senate Finance Committee** **Sponsor: Sen. Bernie Sanders (I-VT)** https://www.congress.gov/bill/115th-congress/senate-bill/1804/text?q=%7B%22search%22%3A%5B%22medicare+for+all%22%5D%7D&r=1	Introduced: 9/13/2017	To establish a Medicare-for-all national health insurance program. TITLE I—ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT Sec. 101. Establishment of the Universal Medicare Program. Sec. 102. Universal entitlement. Sec. 103. Freedom of choice. Sec. 104. Non-discrimination. Sec. 105. Enrollment. Sec. 106. Effective date of benefits. Sec. 107. Prohibition against duplicating coverage. TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE Sec. 201. Comprehensive benefits. Sec. 202. No cost-sharing. Sec. 203. Exclusions and limitations. Sec. 204. Coverage of long-term care services under Medicaid. Sec. 205. State standards. TITLE III—PROVIDER PARTICIPATION Sec. 301. Provider participation and standards. Sec. 302. Qualifications for providers. Sec. 303. Use of private contracts. TITLE IV—ADMINISTRATION Subtitle A—General Administration Provisions Sec. 401. Administration. Sec. 402. Consultation. Sec. 403. Regional administration. Sec. 404. Beneficiary ombudsman. Sec. 405. Complementary conduct of related health	

		programs. Subtitle B—Control Over Fraud And Abuse Sec. 411. Application of Federal sanctions to all fraud and abuse under Universal Medicare Program. TITLE V—QUALITY ASSESSMENT Sec. 501. Quality standards. Sec. 502. Addressing health care disparities. TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES Subtitle A—Budgeting Sec. 601. National health budget. Subtitle B—Payments To Providers Sec. 611. Payments to institutional and individual providers. Sec. 612. Ensuring accurate valuation of services under the Medicare physician fee schedule. Sec. 613. Office of primary health care. Sec. 614. Payments for prescription drugs and approved devices and equipment. TITLE VII—UNIVERSAL MEDICARE TRUST FUND Sec. 701. Universal Medicare Trust Fund. TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 Sec. 801. Prohibition of employee benefits duplicative of benefits under the Universal Medicare Program; coordination in case of workers' compensation. Sec. 802. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans. Sec. 803. Effective date of title. TITLE IX—ADDITIONAL CONFORMING AMENDMENTS	

		Sec. 901. Relationship to existing Federal health programs. Sec. 902. Sunset of provisions related to the State Exchanges. TITLE X—TRANSITION Subtitle A—Transitional Medicare Buy-In Option And Transitional Public Option Sec. 1001. Lowering the Medicare age. Sec. 1002. Establishment of the Medicare transition plan. Subtitle B—Transitional Medicare ReForMs Sec. 1011. Medicare protection against high out-of-pocket expenditures for fee-for-service benefits and elimination of parts A and B deductibles. Sec. 1012. Reduction in Medicare part D annual out-of-pocket threshold and elimination of cost-sharing above that threshold. Sec. 1013. Coverage of dental and vision services and hearing aids and examinations under Medicare part B. Sec. 1014. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities. TITLE XI—MISCELLANEOUS	
H.R. 3706 Native Health and Wellness Act of 2017 **House Energy and Commerce Committee** **Sponsor: Rep. Raul Ruiz (D-CA-36)** https://www.congress.gov/bill/115th-congress/house-bill/3706/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=38	Introduced: 9/7/2017	To amend the Public Health Service Act to improve the public health system in tribal communities and increase the number of American Indians and Alaska Natives pursuing health careers, and for other purposes. **"SEC. 317U. TRIBAL HEALTH BLOCK GRANT.** "(a) In General.—To the extent and in the amounts made available in advance by appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award a grant, in an amount determined pursuant to the formula developed under subsection (e), to each eligible Indian tribe or tribal organization for the purposes of promoting health,	1 cosponsor

		preventing disease, and reducing health disparities among American Indians and Alaska Natives. "(b) Consultation.—The Secretary shall carry out this section, including the development of the formula required by subsection (e), in consultation with eligible Indian tribes and tribal organizations. "(c) Eligibility.—To be eligible for a grant under this section for a fiscal year, an Indian tribe or tribal organization shall submit to the Secretary a plan at such time, in such manner, and containing such information as the Secretary may require. "(d) Use Of Funds.—Each grantee under this section shall use the grant funds— "(1) to establish or support preventive health service programs that facilitate the achievement of health-status goals; "(2) to establish or support public health services that reduce the prevalence of chronic disease among American Indians and Alaska Natives; or "(3) to strengthen public health infrastructure to facilitate the surveillance and response to infectious disease and foodborne illness outbreaks. "(e) Formula.—The Secretary shall develop a formula to be used in allocating the total amount of funds made available to carry out this section for a fiscal year among the eligible Indian tribes and tribal organizations. "(f) Reports.—Each grantee under this section shall submit reports at such time, in such manner, and containing such information as the Secretary may require. **"SEC. 779. RECRUITMENT AND MENTORING OF AMERICAN INDIAN AND ALASKA NATIVE YOUTH AND YOUNG ADULTS.** "(a) In General.—The Secretary shall make grants to Indian tribes and tribal organizations for the purpose of recruiting and mentoring American Indian and Alaska Native youth and young adults in health professions.	

		"(b) Use Of Funds.—An Indian tribe or tribal organization receiving a grant under subsection (a) shall use the grant funds— "(1) to expose American Indian and Alaska Native adolescent youth or young adults to health professions; "(2) to promote science education; "(3) to establish mentoring relationships between— "(A) American Indian and Alaska Native youth or young adults; and "(B) health professionals; "(4) to provide hands-on learning experiences in a health care setting; "(5) to establish partnerships with institutions of higher education (including tribal colleges), local educational agencies, and other community-based entities to develop a larger and more competitive applicant pool for health professional careers; or "(6) to provide counseling, mentoring, and other services designed to assist American Indian and Alaska Native youth or young adults in the pursuit of higher education with respect to health professions.	
H.R. 3704 Native Health Access Improvement Act of 2017 **House Energy and Commerce Committee** **House Natural Resources Committee** **House Ways and Means Committee** **Sponsor: Rep. Frank Pallone, Jr. (D-NJ-6)** https://www.congress.gov/bill/115th-congress/house-bill/3704/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=33	Introduced: 9/7/2017	To amend the Public Health Service Act to improve behavioral health outcomes for American Indians and Alaskan Natives, and for other purposes. **SEC. 506B. SPECIAL BEHAVIORAL HEALTH PROGRAM FOR INDIANS.** "(a) In General.—The Director of the Indian Health Service, in coordination with the Assistant Secretary for Mental Health and Substance Use, shall award grants for providing services in accordance with subsection (b) for the prevention and treatment of mental health and substance use disorders. "(b) Services Through Indian Health Facilities.—For purposes of subsection (a), services are provided in accordance with this subsection if the services are provided	1 cosponsor

		through any of the following entities: "(1) The Indian Health Service. "(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5301 et seq.). "(3) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.). "(c) Reports.—Each grantee under this section shall submit reports at such time, in such manner, and containing such information as the Director of the Indian Health Service may require. "(d) Technical Assistance Center.— "(1) ESTABLISHMENT.—The Director of the Indian Health Service, in coordination with the Assistant Secretary for Mental Health and Substance Use, shall establish a technical assistance center (directly or by contract or cooperative agreement)— "(A) to provide technical assistance to grantees under this section; and "(B) to collect and evaluate information on the program carried out under this section. "(2) CONSULTATION.—The technical assistance center shall consult with grantees under this section for purposes of developing evaluation measures and data submission requirements for purposes of the collection and evaluation of information under paragraph (1)(B). "(3) DATA SUBMISSION.—As a condition on receipt of a grant under this section, an applicant shall agree to submit data consistent with the data submission requirements developed under paragraph (2). "(e) Funding.— "(1) IN GENERAL.—For the purpose of making grants under	

		this section, there is authorized to be appropriated, and there is appropriated, out of any money in the Treasury not otherwise appropriated, $150,000,000 for each of fiscal years 2018 through 2022. "(2) TECHNICAL ASSISTANCE CENTER.—Of the amount made available to carry out this section for each of fiscal years 2018 through 2022, the Director of the Indian Health Service shall allocate a percentage of such amount, to be determined by the Director in consultation with Indian tribes, for the technical assistance center under subsection (d).	
H.R. 3473 **Native American Suicide Prevention Act of 2017** **House Energy and Commerce Committee** **Sponsor: Rep. Raul M. Grijalva (D-AZ-3)** https://www.congress.gov/bill/115th-congress/house-bill/3473/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=1	Introduced: 7/27/2017	To amend section 520E of the Public Health Service Act to require States and their designees receiving grants for development and implementation of statewide suicide early intervention and prevention strategies to collaborate with each Federally recognized Indian tribe, tribal organization, and urban Indian organization in the State.	
H.R. 3495 Opioid and Heroin Abuse Crisis Investment Act of 2017 **House Energy and Commerce Committee** **Sponsor: Rep. Ben Ray Lujan (D-NM-3)** https://www.congress.gov/bill/115th-congress/house-bill/3495/text?q=%7B%22search%22%3A%5B%22opioid%22%5D%7D&r=2	Introduced: 7/27/2017	To amend the 21st Century Cures Act to appropriate funds for the Account for the State Response to the Opioid Abuse Crisis through fiscal year 2023, and for other purposes. "(C) APPROPRIATIONS AFTER FISCAL YEAR 2018.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Account For the State Response to the Opioid Abuse Crisis $500,000,000 for each of fiscal years 2019 through 2023."; 	15 cosponsors

H.R. 3254 Heroin and Opioid Abuse Prevention and Treatment Act of 2017 **House Ways and Means Committee** **House Energy and Commerce Committee** **House Budget Committee** **Sponsor: Rep. Michelle Lujan Grisham (D-NM-1)** https://www.congress.gov/bill/115th-congress/house-bill/3254/text?q=%7B%22search%22%3A%5B%22opioid%22%5D%7D&r=3	Introduced: 7/14/2017	To amend the Internal Revenue Code to impose an excise tax on opioid manufacturers, to make the funds collected through such tax available for opioid (including heroin) abuse prevention and treatment programs, and for other purposes. **SEC. 3. GRANTS TO STATES FOR PREVENTION AND TREATMENT OF OPIOID (INCLUDING HEROIN) ABUSE.** (a) In General.—The Public Health Service Act is amended by inserting after section 399V–6 (42 U.S.C. 280g–17) the following new section: (b) **"SEC. 399V–7. PREVENTION AND TREATMENT OF OPIOID (INCLUDING HEROIN) ABUSE.** "(a) In General.—The Secretary shall provide— "(1) grants to States for research on opioids (including heroin); and "(2) grants to States for opioid abuse prevention and treatment, which may include— "(A) establishing new addiction treatment facilities for opioid addicts; "(B) establishing sober living facilities for recovering opioid addicts; "(C) recruiting and increasing reimbursement for certified mental health providers providing opioid abuse treatment in medically underserved communities or communities with high rates of opioid abuse; "(D) expanding access to long-term, residential treatment programs for opioid addicts and recovering addicts; "(E) establishing or operating support programs that offer employment services, housing, and other support services for recovering opioid addicts; "(F) establishing or operating housing for children whose parents are participating in opioid abuse treatment programs; "(G) establishing or operating facilities to provide care for babies born with neonatal abstinence syndrome;	4 cosponsors

		"(H) establishing or operating controlled opioid take-back programs; and "(I) other opioid abuse prevention and treatment programs, as the Secretary determines appropriate.	
H.R. 2662 Restoring Accountability in the Indian Health Service Act of 2017 **House Natural Resources Committee** **House Energy and Commerce Committee** **House Ways and Means Committee** **House Oversight and Government Reform Committee** **Sponsor: Rep. Kristi Noem (R-SD-At Large)** https://www.congress.gov/bill/115th-congress/house-bill/2662/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=24	Introduced: 5/25/2017	To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes. Sec. 1. Short title. Sec. 2. Table of contents. TITLE I—INDIAN HEALTH SERVICE IMPROVEMENTS Sec. 101. Incentives for recruitment and retention. Sec. 102. Medical credentialing system. Sec. 103. Liability protections for health professional volunteers at Indian Health Service. Sec. 104. Clarification regarding eligibility for Indian Health Service loan repayment program. Sec. 105. Improvements in hiring practices. Sec. 106. Removal or demotion of Indian Health Service employees based on performance or misconduct. Sec. 107. Standards to improve timeliness of care. Sec. 108. Tribal culture and history. Sec. 109. Staffing demonstration project. Sec. 110. Rule establishing tribal consultation policy. TITLE II—EMPLOYEE PROTECTIONS Sec. 201. Right of Federal employees to petition Congress. Sec. 202. Fiscal accountability. TITLE III—REPORTS Sec. 301. Definitions. Sec. 302. Reports by the Secretary of Health and Human Services.	8 cosponsors Related bill: S.1250 Restoring Accountability in the Indian Health Service Act of 2017 6/21/2017 Hearing held in the House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs

		Sec. 303. Reports by the Comptroller General. Sec. 304. Inspector General reports. Sec. 305. Transparency in CMS surveys.	
S. 1250 Restoring Accountability in the Indian Health Service Act of 2017 **Senate Committee on Indian Affairs** **Sponsor: Sen. John Barrasso (R-WY)** https://www.congress.gov/bill/115th-congress/senate-bill/1250/text?q=%7B%22search%22%3A%5B%22S+1250%22%5D%7D&r=1	Introduced: 5/25/2017	To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes. TITLE I—INDIAN HEALTH SERVICE IMPROVEMENTS Sec. 101. Incentives for recruitment and retention. Sec. 102. Medical credentialing system. Sec. 103. Liability protections for health professional volunteers at Indian Health Service. Sec. 104. Clarification regarding eligibility for Indian Health Service loan repayment program. Sec. 105. Improvements in hiring practices. Sec. 106. Removal or demotion of Indian Health Service employees based on performance or misconduct. Sec. 107. Standards to improve timeliness of care. Sec. 108. Tribal culture and history. Sec. 109. Staffing demonstration project. Sec. 110. Rule establishing tribal consultation policy. TITLE II—EMPLOYEE PROTECTIONS Sec. 201. Right of Federal employees to petition Congress. Sec. 202. Fiscal accountability. TITLE III—REPORTS Sec. 301. Definitions. Sec. 302. Reports by the Secretary of Health and Human Services. Sec. 303. Reports by the Comptroller General. Sec. 304. Inspector General reports. Sec. 305. Transparency in CMS surveys. TITLE IV—TECHNICAL AMENDMENTS	2 cosponsors Related bill: H.R. 2662 Restoring Accountability in the Indian Health Service Act of 2017 6/13/2017 Hearing held by the Senate Committee on Indian Affairs
H.R. 2545 **Special Diabetes Program for Indians Reauthorization Act of 2017**	Introduced: 5/18/2017	Referred to the Subcommittee on Health 5/19/2017 This Act may be cited as the “Special Diabetes Program for Indians Reauthorization Act of 2017 ”.	17 cosponsors

House Energy and Commerce Committee **Sponsor: Rep. Norma J. Torres (D-CA-35)** https://www.congress.gov/bill/115th-congress/house-bill/2545/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=7		Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended by striking paragraph (2) and inserting the following: "(2) APPROPRIATIONS.— "(A) IN GENERAL.—For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated— "(i) $150,000,000 for fiscal year 2018; and "(ii) the amount specified in subparagraph (B) for each of fiscal years 2019 through 2024.	
S. 747 Special Diabetes Program for Indians Reauthorization Act of 2017 **Senate Health, Education, Labor and Pensions Committee** **Sponsor: Sen. Tom Udall (D-NM)** https://www.congress.gov/bill/115th-congress/senate-bill/747/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=8	Introduced: 3/28/2017	This Act may be cited as the "Special Diabetes Program for Indians Reauthorization Act of 2017". Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended by striking paragraph (2) and inserting the following: "(2) APPROPRIATIONS.— "(A) IN GENERAL.—For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated— "(i) $150,000,000 for fiscal year 2018; and "(ii) the amount specified in subparagraph	Related Bills: H.R. 2545 Special Diabetes Program for Indians Reauthorization Act of 2017

		(B) for each of fiscal years 2019 through 2024.	
H.R. 1369 Indian Healthcare Improvement Act of 2017 **House Natural Resources Committee** **House Energy and Commerce Committee** **House Ways and Means Committee** **House Budget Committee** **Sponsor: Rep. Tom Cole (R-OK-4)**	Introduced: 3/6/2017	Sec. 101. Reauthorization. Sec. 102. Findings. Sec. 103. Declaration of national Indian health policy. Sec. 104. Definitions. Subtitle A—Indian Health Manpower Sec. 111. Community Health Aide Program. Sec. 112. Health professional chronic shortage demonstration programs. Sec. 113. Exemption from payment of certain fees. Subtitle B—Health Services Sec. 121. Indian Health Care Improvement Fund. Sec. 122. Catastrophic Health Emergency Fund. Sec. 123. Diabetes prevention, treatment, and control. Sec. 124. Other authority for provision of services; shared services for long-term care. Sec. 125. Reimbursement from certain third parties of costs of health services. Sec. 126. Crediting of reimbursements. Sec. 127. Behavioral health training and community education programs. Sec. 128. Cancer screenings. Sec. 129. Patient travel costs. Sec. 130. Epidemiology centers. Sec. 131. Indian youth grant program. Sec. 132. American Indians Into Psychology Program. Sec. 133. Prevention, control, and elimination of communicable and infectious diseases. Sec. 134. Methods to increase clinician recruitment and retention issues. Sec. 135. Liability for payment. Sec. 136. Offices of Indian Men's Health and Indian Women's Health. Sec. 137. Contract health service administration and disbursement formula. Subtitle C—Health Facilities Sec. 141. Health care facility priority system. Sec. 142. Priority of certain projects protected. Sec. 143. Indian health care delivery demonstration projects. Sec. 144. Tribal management of federally owned quarters. Sec. 145. Other funding, equipment, and supplies for facilities. Sec. 146. Indian country modular component facilities demonstration program. Sec. 147. Mobile health stations demonstration program. Subtitle D—Access To Health Services	

		Sec. 151. Treatment of payments under Social Security Act health benefits programs. Sec. 152. Purchasing health care coverage. Sec. 153. Grants to and contracts with the Service, Indian tribes, tribal organizations, and urban Indian organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs and other health benefits programs. Sec. 154. Sharing arrangements with Federal agencies. Sec. 155. Eligible Indian veteran services. Sec. 156. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services. Sec. 157. Access to Federal insurance. Sec. 158. General exceptions. Sec. 159. Navajo Nation Medicaid Agency feasibility study. Subtitle E—Health Services For Urban IndianS Sec. 161. Facilities renovation. Sec. 162. Treatment of certain demonstration projects. Sec. 163. Requirement to confer with urban Indian organizations. Sec. 164. Expanded program authority for urban Indian organizations. Sec. 165. Community health representatives. Sec. 166. Use of Federal Government facilities and sources of supply; health information technology. Subtitle F—Organizational Improvements Sec. 171. Establishment of the Indian Health Service as an agency of the Public Health Service. Sec. 172. Office of Direct Service Tribes. Sec. 173. Nevada area office. Subtitle G—Behavioral Health Programs Sec. 181. Behavioral health programs. Subtitle H—Miscellaneous Sec. 191. Confidentiality of medical quality assurance records; qualified immunity for participants. Sec. 192. Limitation on use of funds appropraited to the Indian Health Service. Sec. 193. Arizona, North Dakota, and South Dakota as contract health service delivery areas; eligibility of California Indians. Sec. 194. Methods to increase access to professionals of certain corps. Sec. 195. Health services for ineligible persons. Sec. 196. Annual budget submission. Sec. 197. Prescription drug monitoring. Sec. 198. Tribal health program option for cost sharing. Sec. 199. Disease and injury prevention report.	

		Sec. 200. Other GAO reports. Sec. 201. Traditional health care practices. Sec. 202. Director of HIV/AIDS Prevention and Treatment. TITLE II—AMENDMENTS TO OTHER ACTS AND MISCELLANEOUS PROVISIONS Sec. 201. Elimination of sunset for reimbursement for all Medicare part B services furnished by certain indian hospitals and clinics. Sec. 202. Including costs incurred by aids drug assistance programs and indian health service in providing prescription drugs toward the annual out-of-pocket threshold under part D. Sec. 203. Prohibition of use of Federal funds for abortion. Sec. 204. Reauthorization of Native Hawaiian health care programs.	
S.465 Independent Outside Audit of the Indian Health Service Act of 2017 **Senate Committee on Indian Affairs** **Sponsor: Sen. Mike Rounds (R-SD)** https://www.congress.gov/bill/115th-congress/senate-bill/465/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=19	Introduced: 2/28/2017	To provide for an independent outside audit of the Indian Health Service. (d) Areas Of Study.—Each assessment conducted under subsection (b) shall address each of the following: (1) Current and projected demographics and unique health care needs of the patient population served by the Service. (2) Current and projected health care capabilities and resources of the Service, including hospital care, medical services, and other health care furnished by non-Service facilities under contract with the Service, to provide timely and accessible care to eligible patients. (3) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Service facilities, including whether it is recommended that the Secretary have the authority to furnish such care and services at such facilities through the completion of episodes of care. (4) The appropriate systemwide access standard applicable to hospital care, medical services, and other health care furnished by and through the Service, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation. (5) The workflow process at each medical facility of the Service for scheduling appointments to receive hospital care, medical services, or other health care from the Service. (6) The organization, workflow processes, and tools used by the Service to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.	2 cosponsors

		(7) The staffing level at each medical facility of the Service and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following: (A) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week. (B) The time spent by such health care provider on matters other than the case load of such health care provider. (C) The amount of personnel used for administration compared with direct health care in the Service being comparable to the amount used for administration compared with direct health care in private health care institutions. (D) The allocation of the budget of the Service used for administration compared with the allocation of the budget used for direct health care at Service-operated facilities. (E) Any vacancies in positions of full-time equivalent employees that the Service— (i) does not intend to fill; or (ii) has not filled during the 12-month period beginning on the date on which the position became vacant. (F) The disposition of amounts budgeted for full-time equivalent employees that is not used for those employees because the positions of the employees are vacant, including— (i) whether the amounts are redeployed; and (ii) if the amounts are redeployed, how the redeployment is determined. (G) With respect to the approximately 3,700 Medicaid-reimbursable full-time equivalent employees of the Service— (i) the number of those employees who are certified coders; and (ii) whether that number of employees is necessary. (8) The information technology strategies of the Service with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by the Service, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Service in Service or non-Service facilities.	

		(9) Business processes of the Service, including processes relating to furnishing non-Service health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows: (A) To avoid the payment of penalties to vendors. (B) To increase the collection of amounts owed to the Service for hospital care, medical services, or other health care provided by the Service for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate. (C) To increase the collection of any other amounts owed to the Service with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate. (D) To increase the accuracy and timeliness of Service payments to vendors and providers. (10) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Service, including the following: (A) The prices paid for, standardization of, and use by the Service of, the following: (i) Pharmaceuticals. (ii) Medical and surgical supplies. (iii) Medical devices. (B) The use by the Service of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services. (C) The strategy and systems used by the Service to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to medical facilities of the Service. (11) The process of the Service for carrying out construction and maintenance projects at medical facilities of the Service and the medical facility leasing program of the Service, including— (A) whether the maintenance budget is updated or increased to reflect increases in maintenance costs with the addition of new facilities and whether any increase is sufficient to support the growth of the facilities; and (B) what the process is for facilities that reach the end of their proposed life cycle.	

		(12) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management, including— (A) the reasons for a lack in transparency in the culture of the Service, leading tribal leadership to request increased transparency and more open communication between the Service and the people served by the Service; and (B) whether any checks and balances exist to assess potential fraud or misuse of amounts within the Service. (13) The lack of a funding formula to distribute base funding to the 12 Service areas, including the following: (A) The establishment of the current process of funding being distributed based on historical allocations and not on need such as population growth, number of facilities, etc. (B) How the implementation of self-governance policies has impacted health care delivery. (C) The communication to area office directors on distribution decisionmaking. (D) How the tribal and residual shares are determined for each Indian tribe and the amounts of those shares. (E) The auditing or evaluation process used by the Service to determine whether amounts are distributed and expended appropriately, including— (i) whether periodic or end-of-year records document the actual distributions; and (ii) whether any auditing or evaluation is conducted in accordance with generally accepted accounting principles or other appropriate practices. (14) Whether the Service tracks patients eligible for two or more of either the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), health care received through the Service, or any other Federal health care program (referred to in this section as "dual eligible patients"). If so, how dual eligible patients are managed. (15) The number of procurement contracts entered into and awards made by the Service under section 23 of the Act of June 25, 1910 (commonly known as the "Buy Indian Act") (25 U.S.C. 47), and a comparison of that number, with—	

		(A) the total number of procurement contracts entered into and awards made by the Service during the 5 fiscal years prior to the date of enactment of this Act; and (B) the process used by the Service facilities to ensure compliance with section 23 of the Act of June 25, 1910 (commonly known as the "Buy Indian Act") (25 U.S.C. 47). (16) Any other items the reputable private entity determines should be addressed in the independent assessment of the Service.	
H.R. 235 Indian Health Service Advance Appropriations Act of 2017 **House Budget Committee** **House Natural Resources Committee** **House Energy and Commerce Committee** **Sponsor: Rep. Don Young (R-AK-At Large)** https://www.congress.gov/bill/115th-congress/house-bill/235/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=16	Introduced: 1/3/2017	To amend the Indian Health Care Improvement Act to authorize advance appropriations for the Indian Health Service by providing 2-fiscal-year budget authority, and for other purposes. **SEC. 2. ADVANCE APPROPRIATIONS FOR CERTAIN INDIAN HEALTH SERVICE ACCOUNTS.** (a) In General.—Section 825 of the Indian Health Care Improvement Act (25 U.S.C. 1680o) is amended— (1) by inserting "(a)" before "There are authorized"; and (2) by adding at the end the following: "(b) For each fiscal year, beginning with the first fiscal year that starts during the year after the year in which this subsection is enacted, discretionary new budget authority provided for the Indian Health Services and Indian Health Facilities accounts of the Indian Health Service shall include advance discretionary new budget authority that first becomes available for the first fiscal year after the budget year. "(c) The Secretary shall include in documents submitted to Congress in support of the President's budget submitted pursuant to section 1105 of title 31, United States Code, for each fiscal year to which subsection (b) applies detailed estimates of the funds necessary for the IndianHealth Services and Indian Health Facilities accounts of the Indian Health Service for the fiscal year following the fiscal year for which the budget is submitted.". (b) Submission Of Budget Request.—Section 1105(a) of title 31, United States Code, is amended by adding at the end the following new paragraph:	

		EXECUTIVE ORDERS & PRESIDENTIAL MEMORANDUMS	
Presidential Executive Order 13781 on a Comprehensive Plan for Reorganizing the Executive Branch https://www.gpo.gov/fdsys/pkg/FR-2017-03-16/pdf/2017-05399.pdf	Issued: 3/13/2017	• OMB, within 180 days after public comment, is to propose a plan to reorganize government functions and eliminate unnecessary agencies and agency programs • Each agency must submit a plan to the OMB director to reorganize the agency, if appropriate, in order to improve the efficiency, effectiveness, and accountability of that agency • OMB will publish a notice in the federal register inviting public comment to suggest improvements in the reorganization and functioning of the executive branch. • In developing OMB's plan, things that should be taken into consideration include: (i) whether some or all of the functions of an agency, a component, or a program are appropriate for the Federal Government or would be better left to State or local governments or to the private sector through free enterprise; (ii) whether some or all of the functions of an agency, a component, or a program are redundant, including with those of another agency, component, or program; (iii) whether certain administrative capabilities necessary for operating an agency, a component, or a program are redundant with those of another agency, component, or program; (iv) whether the costs of continuing to operate an agency, a component, or a program are justified by the public benefits it provides; and (v) the costs of shutting down or merging agencies, components, or programs, including the costs of addressing the equities of affected agency staff. **Recommendations:** Obviously our first concern is keeping IHS. Once the comment period happens, it's important to get notice out to Tribes quickly and get template comments out there asking for preservation of IHS. However we need to be careful about any other suggestions we might make to make the agency more accountable.	IHS will be holding All Tribes Calls prior to the final reform plan submission. https://www.whitehouse.gov/reorganizing-the-executive-branch Importance to head agencies with office of tribal affairs OMB Memo: provides agencies guidance to begin immediate actions to reduce the workforce and cost sayings (President's Budget); **submit an agency reform plan to OMB in September 2017.**

		The other thing to take into consideration is that IHS already has a plan to reorganize the agency to do just what this EO is proposing to do that was started under Mary Smith. It might be prudent to ask IHS to share that plan with Tribes so that they can support it in their recommendations and comments.	
COMMENTS SUBMITTED			
CDC Diabetes Prevention Recognition Program (DPRP) Notice Docket No. CDC-2017-0053	Published: 7/14/2017 **Submitted: 9/13/2017**	NPAIHB applauds the effort of CDC to recognize organizations that deliver preventative services to individuals diagnosed with pre-diabetes through the CDC DPRP. CDC must recognize that tribes do not have the infrastructure and capability to implement and monitor the CDC DPP without additional funding to support the operational and logistical components needed to participate. This program is labor intensive and requires a number of individuals to be key leaders as well as educators and alternates that are needed to increase support and beneficiary participation. NPAIHB and our member tribes recommend that CDC create another recognition path to grandfather SDPI programs using the SDPI measurement and reporting criteria through a CDC pilot project. NPAIHB and our member tribes believe that the CDC Diabetes Prevention Program (DPP) participation requirements are significant barriers for tribal health programs to pursue recognition, especially small community health centers in Indian Country. The program, in its current form, deters tribal health program participation and will not benefit tribal health programs. NPAIHB recommends that CDC work with IHS and tribes through meaningful tribal consultation to incorporate SDPI and tribal participation in the DPP. Additionally, NPAIHB would like to recommend for CDC to conduct an outreach and education initiative for SDPI and tribal health care programs to become CDC-recognized DPP organizations. NPAIHB is concerned about the 12-month data submission to CDC	

		because it is not applicable in our communities to collect the data when there is no support or funding within an already under-served health care community. The CDC recognition process can take up to two years to accomplish full CDC-recognition status. A majority of tribal health care programs are unaware of the process, the criteria, and the period of time it takes programs to become CDC-recognized. NPAIHB requests that I/T/U health programs not be required to coordinate with an additional federal agency to IHS regarding recognition. It is a burden for tribal health programs to report and participate in three different diabetes prevention recognition programs administered by three federal agencies under the U.S. Department of Health and Human Services (HHS). We request that CDC work with the SDPI programs and recipients to ensure there is alignment, consistency, and coordination of these programs to receive recognition and reimbursement for diabetes prevention services. NPAIHB recommends recognition of other health outcome measures for performance payment because weight loss does not provide an incentive, the goal should be to become a healthier Medicare beneficiary to prevent Type II diabetes. There are various successful evidence-based methods that can be utilized in addition to attendance as performance measures such as reductions in blood sugar levels, lower BMI levels, and increased intake of healthy foods and physical activity. NPAIHB recommends the utilization of measures that have been successful variables in the SDPI such as reductions in blood sugar levels, reduced hypertension risk, lower BMI levels, increased intake of healthy foods, increased rate of physical activity, or risk reduction factors should be used instead of weight loss. We also recommend that CDC include a mental health measurement as part of integrated care because behavioral health plays a significant role in changing lifestyle behaviors as well as achieving weight loss, especially in Indian Country where patients may struggle with historical trauma.	

		NPAIHB appreciates the opportunity to submit comments on the CDC DPRP. We note, however, that the public notice and comment period is not a substitute for Tribal consultation pursuant to the CDC Tribal Consultation Policy and Executive Order 13175.	
CMS Medicare Diabetes Prevention Program (MDPP) Proposed Rule CMS-1676-P	Published 7/21/2017 **Submitted: 9/11/2017**	NPAIHB and CRIHB believe that a 1-year core maintenance session is not a realistic time period to see lifestyle behavior changes and weight loss. NPAIHB and CRIHB applaud the effort of CMS to expand services delivered by community-based organizations to Medicare beneficiaries diagnosed with pre-diabetes through the MDPP. However, the structure of the MDPP is problematic with respect to I/T/Us participation. NPAIHB and CRIHB are pleased that CMS will not prevent beneficiaries who develop diabetes from receiving the MDPP services. However, NPAIHB, CRIHB, and our tribal members believe that the program should not be limited to individuals with pre-diabetes. Medicare beneficiaries who have already been diagnosed with diabetes need assistance and support as well. We recommend that Medicare beneficiaries with type II diabetes be included as eligible beneficiaries. NPAIHB and CRIHB recommend that CMS collaborate with SDPI and recipients to ensure there is alignment, collaboration, and consistency with program eligibility. NPAIHB and CRIHB and our member tribes are adamantly against the 5% weight loss goal. The 5% weight loss program participation requirement is a culturally insensitive measurement for AI/ANs. Weight loss alone does not adequately reflect the overall progress a participant is making toward lasting lifestyle changes and the prevention of diabetes. We recommend separate categories for weight loss goals for men and women. Along with the sedentary lifestyle and metabolism barriers, Native women struggle with weight loss more than Native men because of hormonal body changes and gradual lean muscle loss that come with age. We recommend that CMS also take into consideration medical conditions (ex. Thyroid cancer) of Medicare beneficiaries that	 Joint NPAIHB CRIHB Comment on MDPP

		could further limit the possibility to meet the 5% weight loss goal. These are factors that can put further restrictions on the types of Medicare beneficiary participants. NPAIHB and CRIHB would like to reiterate our recommendation that Tribal Health Programs be granted the flexibility to determine their own diabetes prevention measures of success. NPAIHB and CRIHB recommend revalidation of supplier enrollment every five years. NPAIHB and CRIHB would like to restate that the requirement for SDPI Diabetes Prevention (SDPI DP programs be recognized by the Centers for Disease Control and Prevention (CDC) to provide diabetes prevention (DPP) services in order to be eligible to apply for enrollment as a Medicare supplier is an unnecessary requirement. NPAIHB, CRIHB, and our member tribes believe that the MDPP participation requirements are significant barriers for Tribal Health Programs to pursue accreditation in the MDPP, especially small community health centers in Indian Country. The program, in its current form, deters tribal health program participation and will not benefit Tribal Health Programs. NPAIHB and CRIHB propose the creation of another path to grandfather SDPI program recognition using the SDPI measurement and reporting criteria through a CDC pilot project or CMS pilot project. NPAIHB and CRIHB recommend that CMS work with IHS and tribes through meaningful tribal consultation to incorporate SDPI and tribal participation in the MDPP. Additionally, NPAIHB and CRIHB would like to restate our recommendation for CMS and CDC to conduct an outreach and education initiative for SDPI and Tribal health care programs to become CDC-recognized Diabetes Prevention Program organizations in order to enroll in the MDPP beginning on April 1, 2018. NPAIHB and CRIHB support the proposal for MDPP lifestyle coaches to obtain an NPI number. The majority of SDPI programs are already designated as Medicare providers and will only have to obtain an NPI number for their lifestyle coaches. NPAIHB and CRIHB request that more trainings be available to become lifestyle coaches, especially in remote areas.	

		NPAIHB and CRIHB are concerned about the 12-month data submission to CDC because it is not applicable in our communities to collect the data when there is no support or funding within an already under-served health care community. NPAIHB and CRIHB recommend that CMS conduct a pilot program for currently operating SDPI Diabetes Prevention programs to be certified as grandfathered in to provide services and receive reimbursement through the MDPP. NPAIHB and CRIHB would like to reiterate that the request for I/T/U programs to not be required to coordinate with an additional federal agency, the CDC, regarding recognition. It is a burden for Tribal Health Programs to report and participate in three different federal agencies under the U.S. Department of Health and Human Services (HHS). Furthermore, while this proposed rule affects only the Medicare program, NPAIHB and CRIHB recommend implementation of a similar program for Medicaid. In the implementation of a Medicaid Diabetes Prevention Program model, NPAIHB and CRIHB would urge that a mechanism be developed to allow Federally Qualified Health Centers (FQHC) and IHS/Memorandum of Agreement (MOA) clinic providers to receive additional reimbursement outside of their all-inclusive rate when providing these preventive services. . NPAIHB and CRIHB applaud CMS efforts to include a performance category without the 5% weight loss. However, the total performance payment per beneficiary without the 5% weight loss is $125 compared to $810 for a beneficiary who meets the 5% weight loss goal. NPAIHB and CRIHB believe that the reimbursement for beneficiaries who do not meet the 5% weight loss is unacceptable and is not cost beneficial for Tribal Health Programs to participate. NPAIHB and CRIHB recommend increased performance payments per beneficiary who do not meet the 5% weight loss goal. We also recommend recognition of other health outcome measures for performance payment because weight loss does not provide an incentive, the goal should be to become a healthier Medicare beneficiary to prevent type II diabetes.	

		NPAIHB and CRIHB reiterate our recommendation to utilize measures that have been successful variables in the SDPI such as reductions in blood sugar levels, reduced hypertension risk, lower BMI levels, increased intake of healthy foods, increased rate of physical activity, or risk reduction factors should be used instead of weight loss. We also recommend that CMS include a mental health measurement as part of integrated care because behavioral health plays a significant role in changing lifestyle behaviors as well as achieving weight loss, especially in Indian Country where patients struggle with historical trauma in the community. NPAIHB and CRIHB applaud CMS efforts to include MDPP virtual make-up services through virtual service capabilities for reimbursement for Tribal health care programs with broadband capabilities. Tribal health programs that serve patients in rural geographic regions could increase patient access to the Medicare preventive diabetes services if virtual access is expanded. NPAIHB and CRIHB request that CMS provide related funding opportunities to address rural internet access and information technology infrastructure, which are often barriers for rural tribal health care organizations interested in providing virtual services. NPAIHB and CRIHB believe that the restrictions on incentives for participation should not be as limiting because incentives such as cooking classes and gym memberships, which may be more expensive than the monetary value outlined can be key incentives to adjust to a new lifestyle. NPAIHB and CRIHB appreciate the opportunity to submit comments on the Medicare Reimbursement Expansion of the Diabetes Prevention Program. We note, however, that the public notice and comment period is not a substitute for Tribal consultation pursuant to the CMS Tribal Consultation Policy and Executive Order 13175. NPAIHB and CRIHB urge CMS to engage in Tribal consultation with the	

		Indian Health Care system, including I/T/Us, prior to publication of a final rule in addition to consideration of these comments.	
IHS RPMS Electronic Health Record (EHR) DTLL	Published: 06/27/2017 **Submitted: 8/30/2017** **Due Date: Extended to 10/31/2017**	NPAIHB fully supports the modernization and improvement of the RPMS EHR system. NPAIHB requests that IHS conduct Area consultations prior to the final decision of whether to modernize the current RPMS EHR or move to a new EHR system. NPAIHB recommends that the RPMS improvements or the new EHR system must revolve around the benefits to patient care by improving the involvement and utilization of providers in the health IT system. NPAIHB recommends that IHS participate in the forefront of the policy development process for other agencies in the creation of reporting requirements for reimbursement purposes. NPAIHB recommends that there needs to be a boot camp style training in a classroom environment and then one on one support when you run into a problem back at home using a screen share. NPAIHB requests additional training and technical support, especially for smaller tribal health clinics. NPAIHB recommends that IHS utilize a more user-friendly format to identify to providers if the software system needs to be updated. NPAIHB recommends that the RPMS system include a preventative care section for providers to report on. It is a barrier for providers to enter in patient group education and documentation for preventative care. NPAIHB recommends that IHS make operability more of a focus in the modernization of the RPMS or a new EHR system, so that the system is more streamlined and aligned with other EHR systems. NPAIHB recommends that the technical support be more timely available for responsiveness to software issues. The billing package for RPMS is a barrier because it is not robust enough	 NPAIHB RPMS Comment.docx

		to handle sites that see non-tribal members. This is a significant issue because tribal providers are the ones providing health care services in these rural areas, therefore this barrier impacts the tribal health system. NPAIHB recommends that the RPMS EHR system should allow providers to be able to see the brand name and generic name of medications. Additionally, there is a need for better maneuvering of the medications that providers are able to view and interact with.	

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary
for Planning and Evaluation
Washington, D.C. 20201

Dear Tribal Leader:

I am writing to you to invite your input for the *HHS Strategic Plan FY 2018 – 2022*.

Every four years, HHS updates its Strategic Plan, which describes its work to address complex and ever-evolving health, public health, research, and human service issues, as well as strategic priorities for our Secretary, Thomas E. Price, M.D. The draft *HHS Strategic Plan FY 2018 – 2022* is available for public comment now, as required by the Government Performance and Results Modernization Act of 2010 (P.L. 111-352), to enable stakeholders to provide input.

HHS values its relationship with Indian Tribes, and your input is important to us as we look to the future of the Department's work. I invite you to provide us with your comments by October 27, 2017. The draft Strategic Plan is available in a downloadable format through the HHS Web site and can be viewed online at: https://www.hhs.gov/draft-strategic-plan. If you do not have Internet access, a hard copy can be requested from Sarah Potter at (202) 260-6518.

We welcome your thoughts on the draft Strategic Plan; you may find the material under the following Strategic Goals and Objectives of particular interest.

Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play:

- Objective 2.1: Empower people to make informed choices for healthier living
- Objective 2.3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support
- Objective 2.4: Prepare for and respond to public health emergencies

Goal 3: Strengthen the Economic and Social Well-Being of Americans across the Lifespan:

- Objective 3.2: Safeguard the public against preventable injuries and violence

HHS is hosting two conference calls for American Indian and Alaska Native Tribes, tribal organizations, and urban Indian organizations during the review period. Each of these calls will provide an overview of the plan and offer the opportunity for participants to share their preliminary thoughts and to ask questions.

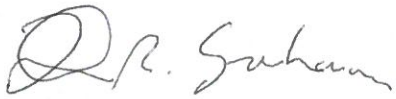
The calls will be held on October 16 and October 19, from 3pm to 4pm (Eastern time). The toll-free phone number for both calls is 1-866-738-2875. When prompted, enter passcode 5626986.

Comments can be submitted in several ways, by October 27, 2017:

Online: https://www.hhs.gov/draft-strategic-plan
E-mail: HHSPlan@hhs.gov
Fax: (202) 690-5882
U.S. Mail: U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Avenue, SW, Room 415F
Washington, DC 20201

Thank you for allowing me to share this information with you. I look forward to your input.

Sincerely,



John R. Graham
Acting Assistant Secretary for
Planning and Evaluation

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Health Care Provider:

The Centers for Medicare & Medicaid Services (CMS) is removing Social Security numbers from Medicare cards. This package includes important information about our work to assign new identification numbers and issue new Medicare cards to all people with Medicare beginning in April 2018. We want to be sure that you know about these changes and have the information you need to make a seamless transition.

We'll replace the current Health Insurance Claim Numbers with a unique, randomly generated number on the new Medicare cards. Your Medicare patients usually call this their "Medicare number." In our official guidance and documents to you, we'll refer to this new Medicare number as the Medicare Beneficiary Identifier or MBI. Our top priorities as we move to new Medicare cards and numbers are to make sure your Medicare patients have continuous access to care and you have the tools and information you need to make the change. You'll be able to look up your Medicare patient's new Medicare number through your Medicare Administrative Contractor's (MAC's) secure web portal starting in June 2018. If you don't already have access to your MAC's portal, sign up now.

If you use vendors to bill Medicare and they haven't already shared their new Medicare card and number system changes with you, contact them and ask if they'll be ready for these changes. We're committed to a successful transition to the new cards and numbers for people with Medicare and for the health care provider community. You can get information on this initiative and other CMS news by signing up for your MAC's electronic mail notifications.

Thank you for helping us change to the new Medicare cards and numbers so we can help protect identities of people with Medicare. Throughout the transition, we'll closely track how the new numbers are used for things like claims and eligibility transactions to make sure things are going smoothly. We appreciate your time and efforts to make this change a success.

TRANSITION TO NEW MEDICARE NUMBERS AND CARDS

Why is CMS issuing new Medicare cards and new Medicare numbers?

The law requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security numbers (SSNs) from all Medicare cards by April 2019. A new unique Medicare number will replace the current Health Insurance Claim Number (HICN) on the new Medicare cards. We're taking this step to protect people with Medicare from fraudulent use of Social Security numbers, which can lead to identity theft and illegal use of Medicare benefits.

When will CMS mail the new cards to people with Medicare?

We'll begin mailing new cards in April 2018 and will meet the statutory deadline for replacing all Medicare cards by April 2019. Your patients who are new to the Medicare program starting in April 2018 and later will only have a card with the new Medicare number.

What do I need to be ready for the change?

Your systems and business processes must be ready to accept the new Medicare number (which we call the Medicare Beneficiary Identifier or MBI in official guidance) **by April 2018** for transactions, such as billing, claim status, eligibility status, and interactions, with our Medicare Administrative Contractor (MAC) contact centers.

There will be a transition period when you can use either the HICN or the MBI to exchange data and information with us. **The transition period will start April 1, 2018, and run through December 31, 2019.** However, your systems must be ready to accept the new MBI by April 1, 2018. It's especially important that you're ready for people who are new to Medicare in April 2018 and later because they'll only get a card with the MBI.

What do I need to do right now?

You may need to change your systems to:

- **Accept the new MBI.** Use the MBI format specifications (see "How will the MBI look" section below) if you currently have edits on the current Health Insurance Claim Number (HICN).
- **Identify your patients who qualify for Medicare under the Railroad Retirement Board (RRB).** You'll no longer be able to distinguish RRB patients by the number on the new Medicare card. You'll be able to identify them by the RRB logo on their card, and we'll return a message on the eligibility transaction response for an RRB patient. The message will say, "Railroad Retirement Medicare Beneficiary" in 271 Loop 2110C, Segment MSG. If you use the number only to identify your RRB patients, beginning in April 2018, you must identify them differently to send Medicare claims to the RRB Specialty Medicare Administrative Contractor, Palmetto GBA.

- **Update your practice management system's patient numbers to automatically accept the new Medicare number or MBI from the remittance advice (835) transaction.** Beginning in October 2018 through the transition period, we'll return your patient's MBI on every electronic remittance advice for claims you submit with a valid and active HICN. It will be in the same place you currently get the "changed HICN": 835 Loop 2100, Segment NM1 (Corrected Patient/Insured Name), Field NM109 (Identification Code).

Where else can I find help with the transition to the new Medicare number?

If you use vendors to bill Medicare, contact them if they haven't already shared their new Medicare card system changes with you; they can also tell you about current HICN edits, how they will return the "Railroad Retirement Medicare Beneficiary" message on eligibility transactions, and how they'll pass the new Medicare number to you from the remittance advice. You'll also be able to look up your Medicare patient's new MBI through your Medicare Administrative Contractor's (MAC's) secure web portal.

Do I need to ask my Medicare patients for information?

Verify your Medicare patients' addresses; they won't get a new card if their address isn't correct. If the address you have on file is different than the address you get in electronic eligibility transaction responses from us, encourage your Medicare patients to correct their address in Medicare's records by either:

- Calling Social Security at **1-800-772-1213**, or going online to their online account at www.ssa.gov/myaccount
- Calling the RRB at **1-877-772-5772** for your patients who qualify for Medicare under the RRB

We will add resources you can share with Medicare patients to the New Medicare Card webpages by fall 2017.

How will the MBI look?

The MBI format is still 11 characters long, contains numbers and uppercase letters, and is unique to each person with Medicare. It will be clearly different from the HICN.

How many characters will the MBI have?

The MBI has 11 characters, like the Health Insurance Claim Number (HICN), which can have up to 11.

Will the MBI's characters have any meaning?

Each MBI is randomly generated. This makes MBIs different than HICNs, which are based on the Social Security Numbers (SSNs) of people with Medicare. The MBI's characters are "non-intelligent" so they don't have any hidden or special meaning.

What kinds of characters will be used in the MBI?

MBIs are numbers and upper-case letters. We'll use numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. This will help the characters be easier to read.

How will the MBI look on the new card?

The MBI will contain letters and numbers. Here's an example: 1EG4-TE5-MK73

- The MBI's 2nd, 5th, 8th, and 9th characters will always be a letter.
- Characters 1, 4, 7, 10, and 11 will always be a number.
- The 3rd and 6th characters will be a letter or a number.
- The dashes aren't used as part of the MBI. They won't be entered into computer systems or used in file formats.

MBI Format

Pos.	1	2	3	4	5	6	7	8	9	10	11
Type	C	A	AN	N	A	AN	N	A	A	N	N

Where will the MBI's characters go?

C – Numeric 1 thru 9 **N** – Numeric 0 thru 9 **AN** – Either A or N
A – Alphabetic Character (A...Z); Excluding (S, L, O, I, B, Z)

Position 1 – numeric values 1 thru 9

Position 2 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 3 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)

Position 4 – numeric values 0 thru 9

Position 5 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 6 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)

Position 7 – numeric values 0 thru 9

Position 8 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 9 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 10 – numeric values 0 thru 9

Position 11 – numeric values 0 thru 9

How will the MBI fit on forms?

MBIs will fit on forms the same way HICNs do. You don't need spaces for dashes.

Who will get a new MBI?

Each person with Medicare will get their own randomly-generated MBI. Spouses or dependents who may have had similar HICNs will each get their own different MBI.

What about Medicare Advantage and Prescription Drug plans?

Medicare Advantage and Prescription Drug plans will continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

How do I use the MBI?

You'll use the MBI the same way you use the HICN today.

During the transition period, on all transactions, you can use **either** the HICN or the MBI in the same field where you've always put the HICN. You don't need to say whether you're using a HICN or MBI because our systems will be able to tell which you've used.

You **cannot** submit both numbers on the same transaction. Once the transition period ends, you must use the MBI in the same field where you previously submitted the HICN.

What about Medicare crossover claims?

We are working closely with other payers, State Medicaid Agencies, and supplemental insurers to make sure the crossover claims process will still work like it does now. During the transition period, we'll process and transmit Medicare crossover claims to other health insurance organizations with either the HICN or MBI.

Do I need to protect the MBI?

The MBI is confidential just like the HICN so you'll have to protect it as Personally Identifiable Information and use it only for Medicare-related business.

How will I know when my Medicare patients get their MBIs?

Starting in **April 2018** when we start mailing the new Medicare cards, you can ask your Medicare patients if they have a new card with an MBI. We're planning wide-scale outreach to help people with Medicare know they need to bring their new Medicare cards and share them when they get medical care.

Also starting in **April 2018** through the end of the transition period, when you use your Medicare patient's HICN to check the eligibility status through the HIPAA Eligibility Transaction System (HETS), we'll return a message on the response that will say, "CMS mailed a Medicare card with a new Medicare Beneficiary Identifier (MBI) to this beneficiary. Medicare providers, please get the new MBI from your patient and save it in your system(s)" in 271 Loop 2110C, Segment MSG. Your eligibility service provider can tell you if they use HETS and how they plan to give you this information.

Then, starting in **October 2018** through the end of the transition period, when you submit a claim using your Medicare patient's valid and active HICN, we'll return both the HICN and the MBI on every remittance advice. The MBI will be in the same place you currently get the "changed HICN": 835 Loop 2100, Segment NM1 (Corrected Patient/Insured Name), Field NM109 (Identification Code) of the Electronic Remittance Advice.

Since we're taking SSNs off Medicare cards, people with Medicare won't have to give their SSNs for Medicare purposes when they get medical care. While we'll tell all people with Medicare to bring their new cards when they get medical care, there may be times when Medicare patients don't or can't.

Starting in **June 2018**, to make it easier for you to get your Medicare patients' MBIs when they can't or don't give them, you can use your MAC's secure portal to look up MBIs. To find MBIs in the portal, your Medicare patients must give you their first name, last name, date of birth, and SSN.

If your Medicare patients don't want to give you their SSN, they can log into www.mymedicare.gov to get their MBI. Your Medicare patients with RRB benefits can ask for a replacement card through the RRB SMAC Beneficiary Contact Center at 1-800-833-4455, log into www.rrb.gov, or call the RRB office at 1-877-772-5772.

What happens after the transition period ends?

On January 1, 2020, even for dates of services prior to this date, you must use MBIs for all transactions; there are a few exceptions when you can use either the HICN or MBI:

- **Appeals** – You can use either the HICN or MBI for claim appeals and related forms.
- **Claim status query** – You can use HICNs or MBIs to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- **Span-date claims** – You can use the HICN for 11X-Inpatient Hospital, 32X-Home Health, and 41X-Religious Non-Medical Health Care Institution claims if the "From Date" is before the end of the transition period (December 31, 2019). You can submit claims received between April 1, 2018, and December 31, 2019, using the HICN or the MBI. If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019.
- **Home Health Claims and Requests for Anticipated Payments (RAPs)** – You can use MBIs or HICNs on home health claims and RAPs with a "From Date" before January 1, 2020. Because you submit home health claims for a 60-day payment episode, there may be times when an episode ends after the transition period on December 31, 2019. If the "From Date" on the RAP or the final claim date is before December 31, 2019, you may submit either the HICN or the MBI. But, you must submit the MBI for RAPs and final claims when the "From Date" is on or after January 1, 2020.

When will CMS share information with the public about the new Medicare card design and the mailing schedule?

We will share information about the new card design in September 2017. The gender and signature line will be removed from the new cards. There will be geographical waves of successive mailings. Mailing everyone a new card will take some time. To protect people with Medicare from scams associated with sharing the mailing schedule, targeted local outreach will occur, including outreach to health care providers, before cards are due to arrive in a geographical area.

Where can I get more information?

Visit our New Medicare Card Home and Provider webpages for the latest details about the transition at: www.cms.gov/Medicare/New-Medicare-Card.

Subject: Question re CMS Emergency Preparedness Rule
Date: Wednesday, July 26, 2017 at 2:57:31 PM Pacific Daylight Time
From: Karol, Susan (CMS/CMCS)
To: Laura Platero
CC: Marx, Kitty (CMS/CMCS), Miles Rudd, Blondiaux, Caecilia J. (CMS/CCSQ)

Good Afternoon Ms. Platero,
Thank you for your question at the STAC meeting this week in Missoula.

The CMS Medicare Emergency Preparedness Final Rule requirements impact the 17 provider types that we discussed during the CMS Medicare Emergency Preparedness Final Rule Webinar on May 18th, 2017. I have attached the provider list above and the recording of the Webinar appears on the CMS Division of Tribal Affairs website which can be viewed at this link: http://www.cmsitutrainings.net/

Basically, if an ambulatory health care clinic is "provider based" (bills through a hospital or Critical Access Hospital) or bills Medicare Part A, they are surveyed by CMS and must meet a number of Conditions of Participation (CoP) for Medicare reimbursement. They need to prepare to meet the Emergency Preparedness (EP) CoP by November 15, 2017.

If the ambulatory health care clinic is free standing and bills only Medicaid then they do NOT have to meet the EP CoP.

FQHC "look-alikes" that are free standing and bill only Medicaid do NOT have to meet the EP CoP.
The Emergency Preparedness requirements only apply to those facilities that are registered as an FQHC *under Medicare*.

AAAHC accreditation status does not deem that the FQHC has met the Emergency Preparedness requirements. These sites will still need to focus on the EP requirements separately from any accreditation they may already have. It is anticipated that accrediting bodies may modify their emergency preparedness standards to align with these CMS requirements in the future.

If needed, an ambulatory healthcare clinic's CEO may email Caecilia Blondiaux who is part of the CMS Survey and Certification Group in the Center for Clinical Standards and Quality (CCSQ) with their Medicare CCN Number. She will let them know if they must meet this CoP. I have added her to the email above.

I hope that is clearer. Please let me or Ms. Blondiaux know if we can be of any further assistance. Thank you for your email.

Sincerely,

CAPT Susan V. Karol, MD, FACS
Division of Tribal Affairs/CMCS
Centers for Medicare and Medicaid Services
7500 Security Blvd. Mail Stop: S1-05-14
Baltimore, MD 21244-1850
Susan.Karol@cms.hhs.gov
410-786-0291

Providers/Suppliers
Facilities Impacted by the Emergency Preparedness Rule

1. Hospitals
2. Religious Nonmedical Health Care Institutions (RNHCIs)
3. Ambulatory Surgical Centers (ASCs)
4. Hospices
5. Psychiatric Residential Treatment Facilities (PRTFs)
6. All-Inclusive Care for the Elderly (PACE)
7. Transplant Centers
8. Long-Term Care (LTC) Facilities
9. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
10. Home Health Agencies (HHAs)
11. Comprehensive Outpatient Rehabilitation Facilities (CORFs)
12. Critical Access Hospitals (CAHs)
13. Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
14. Community Mental Health Centers (CMHCs)
15. Organ Procurement Organizations (OPOs)
16. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
17. End-Stage Renal Disease (ESRD) Facilities

Note: While all 17 Provider/Suppliers are impacted; requirements may differ between types

CMS.gov (https://www.cms.gov/)
Centers for Medicare & Medicaid Services

Centers for Medicare & Medicaid Services: Innovation Center New Direction

Share

In partnership with clinicians, patients, entrepreneurs, state officials, and others, the Centers for Medicare & Medicaid Services (CMS) plays a leading role in safeguarding the health of America's future by providing coverage to over 130 million Americans, more than a third of the population of the United States. Our nation's elderly and most vulnerable citizens depend on these programs for access to care but both programs face fiscal crises. Medicare's main trust fund is projected to run out in just eleven years, and Medicaid is the second largest budget item for states on average (behind K-12 education) and is growing rapidly. Improving quality and reducing costs are imperative.

Background

One of the most important goals at CMS is fostering an affordable, accessible healthcare system that puts patients first. Through this informal Request for Information (RFI) the CMS Innovation Center (Innovation Center) is seeking your feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The Innovation Center welcomes stakeholder input on the ideas included here, on additional ideas and concepts, and on the future direction of the Innovation Center.

Request for Information Details

While existing partnerships with healthcare providers, clinicians, states, payers and stakeholders have generated important value and lessons, CMS is setting a new direction for the Innovation Center. We will carefully evaluate how models developed consistent with the new directions can complement what we are learning from the existing initiatives. In particular, the Innovation Center is interested in testing models in the following eight focus areas:

1. Increased participation in Advanced Alternative Payment Models (APMs);
2. Consumer-Directed Care & Market-Based Innovation Models;
3. Physician Specialty Models;
4. Prescription Drug Models;
5. Medicare Advantage (MA) Innovation Models;
6. State-Based and Local Innovation, including Medicaid-focused Models;
7. Mental and Behavioral Health Models; and
8. Program Integrity.

However, the Innovation Center may also test models in other areas.

To be assured consideration, please submit comments online (https://survey.max.gov/429625) (//www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/External-Link-Disclaimer.html) or by email to CMMI_NewDirection@cms.hhs.gov (mailto:CMMI_NewDirection@cms.hhs.gov) through **11:59 p.m. EST November 20, 2017**.

Additional Information

Request for Information (RFI) online submission (https://survey.max.gov/429625) (//www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/External-Link-Disclaimer.html)
Request for Information (RFI) (PDF) (/Files/x/newdirection-rfi.pdf)
Op Ed Article (https://www.wsj.com/articles/medicare-and-medicaid-need-innovation-1505862017) (//www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/External-Link-Disclaimer.html)

Model Summary

Stage: Not Applicable
Number of Participants: N/A
Category: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
Authority: N/A

Milestones & Updates

Sep 20, 2017
Announced: Request for Information (RFI) seeking comments on future direction posted

Last updated on: 09/20/2017

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

AUG 25 2017

Dear Tribal Leader:

The fiscal year (FY) 2017 budget includes $5 million for the Small Ambulatory Program (SAP). The Indian Health Service (IHS) is accepting applications for the SAP. The authorization for the SAP is in Title 25 U.S.C. Section 1636.

Under the SAP, American Indian and Alaska Native Tribes or Tribal organizations who are operating an Indian health care facility pursuant to a health care services contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, may competitively obtain funding for the construction, expansion, or modernization of small ambulatory health care facilities.

If your Tribe is interested in participating in the FY 2017 SAP, please download and complete the application available online at https://www.ihs.gov/dfpc/ or http://www.fedbizopps.gov by December 1, 2017. If your Tribe wishes to participate in the SAP, detailed proposal instructions are provided in the application package that will outline the requirements for project planning and Tribal administrative and financial capabilities.

If you have any questions, please contact CAPT James Ludington, P.E., Program Manager, Division of Facilities Planning and Construction, IHS, by telephone at (301) 443-1642.

Sincerely,

/Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

SEP 22 2017

Dear Tribal and Urban Indian Organization Leader:

On September 15, the Indian Health Service (IHS) initiated a Tribal Consultation and Urban Confer on the IHS Strategic Plan 2018-2022. I am writing to provide information on ways to submit written and in-person comments and update you on the formation and role of the IHS Strategic Planning Workgroup. There is also an opportunity to provide feedback to the Department of Health and Human Services (HHS) on the HHS Strategic Plan 2018-2022.

The IHS seeks your comments and recommendations on the initial IHS Strategic Plan framework (see enclosure). Specifically we are asking the question on the initial framework:

> ***Do the IHS Mission, Vision, Goals, and Objectives reflect the direction and priorities you feel the IHS should pursue over the next 5 years?***

On Monday, September 25, the Agency will convene the first in-person Tribal Consultation and Urban Confer session during the National Indian Health Board's 2017 National Tribal Health Conference at the Hyatt Regency in Bellevue, Washington. The session will take place from 10:00 a.m. to 12 noon (Pacific) in the Evergreen E-F Room.

The IHS will also host conference calls, for Tribal Leaders and Urban Indian Organization Leaders, to provide comments. Call in information will be posted on the IHS Calendar Web site at https://www.ihs.gov/ihscalendar.

Tribal Consultation and Urban Confer Conference Calls

- Tribal Leaders - Wednesday, October 18, 2017, from 3:00 – 4:00 p.m. (Eastern)
- Urban Indian Leaders - Wednesday, October 11, 2017, from 3:00 – 4:00 p.m. (Eastern)

Written comments will be accepted throughout the duration of the Tribal Consultation and Urban Confer period. **The deadline to provide your comments is October 31, 2017**. Please provide your written comments and recommendations by e-mail at consultation@ihs.gov or urbanconfer@ihs.gov with the "IHS Strategic Plan 2018-2022" as the subject line.

You may also provide comments by postal mail to the address indicated below.

RADM Michael D. Weahkee
Acting Director
ATTN: IHS Strategic Plan 2018-2022
Indian Health Service
5600 Fishers Lane, Mailstop: 08E86
Rockville, MD 20857

Following the comment period, the IHS will form a short-term IHS Strategic Planning Workgroup, comprised of a small group of Tribal Leaders and IHS employees, to review all comments and draft a list of final Goals and Objectives for IHS leadership review and approval. The IHS will work with the Direct Service Tribes Advisory Committee and the Tribal Self Governance Advisory Committee to determine Tribal participants on the IHS Strategic Planning Workgroup.

Once IHS leadership has approved the Goals and Objectives, the IHS Strategic Planning Workgroup will develop Strategies and Measures to achieve the objectives. Input by Tribal and Urban Indian Organization Leaders will again be requested during a 30-day comment period on the draft IHS Strategic Plan including the Strategies and Measures.

As I mentioned in the September 15 letter, HHS is also developing an HHS Strategic Plan for 2018-2022. Please be aware within the next few weeks, HHS will request your review and comment on the HHS Strategic Plan. This HHS request is separate from the IHS Strategic Plan Tribal Consultation and Urban Confer process.

If you have any questions, please contact CAPT Francis Frazier, Director, Office of Public Health Support, IHS, by telephone at (301) 443-0222 or by e-mail at francis.frazier@ihs.gov.

Thank you for your support and partnership. I look forward to your views and comments.

Sincerely,

/Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director

Enclosure
IHS Strategic Plan 2018-2022 Tribal Consultation and Urban Confer Timeline and Draft Framework for IHS Mission, Vision, Goals, and Objectives

IHS Strategic Plan 2018-2022 Tribal Consultation and Urban Confer Timeline	
(September 2017 – February 2018)	
September	Announcement: Tribal Consultation and Urban Confer on IHS Strategic Plan for 2018-2022
September - October	Gathering Input: 30-day comment period on draft IHS Strategic Plan Goals and Objectives framework at listening sessions, Webinars and in person meetings
November - December	Tribal-Federal Workgroup: To review input and draft IHS Strategic Plan goals, objectives, strategies and measures.
January	Comment Period: 30-day comment period on draft IHS Strategic Plan
February	Agency Review, Decision and Publication of IHS Strategic Plan

Draft Framework for IHS Mission, Vision, Goals, and Objectives

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

Vision - A health system that promotes Tribal ownership and pride.

Goal 1: To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

Objectives:

1. Recruit, develop, and retain a dedicated, competent, caring workforce.
2. Build, strengthen, and sustain collaborative relationships.
3. Increase access to quality health care services.

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

Objectives:

1. Create quality improvement capability at all levels of the organization.
2. Provide care to better meet the health care needs of Indian communities.

Goal 3: Strengthen IHS program management and operations

Objectives:

1. Improve communication within the organization, with Tribes and other stakeholders, and with the general public.
2. Secure and effectively manage assets and resources.
3. Modernize information technology and information systems to support data-driven decisions.

HHS Secretary's Tribal Advisory Committee (STAC)

September 21-22, 2017 at the Cherokee Nation

Northwest Portland Area Indian Health Board (NPAIHB) Brief

HHS Secretary Tom Price made a commitment earlier this year to hold the Secretary's Tribal Advisory Committee (STAC) in Indian country and he kept this promise. The September 2017 STAC meeting was held at the Cherokee Nation. Portland Area tribal representative, Chairman Ron Allen, Jamestown S'Klallam Tribe, attended the meeting. NPAIHB provided technical support to Chairman Allen and prepared this brief.

Discussion with the HHS Secretary Tom Price

Tribal leaders from each IHS region stressed the importance of tribal consultation at the national and regional levels. The HHS Secretary Price agreed that the recognition of respecting the tribal treaties and mentioned the importance of the STAC meeting being held in Indian Country. Secretary Price highlighted his gained perspective on the remarkable spirit of caring in Indian Country, "addressing the mind, body, and spirit that is present in Indian Country is remarkable and should be a model for the rest of the nation."

Secretary Price announced that HHS is raising the threshold for Indian Health Service (IHS) capital projects. The construction threshold will be increased from $1 million to $5 million; the renovation threshold will rise from $2 million to $10 million; and the repairs threshold will increase from $5 to $15 million. In addition, projects funded with tribes will now not require HHS approval.

Tribal leaders highlighted the importance of tribal consultation and the HHS consultation policy. When there are critical healthcare events there must be communication between the federal government and tribal governments. Additionally, tribal leaders requested that Secretary Price provide written response letters to the STAC letters that were sent to Secretary Price after the last meeting.

Chairman Allen emphasized the successes of policies from prior Administrations and that there is no need to reinvent the wheel. Chairman Allen highlighted the fact that the tribal healthcare infrastructure is complex and the Administration must take into consideration how an Affordable Care Act (ACA) repeal and replace will apply to tribal health programs. Tribal representatives encouraged Secretary Price to work with Tribal Advisory Committees (TACs) and tribal/federal workgroups. Chairman Allen called for the reinstatement of an advisory committee to create a better agenda moving forward.

Importance of CMS Services and Reimbursement in Indian Country

Tribal leaders expressed the significance of Medicaid services and reimbursement from the Centers for Medicare and Medicaid Services (CMS) including 100% federal medical assistance percentage (FMAP) reimbursement for services provided to American Indians and Alaska Natives (AI/ANs) as well as Medicaid expansion. Additionally, tribal leaders articulated issues with emerging 1115 waiver requirements that states have submitted, which would include work requirements for Medicaid eligibility. On behalf of the STAC tribal leaders, Chairman Allen requested that tribes be exempted from the 1115

waiver work requirement because of the high unemployment in Indian Country, the fallback on an already underfunded health care system, as well as the federal government trust responsibility to tribes.

Opioid Crisis in Indian Country

Tribal Council Cheryl Frye-Cromwell, the STAC Nashville tribal representative, requested a federal partners and tribal workgroup to address the opioid crisis in Indian Country with a demonstration project that was discussed at the last STAC meeting. Tribal representatives requested the need to track funding provided to states to ensure that states are accountable for resources and funding to go to tribes. Chairman Allen stated the importance of tribes being aware of funding and resources between the various HHS departments. Secretary Price commented that the Centers for Disease Control and Prevention (CDC) has released a guideline for prescribing opioids.

In response to the funding comment, Secretary Price stated that it would be beneficial for all IHS and HHS resources for Indian Country to be under the congressional jurisdiction of the Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies because there are more resources and expertise under the Subcommittee. Secretary Price requested that the STAC decide if this is an issue that the STAC should take on or the IHS Budget Committee to support. STAC Chairman Chester Antone, Council Member of Tohono O'odham Nation, asked tribal leadership to consider this issue and for the STAC to evaluate how it will impact tribes.

Healthcare Workforce in Indian Country

Tribal leaders voiced their concerns regarding recruitment of healthcare professionals in rural tribal communities. President Russell Begaye, STAC Navajo Area representative underlined the need to increase payback and get more medical students to provide services in Indian Country. President Begaye requested an HHS directive for a residency program at IHS facilities. In addition, President Begaye raised the foundational need of housing for healthcare professionals. HHS Secretary Price responded that medical schools and residencies are something that they will focus on. Secretary Price affirmed that HHS will make sure access to education and training will be available for Native communities because, generally, where residents train is where the vast majority stay to practice.

SDPI Reauthorization

Tribal leaders stressed the importance of reauthorization of the Special Diabetes Program for Indians (SDPI) and the support that Indian Country needs from HHS to reauthorize SDPI. Secretary Price replied that HHS is working with congressional members on Capitol Hill to get SDPI reauthorized.

Discussion with HHS Office of Intergovernmental and External Affairs Director Jane Norton

President Begaye was elected as Vice Chairman of STAC. Tribal leaders recommended to the Office of Intergovernmental and External Affairs Director Norton that the budget formulation process needs to change to better meet the needs in Indian country. Chairman Allen recommended putting together a workgroup that would propose how the budget formulation could be conducted with proposed instructions and that would take into consideration regional priorities. Additionally, Chairman Allen stated that tribes need to have an idea of how the FY 2017 appropriations from the Office of Management and Budget (OMB) will break down for HHS and which tribes are accessing those funds. Tribal leaders

reiterated the importance of approving Area Directors. Director Norton responded that they have 10 regional directors and two have been appointed while the rest have been identified so they are in a holding pattern.

The Office of Intergovernmental and External Affairs proposed cancellation of the December 5-6, 2017 STAC meeting as well as provided the following proposed dates for future STAC meetings:

i. January 17-18, 2018
ii. March 8-9, 2018 for Annual Tribal Budget Consultation
iii. May 9-10, 2018
iv. September 19-20, 2018
v. July 2018 for Strategic Planning Meeting

HHS Budget Updates with the Acting Assistant Secretary for Financial Resources, Jennifer Moughalian

On September 8, 2017 the Continuing Appropriations Act, 2018 and Supplemental Appropriations for Disaster Relief Requirements Act, 2017 (H.R. 601) became law. The Continuing Resolution will suspend the debt limit and be short term funding through December 8, 2017. Acting Assistant Secretary Moughalian stated that IHS is a priority as they engage with OMB. Acting Assistant Secretary Moughalian has reviewed the STAC's FY 2018 budget recommendations and they are part of the FY 2019 budget conversations.

Discussion with the Administration for Children and Families Acting Assistant Secretary Steven Wagner

Acting Assistant Secretary Steven Wagner acknowledged that the Administration for Children and Families (ACF) will be working toward prevention in the removal of children. With Headstart, the ACF will be preserving slots because participation is only hitting 50% of eligible children. ACF will be looking at setting up a system for children who are neglected and not privileged to participate. The ACF nominated Assistant Secretary is up for congressional approval. There has not been a Deputy Assistant Secretary for Native Affairs identified yet. Tribal leaders made the distinction that tribal temporary assistance for needy families (TANF) is completely different that state TANF, therefore the consultation process must be invoked for the adoption and foster care analysis and reporting (AFCAR). Tribes need data and funds be provided directly to tribal communities. Chairman Allen said that the Jamestown S'klallam Tribe is struggling with the state on the enforcement of the ACF. Chairman Allen also specified that the 477 program has been very successful and tribes need the ACF on board to assist in getting it passed to be a model for welfare reform.

Discussion with Indian Health Service Acting Director Michael Weahkee

The Indian Health Service (IHS) recently sent out a Dear Tribal Leader Letter (DTLL) invoking consultation with tribes on the 2018-2022 IHS Strategic Framework. Comments for the IHS Strategic Framework are due October 31. A tribal/federal workgroup will be reviewing the comments to create a

draft IHS Strategic Framework that will be released for a 30-day comment period prior to final publication. Acting Director Michael Weahkee indicated that recruitment and retention of staff across IHS is a key priority for the agency. Chairman Ron Allen, STAC Northwest Area representative acknowledged that IHS needs help with making recruitment and retention adjustments. Chairman Allen expressed that it is harder to fill positions for tribes and sometimes tribes cannot pay the market value for talent and benefits to retain healthcare staff. IHS is creating a fellowship program for entry level medical officers to develop skills to work within the Indian healthcare system. Acting Director Weahkee affirmed tribal leaders that IHS is creating a search committee for filling key Area Director positions and IHS is working on several Title 38 authorities and benefits packages for recruitment. Numerous tribal leaders emphasized the need for direct services tribes to have the flexibility to move funding around and that IHS needs to ensure that the voice of direct service tribes is heard.

IHS Acting Director pronounced that IHS has finalized a report on diabetes and kidney failure prevention successes, which will be sent out to the STAC. In addition, IHS will work with the VA to ensure that American Indian and Alaska Native (AI/AN) veteran patients are exempt from copays or IHS pays the copays.

Discussion with Centers for Medicare and Medicaid Services Senior Counselor to the Administrator, Calder Lynch

Senior Counselor to the Administrator, Calder Lynch reaffirmed tribal leaders that consultation will continue to play a significant role in policy development to obtain guidance and input from tribes. Chairman Allen voiced the importance of the unique treaty relationship and the need to focus on how to increase access to affordable healthcare services. The first goal for the Centers for Medicare and Medicaid Services (CMS) is to empower doctors, state flexibility and local leadership to develop innovative approaches to improve accessibility and improve the CMS customer experience. CMS is working on the following initiatives: (1) offering more flexible approaches to address the opioid epidemic; (2) enhance Medicaid and CHIP around IT and data; (3) focus on streamlining the state plan amendment and waiver process as well as improve the technology and transparency; and (4) identify and streamline policies to reduce burden.

Tribal leaders articulated the importance of maintaining the 100% federal medical assistance percentage (FMAP) and the need for tribal exemption from emerging provisions like work requirements and eligibility requirements for Medicaid. Senior Counselor Lynch affirmed tribal leaders that there will be continued conversations with TTAG on these issues. CMS is continuing to monitor congressional changes to expand the 100% FMAP ability. Chairman Allen emphasized the importance of engagement with tribal/federal workgroups before connecting with the states. Tribal leaders expressed concern with the drastic sudden funding cut for navigators. Tribal leaders reiterated the need for states to partner with tribes in a concerted effort to improve the health of the AI/AN people.

Senior Counselor Lynch stated that CMS has held a few different technical meetings and webinars to provide technical assistance for the New Medicare Card Project. CMS will be launching a campaign to get the word out about the New Medicare Card Project.

Discussion with the Administration for Community Living Administrator Lance Robertson

The Administration for Community Living (ACL) Administrator Lance Robertson identified that mortality rates for AI/ANs are at 66 years of age versus 76 years of age and the goal of ACL is to keep elders in their home. The ACL is a crossover agency for the older population and individuals with chronic diseases. The Older Americans Act is now funding 270 tribes. ACL has funded 30 tribes for innovative work for elder justice and the falls prevention project has been expanded. ACL Administrator Lance Robertson highlighted the following priorities for the agency: (1) strengthen Title XI program; (2) creation of a tribal consultation policy; and (3) support for innovative programs like chronic disease self-management and work to strengthen services. STAC Northwest Area representative, Chairman Allen highlighted the need for tribal input during the tribal consultation policy creation as well as the formation of a tribal advisory committee (TAC).

Discussion with the White House Council on Native American Affairs Executive Director Ben Keel

White House Council on Native American Affairs Executive Director Keel is currently working on transitioning the Council from a federal agency only participation to a tribal council with tribal representation that will help form and shape federal Indian policy. Executive Director Keel informed tribal leaders that they are in the process of moving the council from the Department of the Interior (DOI) to the White House Office of Intergovernmental Affairs in order to have a true government to government relationship. The White House Council on Native American Affairs would like to continue the Tribal Nations Summit. On November 1, Executive Director Keel will have an update for STAC on the Opioid Task Force Report. Numerous tribal leaders stated issues with public safety and the high rates of domestic violence, child abuse and sexual assault in tribal communities, therefore adding public safety to the list of issues under the White House Council on Native American Affairs. STAC Navajo Nation Area representative, President Begaye recommended that it would be beneficial for tribes to know how various agencies are working together on certain issues like suicide and substance abuse.

Discussion with the Office of the Assistant Secretary for Health Deputy Assistant Secretary for Minority Health Matthew Lin

Assistant Secretary for Minority Health Matthew Lin indicated the importance of a grant funding program for evidence-based practices to address historical trauma and health equity. Tribal leaders discussed management of physicians and the need to permanently fill acting positions. In addition, tribal leaders expressed the significance of the Commission Corp and the concern that it takes 9-15 months to get someone identified through the Commission Corp. IHS Acting Director Weahkee responded that the onboarding process is comprehensive and a full background check must be completed. Assistant Secretary for Minority Health Lin responded that they have not had specific open calls, but physicians and dentists are on a continuous open call and they may be opening for Physicians Assistants soon. IHS Chief Medical Officer Dr. Michael Toedt informed tribal leaders that they are going to work on improving the Commission Corp officer process. Commission Corp officers have to go through a medical evaluation for competencies and physical readiness. Assistant Secretary for Minority Health Lin indicated that they are going to work on cultural competency online trainings for the Commission Corp.

Discussion with Centers for Disease Control and Prevention Office for State, Tribal, Local and Territorial Support Director Carmen Clelland

The Public Health Associate Program has increased participants over the past few years and six tribal areas have received public health associates in Indian Country. This year there will be twenty-one tribal sites for about one hundred and twenty public health associates. Tribal leaders have requested an understanding of how the funds get out to states and tribes and how to track those dollars in a meaningful way to tribes. The Centers for Disease Control and Prevention (CDC) Tribal Advisory Committee (TAC) has requested technical assistance on how to engage with tribes to increase the capacity of epidemiology in Indian Country. Additionally, the CDC TAC has requested a tracking of CDC responses to requests tribes have made to CDC to see how CDC is responding in a meaningful way. Tribal leaders requested that culturally-based practices must be allowed to be utilized in funding opportunities because CDC-identified best practices may not fit in tribal communities. Tribal leaders requested what activities CDC is doing for teen and youth suicide. Director Clelland responded that CDC has engaged with Epidemic Intelligence Service (EIS) officers who have gone out to areas with high rates of teen suicides. CDC has funded a project with regards to adverse childhood experiences to identify where there are at risk children and teens. The CDC requested tribal representation on the state, tribal, local and territorial support social conditions committee, which ties in social determinants of health as well as environmental and ecological factors. Acting Deputy Assistant Secretary for Mental Health and Substance Use within the Substance Abuse and Mental Health Services Administration (SAMHSA) Kana Enomoto responded that SAMHSA is currently looking at ways to have communities learn from one another with regards to zero suicide.

Discussion with the Substance Abuse and Mental Health Services Administration Acting Deputy Assistant Secretary for Mental Health and Substance Use Kana Enomoto

Tribal leaders emphasized the need for prevention efforts and initiative more than treatment as well as coordination with other agencies. Additionally, tribal leaders requested the creation of a federal/tribal workgroup to look into a tribal opioid crisis demonstration project as well as tribal participation on the HOPE committee. Assistant Secretary Enomoto replied that they would be happy to create a federal/tribal workgroup. Tribal leaders requested a funding tracker to make sure that opioid prevention and treatment funding is going to tribes. Tribes raised concerns that the grant language uses the word encourage for States to include tribes in their opioid prevention and treatment strategic plan and funding. Assistant Secretary Enomoto replied that unfortunately the encourage language is tied to the 21st Century Cures Act. The 21st Century Cures Act provides $1 billion in opioid prevention and treatment funding. Assistant Secretary Enomoto announced that SAMHSA has made progress to set aside funding specifically for tribes and has held a webinar for state/tribal grantees. Assistant Secretary Enomoto stated that SAMHSA needs to know more about how opioids are coming into tribal communities because approximately 63,000 AI/ANs are misusing opioids. Assistant Secretary Enomoto announced that SAMHSA is working on the development of an opioid website. STAC Northwest Area representative, Chairman Allen highlighted that the issues of alcohol, methamphetamine and heroin are still an epidemic in Indian Country. STAC Alaska Area representative, Chief Victor Joseph specified the need for flexibility in adjusting treatment services to suit the needs of the individual rather than the static set of treatments as well as the need for substance abuse counselors to have the skills to meet the demands for a variety of addictions. Additionally, Chief Joseph asserted the need for trauma informed care to be tied closely to mental and behavioral health services. Assistant Secretary Enomoto responded that she agreed that too many rely on a single

assessment/treatment tool and that insurance may complicate providing certain services. With regards to trauma informed care, Assistant Secretary Enomoto stated that they look forward to hearing about the direction of the White House Council which has been supportive of trauma informed care initiatives in the past.

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U.S. Department of Veterans Affairs

Honoring Our Heroes:

Building Partnerships to Connect Native Veterans to Care and Benefits

Tribal Consultation Report | 2016

VA

U.S. Department of Veterans Affairs
Office of Tribal Government Relations

Office of
Tribal Government
Relations

Abbreviations, Terms, and Definitions

Abbreviations/ Terms	Definitions
CBO	Veterans Health Administration Chief Business Office
The Choice Act	The Veterans Access, Choice, and Accountability Act of 2014, Public Law 113–146. The Choice Act, as amended, established the Veterans Choice Program under which eligible Veterans receive care through non-VA providers.
CMOP	VA's Consolidated Mail Order Pharmacy
HUD-VASH	U.S. Department of Housing and Urban Development-VA Supportive Housing program, a supportive case management and housing voucher program to assist homeless Veterans
IAA	Interagency Agreement
IHS	Indian Health Service
MOU	Memorandum of Understanding
MyVA	A transformation initiative started in 2014 by VA Secretary Robert McDonald to improve agency performance and the quality of care for Veterans
NADL	Native American Direct Loan program
OMB	Office of Management and Budget
OTGR	VA Office of Tribal Government Relations
PRC	Purchased/Referred Care, a program under Indian Health Service that allows eligible patients to receive care from other private (non-IHS) providers when appropriate
PTSD	Post-traumatic stress disorder, a mental disorder related to exposure to trauma, with diagnostic criteria defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5)
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VSO	Veterans Service Organization, an organization recognized by VA as qualified to represent Veterans in claims for VA benefits

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U.S. Department of Veterans Affairs

Honoring Our Heroes:

Building Partnerships to Connect Native Veterans to Care and Benefits

Tribal Consultation Report | 2016

Table of Contents

Introduction

Of all population groups in the United States, American Indians and Alaska Natives continue to serve in the military at the highest rate of all races, as they have done throughout our Nation's history.

Soy Redthunder

Mr. Redthunder addresses Tribal Veteran representatives and advocates at the OTGR 2-day training for Tribal Veteran Representatives.

In 2016, VA initiated consultation with American Indian and Alaska Native tribal governments on three topics:

- recognition of tribal organizations for representation of VA benefit claimants,
- top three to five priorities for Veterans in Indian Country, and
- a proposed consolidation of non-VA care into a more standardized system under the Veterans Choice Program.

This report presents tribal responses and policy background for each consultation topic. It highlights the top priorities identified through tribal consultation in a special section that begins on page 8.

Reporting on tribal government input received through consultation offers a valuable mechanism for VA agencies to stay informed about the impacts of their policies and proposed actions in Indian Country and to be responsive to the needs identified by tribal governments for effectively serving Veterans.

The audiences for the 2016 tribal consultation report include the following:

- **Tribal nations**, including those who participated in 2016 consultations and those who did not, so they can see the tribal input on current policies and priorities that has been received by VA.
- **VA**, so VA leadership can consider and be informed by the experience, voices, and perspectives of tribal leadership, which offer critical, first-hand insight about the effects of proposed policy or programmatic changes on Veterans living in Indian Country.
- **Congress**, to demonstrate the ways VA upholds its legal mandate to consult with tribes, and so Congress can be informed about recommendations that tribal governments believe would enable VA programs to deliver benefits to Veterans and fulfill VA's mission more effectively.

Three Tribal Consultations in 2016

VA's Office of Tribal Government Relations (OTGR) facilitates VA's relationship with tribal governments and American Indian and Alaska Native Veterans and helps VA implement its Tribal Consultation Policy. As part of those responsibilities, OTGR worked with VA and tribes to conduct consultation on three topics in 2016:

- **Consultation 1:** Recognition of tribal organizations for representation of VA claimants,
- **Consultation 2:** Top three to five priorities for serving Veterans in Indian Country, and
- **Consultation 3:** The proposed consolidation of non-VA care into a standardized system under the Veterans Choice Program.

Each consultation was initiated by a notice in the *Federal Register* and a Dear Tribal Leader letter from VA sent to all federally recognized tribal governments. These notices identified the issues for which VA requested consultation input, offered background about the current status of those issues, and, in some cases, communicated proposed or possible policy changes.

Consultation feedback received from tribes is reported in the following sections for each consultation topic. The section *Top Priorities for Veterans in Indian Country*, on page 8, discusses the 23 priorities identified through tribal consultation. Also included, where available, are updates from VA on policy changes or continued development on the topic that has occurred since the consultation period.

Vietnam War Native American Veteran and Commander Trickster Veterans group

Consultation 1:
Recognition of Tribal Organizations for Representation of VA Claimants

In the first consultation topic of 2016, VA asked tribes to comment on a proposed rule relating to the recognition of tribal organizations. The proposed rule would amend Title 38, Part 14, of the Code of Federal Regulations to recognize tribal organizations that meet the requirements to assist American Indian and Alaska Native claimants with their VA benefits, and alternatively, to allow Tribal government employees to pursue accreditation through existing State organizations.

The goal of the proposed rule is to provide for the needs of American Indian Veterans who might be served by VA-recognized organizations, but are unable to use existing national, State, and local organizations because of geographic isolation, cultural barriers, or a lack of familiarity with non-tribal Veterans' resources.

Consultation 1 Topic and Questions

Recognition of tribal organizations to represent Native Veterans for VA benefits claims

Consultation Period

March 3, 2016 – April 3, 2016

Dear Tribal Leader Letter

Released March 3, 2016.

See Appendix B, page 44, for the full text of the letter.

Webinar

(No consultation event)

Available online: http://www.anymeeting.com/091-256-324/E953D68584493D

This consultation topic was not supported by an in-person consultation event. It was introduced by letters to tribal leaders, and all feedback was collected via mail, email, or fax. (See Appendix B, page 44, for the full Dear Tribal Leader letter text.) VA hosted a webinar explaining the proposed rule and answering questions.

VA Consultation Updates

On January 19, 2017, VA amended its regulations consistent with the approach that was set forth in this consultation. The new rule became effective on March 21, 2017. Notices in the *Federal Register* documenting these changes can be found online at https://www.federalregister.gov/documents/2017/02/21/2017-03328/recognition-oftribal-organizations-for-representation-of-va-claimants-delay-of-effective-date

Consultation 2:
Priorities for Serving Veterans in Indian Country

Consultation 2 Topic and Questions

Top 3–5 priorities for serving Veterans in Indian Country

Consultation Period

May 19, 2016 – October 7, 2016

Dear Tribal Leader Letter

Released May 19, 2016.

See Appendix C, page 46, for the full text of the letter.

Consultation Event

June 29, 2016, in Spokane, WA, in conjunction with the National Congress of American Indians' Mid-Year Conference.

In the second consultation topic of 2016, VA asked tribes to identify their top three to five priorities for serving Veterans in Indian Country.

The goal for gathering these priorities is to keep VA informed on an ongoing basis about the needs that tribal governments face when serving Veterans, especially needs that may be unique to Indian Country and tribal communities. Tribal government priorities can inform VA as it identifies needs among Veteran populations, makes decisions about how to deliver services and benefits, and considers how best to fulfill its mission among American Indian and Alaska Native Veterans.

To facilitate this consultation, VA created a fact sheet describing current areas of programming and focus that VA has for serving American Indian and Alaska Native Veterans. The fact sheet gave information on the current status and activities of these programs and asked respondents to name priorities for serving Veterans, either by choosing among the programs named or by identifying other priorities or needs not addressed on the fact sheet.

Consultation Event

This consultation was supported by the release of a Dear Tribal Leader letter on May 19, 2016, to 567 federally recognized tribal governments, inviting tribes to offer written consultation feedback. (See Appendix C, page 46, for the full text of the letter). It was also supported by a consultation event that took place on June 29, 2016, in Spokane, WA, where testimony from tribal leaders and representatives was received by VA representatives.

To reach the widest possible audience of tribal leaders, the consultation event was scheduled in conjunction with the National Congress of American Indians' Mid-Year Conference.

The consultation event was facilitated by:

- **James Albino**, Deputy Assistant Secretary for Intergovernmental Affairs, and
- **Stephanie E. Birdwell**, Director, Office of Tribal Government Relations.

The following officials represented VA and its administrations and departments, as well as its regional and local units for the Spokane, WA, event:

- **Michael J. Murphy**, Interim Director, VA Northwest Health Network;
- **J. Ronald (Ron) Johnson**, Director, Mann-Grandstaff (Spokane) VA Medical Center;
- **Pritz Navaratnasingam**, Director, Seattle Regional Benefit Office, Veterans Benefits Administration;
- **Allegra Long**, Relationship Manager, Pacific District Veterans Experience Office; and
- **Majed Ibrahim**, IHS/Tribal Health Program Reimbursement Agreements Program Manager, Chief Business Office, Veterans Health Administration.

Representatives from related organizations also joined the panel:

- **Christopher Mandregan**, Jr., Acting Deputy Director, IHS, and
- **Alfie Alvarado-Ramos**, Director, Washington State Department of Veterans Affairs.

Consultation Input

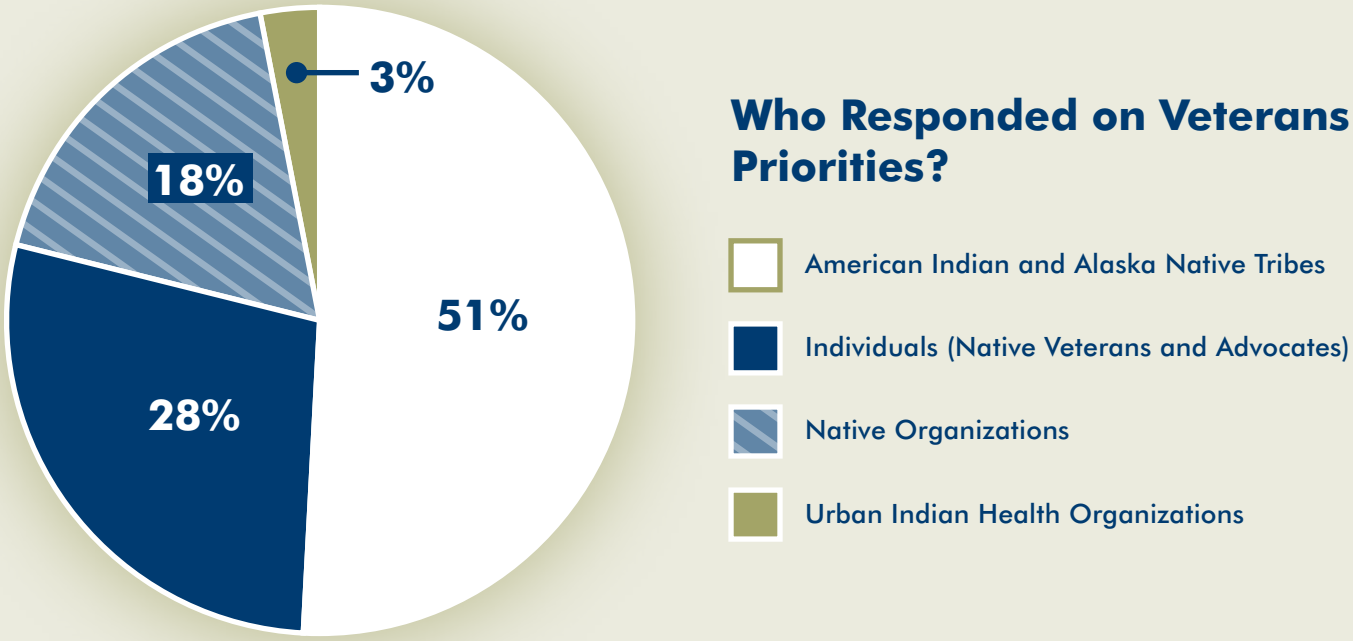
This consultation's unique format, where participants named and ranked priorities for Veterans, creates the opportunity for analysis of consultation input in a way that is not usually possible in the detailed policy discussions that occur in some consultations.

The consultation input received represents the wide range of stakeholders on Veterans' issues in Indian Country. Input came primarily from tribal leaders of federally recognized tribes, but also from Native Veterans, stakeholders who serve and advocate for Native Veterans' needs, national and regional Native health and advocacy organizations, and urban Indian health organizations. There were 71 total responses in this consultation, including written input and priorities discussed in testimony at the consultation event, which came from the following consultation participants:

- 36 tribes,
- 20 individuals (Native Veterans and advocates),
- 13 Native organizations, and
- 2 urban Indian health organizations.

These respondents are shown by percentages in Figure 1.

Figure 1. Consultation Respondents



To understand the scope of the input gathered for this consultation, it is important to understand the role of regional and national Native organizations. Some Native organizations who gave input in this consultation included:

- **National Indian Health Board**, representing all federally recognized tribes and the 12 regional Indian Health Boards that represent each IHS area;
- **National Council on Urban Indian Health**, representing 34 federally funded urban Indian health organizations nationwide that serve the majority (70 percent) of the American Indian and Alaska Native population who live in urban areas; and
- **Alaska Native Tribal Health Consortium**, representing all tribal health care systems in Alaska and serving the 229 federally recognized tribes of Alaska.

Taken together, the input of Native organizations (especially national Native organizations) on this consultation represents input on behalf of all 567 federally recognized tribes, indicating the wide range of responses received. The priorities identified and prioritized through tribal consultation are discussed in detail in a special section beginning on page 8.

Brenda McEwing (left) and Julia Kelly

First Nation Women Warriors, Native American Indian Veterans,
and Iraqi War Veterans

Top Priorities
for Veterans in Indian Country

Based on consultation input, the majority of priorities identified for Veterans fell within the current programs undertaken by VA for Native Veterans, showing that VA's current activities have a high degree of alignment with the needs and priorities identified by tribes. However, consultation input did include other priorities identified by tribal leaders that were not part of VA's list of current efforts, suggesting needs in tribal communities and among Native Veterans that VA should investigate.

VA asked tribes to identify their top priorities from among current VA priorities, some of which are specifically related to AI/AN tribal governments and tribal Veterans. During tribal consultation on this subject, tribes identified several additional priorities. The Other Priorities section below describes the additional priorities that were gathered through tribal consultation and explains why they are important to tribal governments.

What Priorities Were Identified?

All priorities for serving Veterans in Indian Country include the following.

71 responses from tribes, Native organizations, urban organizations, and individuals (Native Veterans and advocates) identified **23 priorities** for Veterans in Indian Country.

13 priorities were part of VA's current programming.

All 13 current VA programs and initiatives for Native Veterans were ranked as priorities in consultation input.

10 other priorities were identified by tribes.

Current VA Priorities Supported by Tribes

- Access to Medical Care
- Benefits for Families
- Employment/ Vocational Rehabilitation
- Homelessness
- Housing
- Suicide Prevention
- Transportation
- Treatment for Post-Traumatic Stress Disorder (PTSD) and Mental Health
- Tribal Consultation and Listening Sessions
- Tribal Veterans Representatives
- Understanding Benefits
- VA and IHS or Tribal Facilities Working Together
- VA Supporting Traditional Providers/Treatments

Other Priorities Identified by Tribes

- Care in the Community – VA's Consolidated Care Plan
- Dental Care
- Including Urban Indians and Urban Indian Organizations
- Increasing VA's Cultural Sensitivity
- Nursing Care for Veterans
- Substance Abuse Treatment
- Tribal Veterans Advisory Committee
- Tribal Veterans Cemeteries
- VA Outreach to Tribal Communities
- Veterans Status

Figure 2 and Figure 3 examine tribes' top priorities for serving Veterans. Within both charts, current VA priorities supported by tribes are shown in green. Additional priorities identified by tribes through the consultation process are shown in blue.

Native American Indian Veterans prepare for the Formal Grand Entry ceremony during the Second Annual National Gathering of American Indian Veterans.

Figure 2 shows which priorities were identified the most frequently by consultation respondents. Priorities already included in VA's list of current programs are shown in green, and priorities identified by consultation respondents in addition to VA's list of priorities are shown in blue. This graph focuses on how often a priority was named and does not include whether or not any particular priority was ranked more highly than another.

Figure 2. Percentage of Consultation Respondents Identifying Each Priority

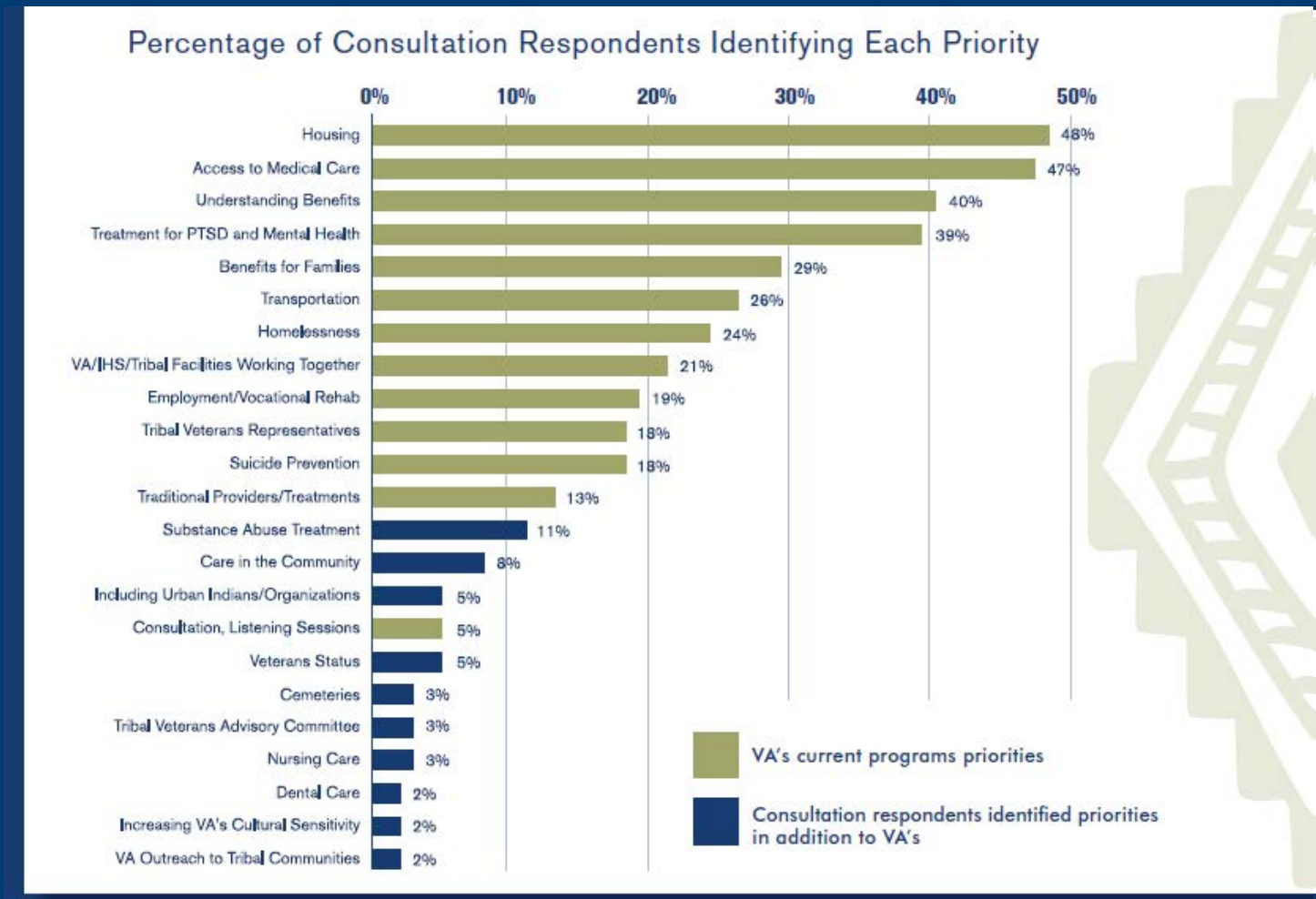
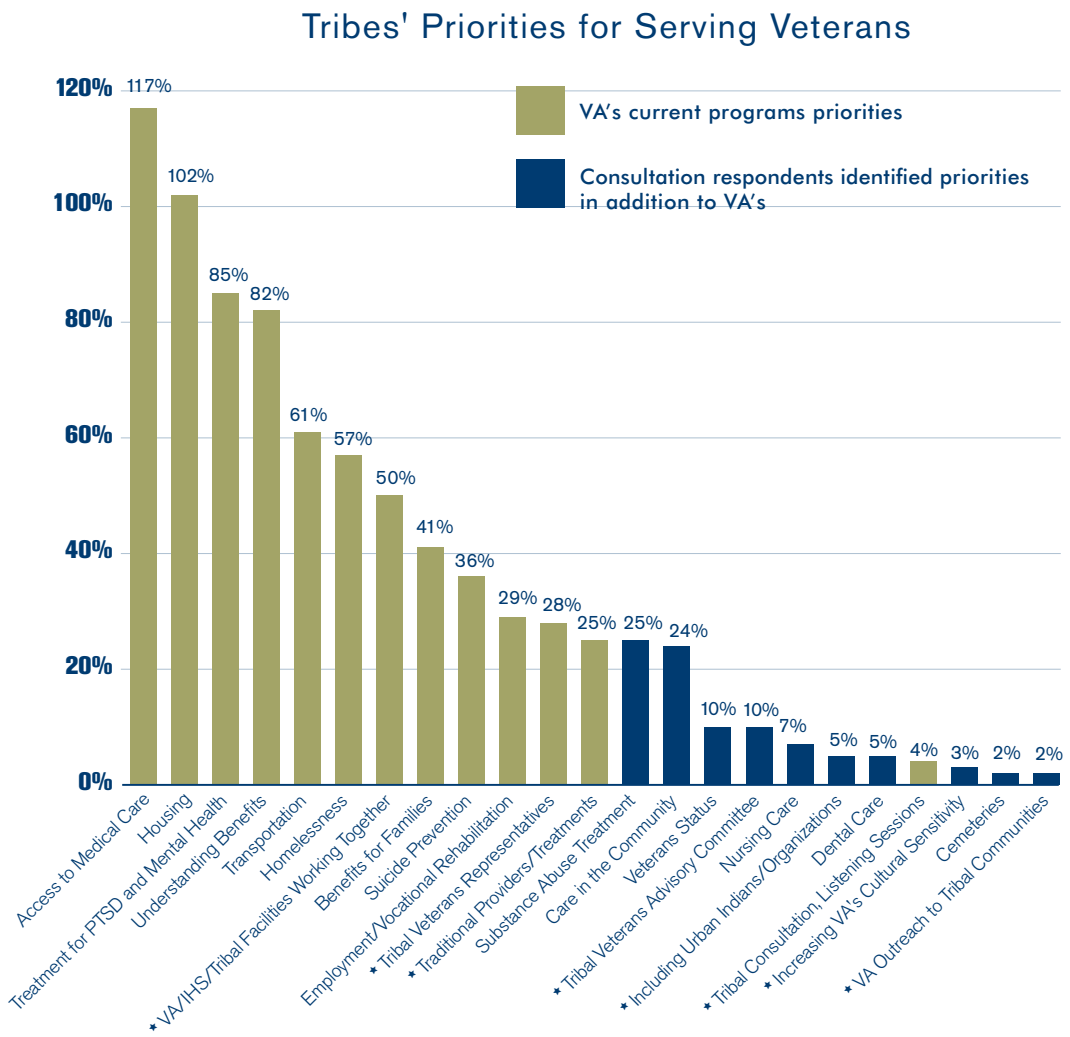


Figure 3 shows how these priorities were ranked. In ranking their priority issues from 1 through 5, consultation respondents gave information about which issues they thought were the most important, relative to other issues. Although ordering the list by ranking does not change the order significantly, it does reveal that **access to health care** was most consistently ranked as the highest priority among consultation respondents. Starred priorities are culturally specific items relevant to AI/AN tribal governments and Veterans.

Figure 3. Ranks Awarded to Each Priority



Based on comparing both lists and combining topics that are closely related, OTGR identified the following priorities for serving Veterans in Indian Country, as expressed by consultation participants in 2016.

Top Priorities for Serving Veterans in Indian Country

1. **Access to health care**
2. **Addressing housing and homelessness**
3. **Treatment for PTSD and mental health**
4. **Understanding benefits, including benefits for families**
5. **Transportation**

Other Priorities

In consultation feedback that OTGR collected, some responses included priorities that were not already identified in the list of VA's current programs and priorities for Veterans in Indian Country. This section discusses these priorities, providing additional information on what they include and why they are important to tribal governments. These other priorities are listed in the order of the frequency and rank with which they were identified in consultation responses.

Substance abuse treatment – Many tribal representatives mentioned the importance of substance abuse treatment resources for Veterans in Indian Country. Of all other priorities identified, this one was identified with the most frequency. Several respondents identified it as their highest priority.

Care in the Community: VA's Consolidated Care Plan – Tribal representatives named the outcomes of VA's Plan to Consolidate Care in the Community as an important issue in their priorities for serving Veterans. Some tribes and organizations, including multiple organizations representing tribes and Native health organizations across the state of Alaska, named the continuation of tribal reimbursement agreements as their highest priority in this consultation. Other tribes indicated the need for assistance in finalizing tribal reimbursement agreements that were currently in process.

> *For further discussion of tribal responses to VA's Plan to Consolidate Care in the Community, see* ***Consultation 3: Care in the Community, on page 17.***

Southcentral Foundation's top three to five priorities can be encapsulated as one: ensuring that the VA and tribal facilities continue to work together by extending the Alaska Sharing and Reimbursement Agreements for at least an additional 5 years.

—Southcentral Foundation (Alaska)

Including urban Indians and urban Indian organizations – Of the three sectors making up the Indian health system—IHS facilities, tribally operated health care facilities, and urban Indian health organizations—urban Indian organizations are the fewest in number and, often, are not explicitly addressed in health policy or programs. Tribal consultation respondents recommended that urban Indian health organizations be represented at tribal consultations and be able to enter into reimbursement agreements with VA.

Veterans status – Some representatives listed determining and changing Veterans' statuses, including their benefit, disability, and discharge status, as a priority. They reported that Native Veterans with other-than-honorable discharges need assistance in changing their discharge status, and Veterans living in remote locations (such as Alaska Native villages) need a way to stay informed about changes in their Veteran status.

Tribal Veterans cemeteries – Some tribes requested assistance in accessing VA's Veterans Cemetery Grants Program through the National Cemetery Administration, which offers grants for tribal governments to establish cemeteries on tribal trust lands.

A tribal Veterans advisory health care committee – Two national Indian organizations, the National Indian Health Board and the National Council on Urban Indian Health, strongly recommended the creation of a tribal Veterans advisory committee on health care. These organizations pointed out that such an advisory committee would follow the model already in use by most agencies within the Department of Health and Human Services, where tribal advisory committees at the agency level are common.

Finally, a small number of consultation respondents mentioned these priorities in serving Veterans:

- Nursing home care and benefits,
- Dental care,
- Increasing VA's cultural sensitivity, and
- Ongoing VA outreach to tribal communities.

VA Consultation and Program Updates

Based on 2016 consultation efforts, VA's Office of Tribal Government Relations has used tribal input to identify the highest shared priorities that American Indian and Alaska Native tribal governments hold for serving Veterans in Indian Country. OTGR has also gained valuable input on the wide range of concerns that tribal governments have when addressing their Veterans' needs. OTGR will share the identified priorities with tribal governments, with Native Veterans organizations, and with other stakeholders. OTGR will also use these priorities to inform VA's administrations and Congress on an ongoing basis about issues that are most important for tribes and for Veterans in Indian Country.

VA works on an ongoing basis to address the needs of Veterans in Indian Country and to advance the current VA programs and priorities that continue to serve Native Veterans and tribal nations.

The Veterans Health Administration, which manages VA's health care activities across the Nation, reported the following accomplishments in 2016 regarding reimbursements between VA, IHS, and tribally operated health programs.

- **99 total reimbursements agreements** have been signed between tribally operated health programs and local VA medical centers, with 10 new agreements finalized in 2016.
- **83 implementation plans** covering 105 IHS sites are active as of 2016. These implementation plans operationalize the processes of VA reimbursement for IHS health facilities.
- **$17.4 million total in VA reimbursements** were issued to IHS and tribal health programs in 2016.

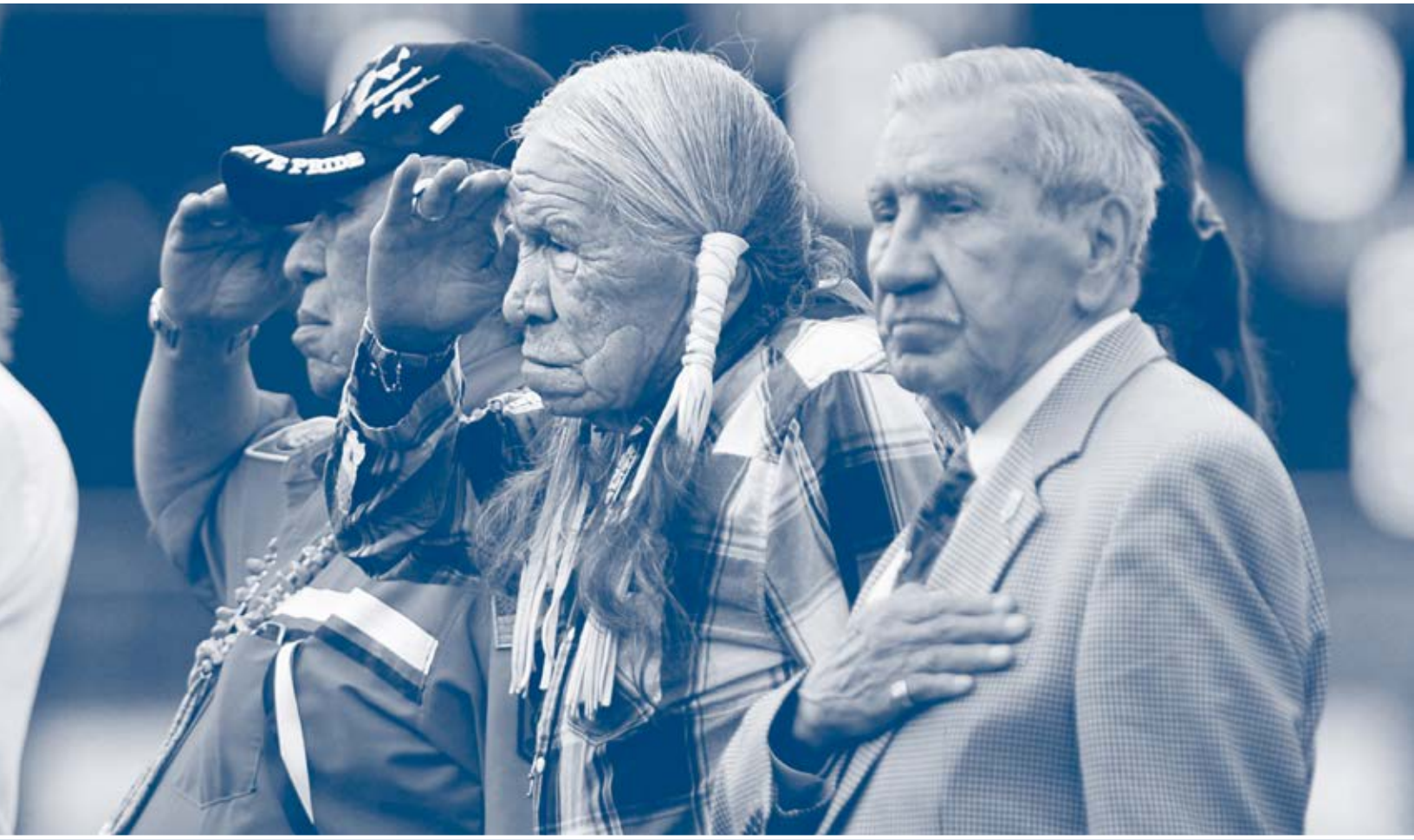
The National Cemetery Administration administers the Veterans Cemetery Grants Program. This program offers grants for tribal governments to establish, expand, and improve cemeteries on tribal trust lands as well as grants for operation and maintenance of such cemeteries. The National Cemetery Administration reported that four new tribal Veterans cemeteries were dedicated or opened in 2016:

- **San Carlos Apache Veterans Cemetery** in San Carlos, AZ;
- **Big Sandy Rancheria Band of Western Mono Indians Veterans Memorial Cemetery** in Auberry, CA;
- **Apsaalooke Veterans Park (Crow Nation)** in Crow Agency, MT; and
- **White Eagle Cemetery (Ponca Tribe)** in Kay County, OK.

Including these four newest cemeteries, there are now **nine tribal Veterans cemeteries fully operational on tribal lands**, which have received funding through the National Cemetery Administration's grant program.

The Native American Direct Loan (NADL) program, administered by the Veterans Benefits Administration, assists eligible Native Veterans in financing, buying, or improving homes on tribal lands by providing loans with no downpayment and low closing costs. Before VA can make a loan to a Veteran, VA and the respective tribal government must sign an MOU. As of 2016, there are **97 total NADL MOUs** between tribes and VA, with four new MOUs finalized during 2016.

VA continues outreach for all of these programs at regional and local levels so tribes and Veterans can learn about the benefits and programs that may be available to them.



Mr. Saginaw Grant (center), Mr. Norman Shay (right), Mr. Joe Yazzie (left)

Native American Indian Veterans perform opening festivities, including "First Pitch" and Color Guard ceremony, complete with Eagle Staffs, during the Second Annual National Gathering of American Indian Veterans held at Cantigny Park in Wheaton, Illinois, on August 19-21, 2016.

Consultation 3:
Care in the Community

In the third consultation topic of 2016, VA asked tribes for input on questions related to consolidating health care provided to Veterans through non-VA health facilities into a standard system. This vision for consolidation was described in VA's *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, which was drafted by the Veterans Health Administration. The plan was required by the VA Budget and Choice Improvement Act, section 4002, and was submitted to Congress in October 2015.

The goal for this consultation was to seek tribal input about the possible impacts of proposed consolidation measures that would assist VA in developing a more standardized and consolidated health care network. VA asked tribes to comment specifically on the following issues:

- Transitioning from the current reimbursement structure (based on reimbursement agreements between VA and IHS and tribal health programs) to a standard arrangement for reimbursement managed by a third-party administrator for VA;
- Expanding direct care services under this new structure, to include reimbursements for care provided to Veterans enrolled in VA health care, whether or not they are eligible for IHS or tribal health care;

Consultation 3 Topic and Questions

- Consolidation of non-VA care, including:
  - ◊ Standardized reimbursement structure;
  - ◊ Serving non-Native Veterans;
  - ◊ Reimbursement rates; and
  - ◊ Extension of existing reimbursement agreements.

Consultation Period

September 12, 2016 – November 30, 2016

Dear Tribal Leader Letter

Released September 12, 2016.

See Appendix C, page 46, for the full text of the letter.

Consultation Event

September 28, 2016, in Washington, DC, in conjunction with White House Tribal Nations Conference.

- Receiving standardized reimbursements based on a Medicare plus a feasible percentage rate within a new consolidated system; and
- Extending any new and existing reimbursement agreements between VA and tribal health programs through December 2018, as VA works to implement a consolidated care program.

Consultation input from tribes and Native organizations is listed in **Consultation Questions and Answers on page 20,** and grouped according to these four issues.

2015 Consultation as Background: Including IHS/Tribal Providers in VA's Core Provider Network

In 2015, VA conducted consultation with tribal governments on questions related to the proposed transition to a consolidated system.

As it prepared to submit its plan to consolidate community care, required by the VA Budget and Choice Improvement Act, section 4002, VA proposed to refer to IHS and tribally operated health programs as members of VA's core provider network. In VA's plan for community care, inclusion in the core provider network would preserve and build on VA's existing relationships with IHS and tribal health providers and facilitate future collaboration to improve health care services provided to all eligible, enrolled Veterans. The 2015 tribal consultation asked for input from tribes on the proposed inclusion of IHS and tribal health care facilities in VA's core provider network, as well as VA's efforts to streamline the provision of non-VA care to Veterans.

VA requested tribal input in two consultation letters, and the final comment period closed on October 26, 2015. Feedback from tribes who responded to this consultation opportunity included:

- Strong support for including IHS facilities and tribal health programs as key partners in VA's community network;
- A desire to maintain and strengthen current agreements VA has with IHS and tribal health programs; and
- Interest from IHS and tribal health programs to potentially serve non-Native Veterans.

Tribal input received during this consultation was used to inform the plan to consolidate community care that VA submitted to Congress on October 30, 2015. Consultation in 2016 continued the discussion about how VA will shape and structure its core provider network and other non-VA care to deliver care to Veterans, and how IHS and tribal health care facilities will be incorporated.

Consultation Event

The 2016 consultation on care in the community was supported by the release of a Dear Tribal Leader letter on September 12, 2016, which invited tribes to submit written input and attend an in-person consultation event. (See Appendix D, page 50, for full text of the letter). The consultation event took place on September 28, 2016, at the National Museum of the American Indian in Washington, DC, scheduled in conjunction with the White House Tribal Nations Conference, which took place on September 26 and 27, 2016.

The consultation event was facilitated by:

- **James Albino,** Deputy Assistant Secretary for Intergovernmental Affairs, and
- **Stephanie E. Birdwell,** Director, Office of Tribal Government Relations.

The following officials represented VA and its departments, particularly the Veterans Health Administration, which authored the plan for consolidated care:

- **Dr. Richard Stone**, Principal Deputy Under Secretary for Health;
- **Dr. Baligh Yehia**, Assistant Deputy Under Secretary for Health, Community Care, Veterans Health Administration; and
- **Majed Ibrahim,** IHS/Tribal Health Program Reimbursement Agreements Program Manager, Chief Business Office, Veterans Health Administration.

Consultation Input

Of the topics in 2016, consultation on care in the community gathered the most detailed policy input on VA's proposed care strategies. This report summarizes that input, so that VA has a record of the concerns and input shared by tribes as it continues to develop and refine its care in the community proposal.

Including written testimony and testimony at the in-person event, consultation input was received from:

- 30 tribes and tribal and urban health organizations and
- 9 national and regional Native organizations.

The nine regional and national Native organizations that gave consultation input represented tribes across the nation. There are 567 federally recognized tribes, and some tribes were represented by more than one organization. National Indian organizations with broad membership and representation who gave consultation input included, but were not limited to:

- **National Indian Health Board,** representing the health interests of all tribal governments, including those that operate their own health care systems and those served by IHS;

- **National Council on Urban Indian Health,** representing 34 federally funded urban Indian health organizations nationwide that serve 70 percent of the American Indian and Alaska Native population that live in urban areas (areas that are not on reservations);
- **Tribal Self Governance Committee,** representing 360 self-governance tribes (tribes that are contracted with IHS to operate their own health programs); and
- **Alaska Native Health Board,** representing all 229 federally recognized tribes in the state of Alaska.

Consultation Questions and Answers

Based on the four questions from VA in the Dear Tribal Leader letter (included as Appendix D, page 50) for this consultation topic, input from tribal and Native organizations is listed below.

Question 1: Standardizing Reimbursement Structure, with Third-Party Administrator

What would be the impact of transitioning from the existing reimbursement agreement structure, which requires each tribe to enter into an individual reimbursement agreement with VA, to a standard arrangement for reimbursement of direct care services provided to eligible Veterans managed by a third-party administrator for VA?

Summary of Tribal Responses to Question 1

All tribes and organizations that responded uniformly expressed that they do not support transitioning to a standardized agreement for reimbursement. The main reasons tribes oppose this change are because it groups American Indian and Alaska tribes with VA vendors and other businesses, instead of respecting tribes' unique relationship with the Federal Government. This relationship includes the federal trust responsibility and the government-to-government relationship, both of which substantially predate the Choice Act. Tribes prefer the current Memorandum of Understanding Between the Department of Veterans Affairs (VA) and Indian Health Service (IHS) (VA-IHS MOU) and the IHS and tribal health program reimbursement agreements to the proposed consolidation and argue that the VA-IHS MOU and IHS/tribal reimbursement agreements should be fully implemented, extended, and improved as the best strategy to address VA's health care delivery goals. No tribal respondents indicated support for the proposed consolidation. When tribes addressed a possible consolidation, it was to enumerate concerns they anticipated with its implementation.

Standardized Reimbursement Structure

Tribes stated that they are not vendors, and a standardized agreement that consolidates tribes with other VA vendors is not acceptable.

A standard agreement developed by a third-party administrator would not reflect tribes' government-to-government relationship with VA and with the Federal Government. IHS and tribal health programs are not a procurement source. They are federally funded programs

carrying out federal responsibilities alongside VA. The federal trust responsibility that VA has toward tribes, and the authorization of sharing arrangements through the Indian Health Care and Improvement Act of 2010, are distinct from and supersede the Choice Act.

As Secretary McDonald expressed so eloquently when he met with tribes in Alaska [in 2015], it makes no sense for VA to pay a vendor to manage VA's relationships with governmental partners, including Indian health providers. Introducing a vendor into the mix as a go-between merely complicates the referral process for the Veteran, the local Veterans Health Administration programs, and the Indian health programs.

—Alaska Native Tribal Health Consortium

Tribes reminded VA that the U.S. Federal Government has a trust responsibility to provide health care to tribal nations and to American Indian and Alaska Native citizens based on the treaties signed between the U.S. Government and tribes.

The United States has a trust obligation to provide health care to all American Indian and Alaska Native citizens, which has been recognized through treaties, statutes, executive orders, and Supreme Court case law. This trust obligation extends to the entire Federal Government, including VA, which is a critical component of the Federal Government's trust responsibility to provide health care to Native Veteran patients. Many tribes explained how decreases in services, resulting from any decreases in reimbursement rates or access to care, would violate the Federal Government's trust responsibility. Some tribes argued that a breach in the current reimbursement agreements would be a failure of the Federal Government to provide treaty-secured health care to Native Veterans.

Tribes reminded VA that VA's Secretary committed to maintain a direct government-to-government relationship with tribes when he addressed Alaska tribes in 2015.

In August 2015, VA Secretary Robert McDonald visited Alaska and addressed the Alaska Native Health Board Mega Meeting, recognizing the sovereign status of tribes and committing to a government-to-government relationship in line with President Obama's 2009 memorandum on tribal consultation. The Secretary said he viewed VA's relationship with tribes as having "favored status," in line with working with other arms of the government, such as the Departments of Defense and Health and Human Services. The Secretary explained that it makes no sense for VA to pay a vendor to manage VA's relationships with governmental partners, including Indian health providers. Introducing a vendor into the mix as a go-between merely complicates the referral process for Veterans, local Veterans Health Administration programs, and Indian health programs.

In August 2015, Secretary McDonald recognized the sovereign status of tribes and committed to a government-to-government relationship in line with President Obama's efforts. He shared he viewed the Department of Veteran Affairs' relationship with tribes as having "favored status," in line as working with other arms of the government, such as the Department of Defense and the Department of Health and Human Services. Tribes assert that we are not vendors, and thusly, should not be categorized as part of the Community Care program.

—Alaska Native Health Board

Tribes referenced the consolidation plan that the Veterans Health Administration submitted to Congress, which stated that VA will honor its current relationship with federal partners, including IHS and tribal health programs.

In October 30, 2015, VA reported to Congress on its "Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care" as part of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. In this report, VA stated its intent to "...honor VA's special relationships with strategic partners, such as DoD [the Department of Defense], IHS, THP [tribal health programs], FQHC [federally qualified health centers] ..." in its efforts to implement a new purchased care strategy. Going further, the report explicitly identified IHS and tribal health programs, explaining that "VA will continue to use established payment mechanisms with DoD, IHS, THP, FQHC, and academic teaching affiliates while at the same time moving toward paying Medicare rates for commercial partners." Tribes said they agree with these recommendations and asked why VA contravened its commitment to IHS, tribal health programs, and its own plan that it submitted to Congress.

Tribes are concerned about the problems they anticipate under a third-party-administered VA system, and they believe that the terms of new agreements would be unfavorable compared to current reimbursement agreements.

Tribes anticipate the following undesirable consequences of a consolidation:

- Services would require pre-authorizations, interrupting continuity of care and causing delays.
- Native Veterans would be expected to pay copays, which is unacceptable given the federal trust responsibility.
- A third-party administrator would add a layer of costly bureaucracy between VA and tribal health programs.

- Reimbursement rates to tribal health programs would decrease.
- The third-party administrator would not be knowledgeable about the Indian health system.
- A new system might be like the military's Tricare, which has delays, poor customer service, and highly stringent reimbursement requirements.
- IHS and tribal health programs would need to re-learn a new process for billing, creating administrative challenges and costs.

Tribes said that individual agreements between tribes and VA are necessary, instead of one consolidated agreement.

Each tribe has its own government-to-government relationship with VA and is entitled to negotiate its own terms that best meet the needs of its Veterans. Common language, or an agreement template, could be provided as a starting place for negotiations. Tribal consultation would be a critical element of developing such a common template.

Tribes expressed a belief that consolidating reimbursement agreements under a standardized VA plan would also nullify the current VA-IHS MOU, and conveyed that changes to the MOU are undesirable.

Tribes indicated that, instead of consolidating reimbursement agreements under VA, the VA-IHS MOU should be continued and fully implemented. Consolidation would cause the loss of the MOU's many provisions for collaboration and resource sharing between VA and IHS, including cooperation on staffing, facilities, and tribal access to the Consolidated Mail Order Pharmacy.

Tribes explained that current reimbursement agreements provide unique values and benefits that would not be captured by a consolidated plan.

The current reimbursement agreements provide access to care for AI/AN Veterans close to home in rural areas. They ensure that AI/AN Veterans have access to culturally sensitive care. Several tribes identified keeping in place the VA-IHS MOU and the related reimbursement agreements between tribal health programs and IHS as their highest priority for serving Veterans in Indian Country. Tribes recommended that the VA-IHS MOU model be used as a foundation for implementing services under the Choice Act because of its current successes.

Tribes requested further consultation if the consolidated plan moves forward.

Tribes reminded VA that, if a future consolidation agreement is developed, it needs to be communicated clearly to tribes. VA should provide opportunities for consultation to ensure tribal input and feedback is included.

VA provides the following response on a standardized reimbursement structure.

At this time, VA will maintain a direct relationship with tribes and IHS through the current reimbursement agreement structure. Without changing any significant terms, VA proposes to amend all existing agreements to reflect a new expiration date of June 30, 2019. Meanwhile, VA will work closely with tribal health programs, through consultation and other collaborative activities with tribes, to ensure that VA's consolidated community care program allows for the continuation and growth of the unique relationship that tribal health programs have with VA and Veterans.

VA has the responsibility of paying for care provided to eligible Native and non-Native Veterans in a manner that is fair, reasonable, and properly reflects the services provided. Between now and June 30, 2019, VA would like to work with tribes to consider how some of the agreements' terms, such as the rate structure, could be changed in future agreements to reflect a more recent industry-standard, value-based structure that benefits the Veterans who receive care.

Third-Party Administration

Tribes recommended that third-party administration of a standardized VA system, if it occurs, needs careful oversight and monitoring.

Tribes indicated that VA must ensure respectable reimbursement timelines, acceptable processing guidelines, and tribal customer service representatives.

VA provided the following response on third-party administration.

At this time, VA will not employ a third-party entity to administer the reimbursement process between VA and tribes. Instead, VA will continue to maintain a direct relationship with tribes through reimbursement agreements. VA will also continue to process claims received from tribes in a timely manner, within 30 days from the receipt and approval of the claim.

Support for the VA-IHS MOU

Tribes believe that consolidating reimbursement agreements under a standardized VA plan would also nullify the current VA-IHS MOU, and that changes to the MOU are undesirable.

Instead of consolidating reimbursement agreements under VA, the VA-IHS MOU should be continued and should be implemented fully. Consolidation would cause the loss of the many provisions for collaboration and resource sharing between VA and IHS in the MOU, including cooperation on staffing, facilities, and tribal access to the Consolidated Mail Order Pharmacy.

We do not support or recommend that tribal [reimbursement] agreements be standardized to incorporate Choice Act provisions because the current agreements are successful in providing additional care to AI/ANs and respect the government-to-government relationship.

—Tribal Self Governance Advisory Committee

VA provided the following response on the VA-IHS MOU.

Activities under the reimbursement agreements fall under only one provision of the larger 2010 VA-IHS MOU. Efforts related to the reimbursement agreements would not affect the ongoing implementation of other elements of the MOU. At this time, VA will maintain its direct relationship with IHS and tribes through the current reimbursement agreements structure. Along with tribal health program reimbursement agreements, the Agreement Between the Department of Veterans Affairs Veterans Health Administration and Department of Health and Human Services Indian Health Service for Reimbursement for Direct Health Care Services (VHA-IHS Reimbursement Agreement) has been amended to reflect a new expiration date of June 30, 2019.

Meanwhile, VA will work closely with IHS and tribes to enhance the reimbursement agreement for the benefit of Veterans.

Expansion and Improvement of Current Agreements

Tribes noted that the current reimbursement agreement model has great capacity to be extended to other tribes.

Tribes expressed a belief that too few reimbursement agreements have been finalized, suggesting there is much more capacity to improve access to care for Veterans, especially in remote and rural locations.

Tribes argued that current reimbursement agreements can be improved by streamlining the process to create and approve them.

Some tribes reported waiting multiple years for reimbursement agreements to be finalized and wanted to see improvements to this timeline.

Tribes said that the coordination of care between VA and IHS under the VA-IHS MOU and current reimbursement agreements still needs improvement.

Tribes explained that VA does not reimburse IHS purchased and referred care or tribal health program refereed care, and that Veterans must receive multiple referrals for the same health need.

VA provided the following response on expanding and improving current agreements.

VA currently has 99 reimbursement agreements in place and is actively seeking additional agreements with interested tribes. In coordination with IHS and OTGR, the VA team that oversees IHS and tribal health program reimbursement agreements continues to conduct multiple outreach activities to increase the number of agreements.

The average time to establish a reimbursement agreement is about 3 months from the time the tribe attends the initial orientation call. However, this time varies and may extend to years if tribes are interested in changing the terms of the established agreement template or if site readiness documentation is not completed and submitted in a timely manner. In a few cases, VA was not able to execute agreements with tribes because of the changes the tribes asked for. The tribal health program reimbursement agreement template is based on the VA-IHS Reimbursement Agreement, which has been reviewed for compliance with appropriate legal authorities. Significant deviations from the template result in additional reviews for statutory and regulatory compliance, which causes delays and may ultimately be outside the authority or scope of these specific agreements.

VA acknowledges that current reimbursement agreements cover direct care services and exclude referred care services. Moving forward, VA will work with IHS and tribal health programs to explore the possibility of properly and feasibly including referred care in reimbursement agreements.

Question 2: Serving Non-Native Veterans

Would tribal health programs be interested in expanding direct care services under this new structure to include reimbursements for care provided to all Veterans enrolled in VA health care, regardless of whether they are eligible for IHS-funded health care or not?

Summary of Tribal Responses to Question 2

Most tribes responded that they would be interested in expanding services to non-Native Veterans, providing that the reimbursement rate for services remains the same as that for Native Veterans. These tribes also clarified that as a general rule that serving non-Native Veterans must be adopted at the choice of each tribe and could not be dictated by an outside source. Tribes in Alaska are already serving non-Native Veterans under their current statewide reimbursement agreements, and they reported that this is a successful arrangement. A small number of tribes reported that they were not interested in serving non-Native Veterans or that serving non-Native Veterans was specifically unallowable under their tribal health program.

Serving Non-Native Veterans

Tribes already have the authority to serve non-Native patients in tribal health facilities, and this change is desirable.

Under existing policy, including Section 813 of the Indian Health Care Improvement Act, tribes and tribal organizations may elect, but are not required to provide health care services to non-IHS beneficiaries. This existing authority is the least administratively burdensome way to extend care to non-Native Veterans living in remote areas served by tribal health programs.

Alaska tribes are already successfully serving non-Native Veterans.

Alaska tribes currently serve 6,500 non-Native Veterans in their tribal health system, and they report that their referral and approval system for serving non-Native Veterans could be easily exportable to other areas. In the Alaska system, non-Native Veterans are seen by tribal health programs when they are referred to a tribal health facility by VA, often because nearby VA facilities lack the capacity to serve their medical needs or when they live more than 40 miles away from a VA health facility.

We serve a large non-Native population [already], particularly in our rural communities where we're the only [health care] provider … it's a very sophisticated system … [and] the Alaska tribal sharing agreement actually became the model for the Choice program.

—Norton Sound Health Corporation (Alaska)

Tribes that agree to serve non-Native Veterans should have choice and flexibility around how to implement this change.

Tribes that agree to expand care to non-Native Veterans recommend that the impact be continuously monitored to ensure that care for IHS-eligible patients does not diminish in quality. Any reimbursement agreement relating to non-IHS Veterans should allow tribes to define what direct care services it can make available.

Tribes argued that reimbursement rates for non-IHS patients should be the same as for Native Veterans.

Tribal health programs should be reimbursed for all VA patients, regardless of whether they qualify for IHS care, and the same rates should be paid for all Veterans. Current cost-based reimbursement is designed to ensure the viability of extending and maintaining access in some of the most remote and rural parts of the United States, and this rate should be maintained.

Some tribes do not plan to see non-IHS-beneficiary patients because of regulations and because it may diminish the quality of care for existing patients.

These tribes explain that providing services to non-eligible patients would be inappropriate, given the unmet needs of their existing eligible patients, or unallowable, because of current service agreements.

VA provided the following response on serving non-Native Veterans.

VA understands that tribes can and do currently elect to provide care to non-Native Veterans at their tribal health facilities. VA particularly acknowledges the success that Alaska tribes have had in serving non-Native Veterans. VA will continue to reimburse Alaska tribal health programs for care provided to non-Native Veterans in Alaska. Without changing any significant terms, including reimbursements for non-Native Veterans, VA proposes to amend the existing reimbursement agreements with Alaska tribes to reflect a new expiration date of June 30, 2019.

For tribal health programs desiring to serve non-Native Veterans, VA will work closely with interested programs to assess their capacity to expand care to non-Native Veterans. Regarding reimbursement rates specifically for non-IHS patients, VA will work with tribes to explore what mechanisms may be available to reimburse care for non-Native Veterans, including the agreement terms, and work to implement a system that is best for Veterans. VA also understands that expanding care to non-Native Veterans is a choice on the part of each tribal health program, and that not all programs are able to provide care to non-Native Veterans. For tribes or programs where interest exists in expanding care to non-Native Veterans, VA will explore with the health programs what mechanisms may be available to achieve it. VA will work with individual tribes to determine what is appropriate before any action is taken.

Question 3: Standardizing Reimbursement Rates

Would tribal health programs be interested in receiving standard reimbursement rates based on Medicare rates, plus a feasible percentage of those rates that minimize improper payments and comply with industry standards?

Summary of Tribal Responses to Question 3

Tribes uniformly reject the proposal to be reimbursed at a standard Medicare-plus rate, because current reimbursement agreements are based on the rate set by the Office of Management and Budget (OMB), a rate that is used throughout the Indian health system. The OMB rate is a higher, encounter-based rate that more accurately estimates the costs

of delivering health care within the rural and remote locations of the Indian health system. Tribes argue that VA provides a critical resource stream for IHS/tribal health program facilities, and that a reduction in reimbursement rates would result in a direct decrease in the quality of care available to Veterans. Tribes also strongly recommend that purchased and referred care (along with direct care services) be reimbursed by VA to fully implement the directive in the Indian Health Care Improvement Act that IHS/tribal health programs are always the payers of last resort.

Standardizing Reimbursement Rates

Tribes do not approve switching away from the OMB rate to a Medicare-plus rate.

The Indian health system, because of its uniqueness, uses the encounter rate established by OMB. When the prospective payment system was developed for Medicare and Medicaid, the Indian health system was exempted from it and continues to use the encounter rate. The rate is established based on the costs for the facility, infrastructure, and provision of care in the Indian health system. This rate is established similarly to how federally qualified health centers establish their rates. Nothing about the encounter rate is improper or out of line with established industry standards.

> *[National Indian Health Board] strongly opposes the standard rate and any reduction in the rate because of the circumstances that AI/ANs face with regards to physical health and social determinants of health. Any reduction in reimbursement will further exacerbate the conditions that the Indian Health System faces.*
>
> **—National Indian Health Board**

Tribes explained that any decrease in reimbursements to IHS/tribal health program facilities will exacerbate current resource shortages in the Indian health system and ration care for Veterans.

Reductions in payments to IHS/tribal health program facilities will reduce the number of services available to Native Veterans, which will diminish access to quality care and widen existing health disparities. IHS and tribal health programs are only funded at around 54 percent of the need, and lower reimbursement rates from VA for more services will further drain their limited health care resources.

Tribes are concerned that switching to a new rate will incur administrative costs for tribes and for VA. The current VA-IHS MOU and reimbursement rates provide care for the least administrative burden.

Transitioning to a new and separate reimbursement process will require special administration and technical staffing for both tribal and VA staff—not just for billing, but also in setting the feasible percentage and proposed rates for non-Native Veterans. Tribes are concerned that a new agreement would diminish the quality of care and services for Veterans and other IHS/tribal health program patients.

VA reimbursements to IHS/tribal health program providers, even at the higher OMB rate, are a negligible part of VA's budget.

In 2015, VA provided $33 million in reimbursements to IHS/tribal health program facilities, representing approximately 0.06 percent of VA's entire health budget and 1 percent of the IHS budget. Further, Veterans' health is funded at twice the level per person that IHS is funded. IHS appropriations are currently at approximately $3,200 per patient, which is far below VA health resources per patient and below the national average for health spending. VA's budget for 200,000 homeless Veterans is equivalent to the total funding for the more than 5 million eligible individuals served by IHS.

VA Responses on Standardizing Reimbursement Rates

VA has the responsibility of paying for care provided to Native and non-Native Veterans in a manner that is fair, reasonable, and properly reflects the services provided, regardless of the total dollar amount reimbursed to IHS and tribal health programs in comparison to the total VA health care budget. To support this responsibility, VA proposes to maintain the current direct relationship with tribes and, without changing any significant terms, amend all existing reimbursement agreements to reflect a new expiration date of June 30, 2019. VA will also work with tribal health programs to ensure that VA's consolidated community care program allows for the continuation and growth of the unique relationship that tribal health programs have with VA and with the Veterans they serve in their communities.

VA will work closely with tribes to revisit some of the terms, including potentially changing the rate structure to a more recent industry-standard, value-based structure that benefits the Veterans who receive care and enhances the quality of that care.

Reimbursements for Purchased and Referred Care

Reimbursements must be expanded to include purchased and referred care.

The current national reimbursement agreement with IHS and, by default, nearly all tribal health program agreements, do not include reimbursements for purchased/referred care. Reimbursement for specialty care provided through purchased and referred care is essential to ensure that Veterans receive the best care possible. Nationally, only 1 in 13 visits is an inpatient visit, but Veterans often need additional services, which cannot be provided directly by IHS/tribal health program providers. Failure to include purchased and referred care in the initial agreement further rations the amount of health care IHS/tribal health programs can provide to Native Veterans and other eligible American Indians and Alaska Natives in the system. It also reflects the fact that Section 405(c) of the Indian Health Care Improvement Act has not been fully implemented. This section specifies that Indian health programs are always the payer of last resort.

Failure to include purchased/referred care in the [reimbursement] agreements further rations the amount of health care IHS and [tribal health programs] can provide to Native Veterans and other eligible American Indians and Alaska Natives in the system.

—Northwest Portland Area Indian Health Board

VA provided the following response on reimbursements for purchased and referred care.

Currently, reimbursement agreements cover direct care services and exclude referred care services. Moving forward, VA will work with IHS and tribal health programs to explore the possibility of properly and feasibly including referred care in reimbursement agreements.

Improper Payments

Tribes are confused and upset as to why VA would imply that tribes have made improper payments.

VA has or can request access to the health records that establish that the care provided by IHS/tribal health program facilities is clinically needed and necessary. VA has not shared any concerns with IHS/tribal health programs about their services or payments.

VA provided the following response on improper payments.

VA did not intend to imply that tribes have intentionally made or would make improper payments. Errors by both VA and tribal health programs may occur unintentionally.

Question 4: Extending Existing Reimbursement Agreements

Would tribal health programs be interested in extending existing reimbursement agreements between VA and tribal health programs through December 2018 and ensuring any new reimbursement agreements between VA and tribal health programs extend through December 2018, as VA works in collaboration with tribes and other VA stakeholders on implementing a consolidated community care program?

Summary of Tribal Responses to Question 4

Tribes agreed that existing reimbursement agreements should be extended, but they did not agree that an extension should be for the purpose of implementing a consolidated program. Many tribes agreed with extending existing agreements through December 2018, but more tribes recommended to extend them for 5 years. Some tribes recommended that the current agreements should be extended indefinitely. While tribes consistently supported extending the agreements, they offered different justifications for the extension, as described below.

Extending Reimbursement Agreements

Tribes recommend to renew existing agreements for 5 years to accommodate tribal health programs' need for stability, continuity, and capacity planning.

The current capacity of IHS/tribal health programs did not occur overnight. It was the product of long-term capacity building. VA reimbursement agreements are part of this capacity and can inform health system development if they are implemented with appropriate timeframes. A renewal timeframe of 5 years is needed to accommodate any kind of transition from current agreements.

Tribes recommend to extend current agreements indefinitely and to create a mechanism that allows automatic renewal. Tribes recommended that reimbursement agreements be extended instead of transitioning to a consolidated system.

VA should extend existing reimbursement agreements through December 2018 at a minimum and work to improve the execution of existing agreements, rather than eliminating them and moving towards consolidation into Community Care. Tribes recommend further discussions and consultation regarding auto-renewals for existing agreements, which would address the delays in finalizing current agreements and allow agreements to be extended indefinitely. Some tribes identified the extension of current reimbursement agreements as their highest priority for serving Veterans in Indian Country.

Some tribes agreed with extending current agreements through December 2018.

Tribes see the benefits of extending the existing reimbursement agreements between VA and tribal health programs through December 2018, at a minimum. VA has not provided any compelling evidence to Congress, IHS, or tribes to discontinue the current agreements.

VA should extend the IHS-VA agreements through December 2018 at a minimum, and work to improve the execution of existing agreements, rather than eliminating and moving towards consolidation into Community Care. If the VA is committed to fulfilling its federal trust responsibility … strengthening the VA-IHS agreements will be critical to achieving this goal.

—United South and Eastern Tribes

VA provided the following response on extending reimbursement agreements.

VA is proposing to amend its existing agreement to reflect a new expiration date of June 30, 2019. VA is unable to renew existing agreements indefinitely. VA is planning to work closely with IHS and tribal health programs to continue a mutually beneficial relationship beyond that date.

Facilitating Agreements for Additional Collaboration

Tribes recommend that mechanisms allowing agreements to be finalized faster should be implemented, creating an incentive for greater collaboration between VA and IHS/tribal health programs.

Tribes report that it can take years to finalize service expansion agreements between VA and IHS/tribal health program facilities, which could limit incentives to pursue such agreements. For example, in one area, it took 3 years to process an agreement to allow a VA medical center to use a small area in an IHS facility for 2 days per week, in part due to VA's lengthy legal and contracting reviews and the layers of approval required to establish an agreement.

VA provided the following response on facilitating agreements for additional collaborations.

The 2016 consultation is about reimbursement agreements between VA and tribes. The consultation is not related to other types of agreements or memoranda of understanding that tribes may seek to establish with individual VA medical centers. The average time to establish a reimbursement agreement is about 3 months from the time the tribe attends the initial orientation call. However, this time varies and may extend to years if tribes are interested in changing the terms of the established agreement template or if site readiness documentation is not completed and submitted in a timely manner.

Other Consultation Input

Tribes and tribal organizations offered other recommendations that did not fall directly under the four consultation questions about the standardization of VA care delivery.

Summary of Other Tribal Comments and VA Responses

In addition to recommendations on care consolidation, tribes raised the following priorities: (1) discontinuing copays for Native Veterans; (2) allowing tribal health programs to access the Consolidated Mail Order Pharmacy, as IHS does; (3) addressing the needs of urban Indians and collaborating with urban Indian health organizations; (4) creating a workgroup or VA advisory committee that includes IHS, tribal, and urban Indian health program representatives; and (5) reimbursing traditional providers. Tribal consultation input and VA responses on these topics are listed below.

Collection of Copays from Native Veterans

Tribes argue that the practice of collecting copays from Native Veterans should be discontinued.

Currently, Native Veterans who present at a VA facility are assessed copays. Tribes have previously expressed concerns that this practice is wrong, given the federal trust responsibility. IHS and tribes are the payer of last resort, whether or not there is a specific agreement in place for reimbursement. Neither the Native Veteran nor the Indian health system should be responsible for any copays. Often, Native Veterans do not go to VA facilities because of the financial burden of the required copays.

VA provided the following response on copays.

VA is required by law to assess copayments to certain Veterans who receive VA health care. VA cannot waive copayments or exempt categories of Veterans from copayment requirements without authorizing legislation. However, if IHS or a tribe will pay such a copayment on behalf of the Veteran, VA will accept the payment.

Tribal Access to the CMOP

Tribes recommend that tribal health programs be allowed to access the Consolidated Mail Order Pharmacy (CMOP).

VA contracts with IHS to access the National Supply Service Center and save federal funding on high volume prescriptions. However, VA has not extended the same opportunity to tribal health programs. Tribes are assuming and operating the same health programs previously operated by IHS, but when tribes assume operation of these IHS facilities, their access to the CMOP is terminated. Requests to VA to enter contracts with tribal health programs have been rejected thus far. There are significant cost savings to Indian health programs if VA's pharmacy services can be used, and these services would also provide alternatives to patients with transportation challenges and decrease their travel costs.

VA provided the following response on access to CMOP.

VA completed an Interagency Agreement (IAA) with IHS that enables Tribal health programs (THP) access to CMOP. It was signed on December 15, 2016. The IAA, identified by IHS with an internal administrative control number (2-OD-17-0008), provides THPs access to CMOP fulfillment services, as long as the THPs and IHS comply with the terms agreed upon in the IAA.

Addressing the Needs of Urban Indians

Tribes recommend that VA increase its ability to address the needs of urban Indians, by addressing the following concerns.

- The 2010 VA-IHS MOU states a commitment to work with urban Indian health programs, but there are currently no reimbursement agreements with any urban Indian programs.
- Urban Indian organizations that gave consultation input would be interested in providing care to non-IHS-eligible Veterans and seeing existing reimbursement agreements extended and expanded.
- VA should include urban Indian health programs and build strong relationships with them to increase the number of Native Veterans who access VA services. When asked at the National Indian Health Board conference why VA has not worked with urban Indian programs to fulfill the Federal Government's trust responsibility, VA stated that there are VA offices in urban settings and working with urban Indian programs was unnecessary. However, many urban Indians prefer to receive health care through urban Indian health programs because of shorter wait times and culturally appropriate care.
- VA's trust obligation to American Indians and Alaska Natives extends to the 70 percent of the Native population that lives in urban areas.

The U.S. Government has a special obligation to provide health services to American Indians and Alaska Natives … Today, 70 percent of all American Indians and Alaska Natives live in areas away from the reservation, many of whom rely on culturally relevant services like NARA. The culturally competent health care and services that NARA provides are vital to the health of our Veterans.

—Native American Rehabilitation Association (NARA), a Portland, OR, urban Indian health organization

VA provided the following response on addressing the needs of urban Indians.

The legal authorities for VA's reimbursement agreements with tribal health programs are 25 U.S.C. 1645 and 38 U.S.C. 8153. Because urban Indian organizations are not included in 25 U.S.C. 1645, VA has not entered into such agreements with urban Indian organizations. However, VA's other authorities allow for urban Indian organizations to potentially become community providers. VA is willing to discuss and explore options for working with urban Indian organizations as community providers.

Establishing a Tribal Workgroup

Tribes recommend that VA establish a workgroup or tribal advisory council that includes IHS, tribal, and urban Indian representatives.

Tribes request that VA establish an IHS/tribal/urban Indian workgroup to engage in discussions and provide recommendations on issues related to the VA-IHS MOU and cooperation with IHS/tribal and urban Indian health programs. Such a process would assure that the differences among the IHS, tribal, and urban Indian health programs are recognized and addressed from the start. Indian health providers have vast experience in working through representatives to negotiate model agreements that do not displace government-to-government negotiations and individual program autonomy, but speed up the process of reaching workable solutions that can be rapidly implemented. While IHS plays a significant role in the funding and support of tribal and urban programs, it cannot be the decisive voice for them. VA should receive input directly from tribal and urban representatives, and tribal and urban representatives should be at the negotiating table with VA and IHS when VA creates agreements with IHS and tribal programs.

VA provided the following response on a tribal workgroup.

VA will consult with IHS and tribes on ways to ensure that the specific and unique needs of IHS, tribal health programs, and urban Indian representatives are recognized and addressed in future agreements.

Reimbursement for Traditional Providers

Tribes recommend that VA reimburse traditional providers.

Traditional healers are essential components of care within many tribal and urban Indian communities, and Veterans' choices should not be limited to a certain type of provider.

VA provided the following response on reimbursement for traditional providers.

The reimbursement agreements between VA and tribal health programs specify that VA will reimburse tribal health programs only for direct care services provided in the VA Medical Benefits Package available in accordance with 38 C.F.R. § 17.38 or otherwise available under statute or regulation to eligible Veterans from VA. VA would need more information to determine whether the agency can reimburse or otherwise contract for traditional healing.

VA Consultation Updates

One of the highest priorities to emerge in the Care in the Community consultation was tribes' desire to see tribal reimbursement agreements continued and extended, rather than combined with other vendors under VA's plan to standardize health care delivery among its community partners. In response to this clear statement of priority, VA proposes to extend the current reimbursement agreement through June 30, 2019. In January 2017, VA and IHS signed an amendment to the VA-IHS reimbursement agreement (originally signed between the two agencies in 2012) **extending the agreement through June 30, 2019**. Based on these amendments, reimbursement from VA to IHS sites, as well as local reimbursement agreements between tribally operated health programs and local VA medical centers, will continue throughout the extension period.

IHS announced this extension in a Dear Tribal Leader letter dated January 17, 2017, which is available online at https://www.ihs.gov/newsroom/triballeaderletters/. IHS also published a summary of this agreement online at https://www.ihs.gov/newsroom/index.cfm/ihs-blog/january2017/ihs-and-va-renew-expand-partnership/. In addition, VA and IHS also signed an interagency agreement authorizing IHS to continue using VA's mail order pharmacy services, which is also available online at the above address.

Conclusion

Through the consultation activities of 2016, VA continued to build and solidify its relationship with tribal governments as partners in delivering services to Veterans. As a result of amendments to VA's regulations about recognition of Tribal Organizations for representation of VA claimants, tribal Veterans service organizations and Veterans service officers can now be credentialed to assist Veterans with their VA benefits, increasing outreach and services to Veterans and communities in Indian Country. As a result of consultation on tribes' top three to five priorities for serving Veterans, VA has received a clear statement of tribal priorities to serve as a guide as VA continues to determine how to serve Veterans in Indian Country more effectively. Finally, as a result of consultation on a plan to standardize VA's care delivery among contracted community partners, VA has reaffirmed and extended one of its most valued mechanisms for cooperation in Indian Country: reimbursement agreements with IHS and tribal health programs. As 2016 consultations conclude, VA reaffirms its appreciation for tribal governments as partners and its respect for the government-to-government relationship that exists between VA and tribal nations.

VA recognizes the critical role that tribal governments will play, in 2017 and beyond, in reaching Veterans in and near Indian Country and acknowledges the stated desire of many tribes to work with VA in serving non-Native Veterans that live in their communities through existing tribal programs. Especially after policy and regulatory changes in 2016, tribal governments and programs are better equipped than ever before to act as an access point to VA services for Native and non-Native Veterans. VA respects tribal governments' unique capacities in this area and will continue to work with them to expand opportunities for collaboration.

With ongoing involvement from tribes, VA plans to capitalize on the existing framework for health care collaboration between VA and Indian health programs, continue engaging in consultation with tribal governments, continue providing technical assistance to tribal programs and communities, and build cooperative relationships with tribal Veterans service officers and other partners in tribal communities.

Particularly as we face an uncertain future, VA wishes to thank tribal governments for their ongoing cooperation and request their continued support and engagement in the future, as VA continues to improve the way it engages and serves Veterans in Indian Country and beyond.

Appendices

Appendix A. VA and IHS: Two Federal Commitments to Health Care

Left to right: **Allegra Long**, Relationship Manager, Pacific District Veterans Experience Office; **Stephanie Birdwell**, Director, OTGR; **Majed Ibrahim,** Chief Business Office, VHA; and **Christopher Mandregan, Jr**., Acting Deputy Director, IHS

In 2016, VA's topics for tribal consultation focused indirectly and directly on health care and on the commitments the Federal Government has made about delivering health care to certain populations and beneficiaries. To understand the policy outcomes at stake in these topics for Veterans, it is important to understand the histories and missions of both VA and the Indian Health Service (IHS), the federal agency tasked with providing for American Indian and Alaska Native (AI/AN) health.

Through the missions of these two agencies, the U.S. Federal Government has made two commitments to health care: for Veterans, who have earned the benefit of health care through VA by their military service, and for American Indians and Alaska Natives, whose right to health care through IHS is grounded in the treaties, case law, and statutes.

VA's Mission: Caring for Those Who Have Borne the Battle

VA's commitment to deliver health care to qualifying Veterans is grounded in the heart of VA's mission as an agency. In 1865, during the Civil War, President Abraham Lincoln spoke to the nation in his second inaugural address, describing the country's need to heal and reconcile, and, in particular, its obligation "to care for him who shall have borne the battle and for his widow, and his orphan…" Lincoln's quote has been adopted as VA's mission statement, describing the agency's commitment to care for the needs of individual Veterans and their families, in recognition of their military service to our Nation.

Today, in reflection of the diversity of Service members, Veterans, and their families and loved ones, VA describes its mission this way:

> *To care for those "who shall have borne the battle," and for their families and survivors.*

Since Lincoln's words in 1865, presidents, elected officials, and VA itself have called caring for our country's Veterans a "sacred obligation."[1] VA takes primary responsibility for this sacred obligation, but also shares it with many other organizations and partners who contribute to ensure that Veterans' needs are addressed as fully and efficiently as possible.

Through health care benefits, VA supports the services that promote, preserve, and restore the health of individual Veterans over the course of their lives following their military service. Health care for Veterans is delivered by the Veterans Health Administration, the largest integrated health system in the Nation, along with other contracted community providers. Currently, there are over 21 million Veterans in the United States,[2] and VA serves more than 9 million of them each year. VA's health system has a history of cooperating with community providers to ensure Veterans can receive the comprehensive services they need. Over time, VA's contracts and collaborations have created a network of providers that have longstanding relationships with VA in delivering health care to Veterans. This includes IHS facilities, tribal health programs, Department of Defense health facilities, federally qualified health centers, academic teaching affiliates, and other private and commercial partners.

The massive scale of VA's care network and the many organizations involved have resulted "in a complex and complicated landscape that Veterans and their caregivers must navigate."[3] To best meet the needs of Veterans, providers, and VA staff, VA faces the obligation to effectively manage this complex landscape on an ongoing basis.

1 VA. (2015, February 26). Taking care of Veterans: a shared responsibility. VAntage Point: Official Blog of the U.S. Department of Veterans Affairs. Retrieved from http://www.blogs.va.gov/VAntage/17472/taking-care-veterans-shared-responsibility/

2 VA National Center for Veterans Analysis and Statistics. (2016). Veteran Population. Retrieved from https://www.va.gov/vetdata/veteran_population.asp

3 VA. (2016, September 12). Dear Tribal Leader letter to American Indian and Alaska Native tribes for consultation. See Appendix D (Page 50)

The Choice Act and MyVA: Connecting with the Community to Meet Veteran Needs

VA's structure for health care delivery has necessarily grown and changed dramatically throughout its history, since the first soldiers' facilities in the Civil War. Today's increasing patient population and complex health care market have sparked two new wide-scale changes that are necessary to address Veterans' health care needs: the Choice Act and MyVA.

In 2014, Congress passed **the Veterans Access, Choice, and Accountability Act of 2014[4] (often refered to as "the Choice Act")** to address problems of health care access and delays in care in VA's system. In the Choice Act, Congress provided new funding and new authority to VA to address these issues. The VA Budget and Choice Improvement Act, section 4002, required VA develop a plan to consolidate all non-VA provider programs by establishing a new, single program.

VA's I CARE Values

- **I**ntegrity
- **C**ommitment
- **A**dvocacy
- **R**espect
- **E**xcellence

The MyVA vision is to provide a seamless, unified Veteran experience across the entire organization and throughout the country.

In October 2015, VA submitted to *Congress the Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*. The plan described VA's vision of a consolidated community care program that would better meet the needs of Veterans, community providers, and VA staff.

With the expiration of the current Choice Act set for August 2017, the question of how VA's care network will be consolidated and transformed to better meet the health care needs of all Veterans remains a critical topic.

The **MyVA** transformation initiative, started in 2014 by VA Secretary Robert McDonald, also aims to fundamentally reimagine the way VA delivers benefits to Veterans, modernizing how the agency does business and putting Veterans in greater control of how, when, and where they receive services. MyVA articulates VA's values and vision and identifies a set of strategic actions to achieve quality and high performance in delivering services.

4 Public Law 113–146

MyVA is already showing success in achieving its goals, with Veterans reporting improvements in their VA experiences and increasing trust in VA as a service provider.

From 2014 to 2016, VA saw decreases in overall wait times for appointments. By late 2016, more than 90 percent of appointments met the 14-day mark, and more than 85 percent were completed within 7 days. There is also an increase in appointments being fulfilled outside of VA, due in part to the ongoing expansion of VA's network of community care options, encompassing more than 350,000 community providers.[5]

MyVA, in its current implementation and its future goals, sets VA on a trajectory to continue meeting Veterans' needs and expectations in benefits, and particularly in health care delivery, by offering flexibility and choice in where and how benefits are delivered.

IHS' Mission: Raising AI/AN Health to the Highest Levels

MyVA and the use of community providers under the Choice Act acknowledge the role that community providers play in delivering health care to Veterans. With a focus on improving Veterans' experiences through choice and flexibility, VA aims to capture the advantages that non-VA providers offer to Veterans with special circumstances, such as those who live in rural locations with few health facilities nearby.

For the approximately 140,000 American Indian and Alaska Native Veterans nationwide,[6] some portion of which are enrolled in the VA health care system[7] a common alternative to receiving medical care through VA is receiving care through the Indian health system. IHS is the Federal agency tasked with providing health services to eligible American Indians and Alaska Natives, and it has evolved since the 1800s out of various federal strategies to provide health care for Native populations. In the 1800s, the U.S. Government gave health services to American Indian communities through the War Department, with military physicians periodically delivering health care and infectious disease vaccinations for tribes living near military forts. In 1849, the government transferred responsibility for Indian health activities to the Bureau of Indian Affairs in the Department of the Interior, along with the first federal appropriations for Indian health. Finally, in 1955, Indian health activities moved under the U.S. Public Health Service (within the Department of Health and Human Services) and became IHS, the federal organization that administers health services for AI/AN communities today.

Another important evolution in the Indian health system has been the formal decentralization of the operation of health programs to tribal governments through self-governance.

5 VA.(2016, November).*MyVA: Putting Veterans First. Transformation Update*.p.8.Retrieved from http://www.blogs.va.gov/VAntage/32779/va-releases-major-report-on-progress-of-myva-transformation-process/

6 VA National Center for Veterans Analysis and Statistics. (2015, May). *American Indian and Alaska Native Veterans: 2013 American Community Survey*. Retrieved from https://www.va.gov/vetdata/report.asp

7 Sprenger, David. (2013). *Coordination of Benefits: Access to care for AI/AN Veterans*. Retrieved from http://www.va.gov/TRIBALGOVERNMENT/docs/resources/western_region_veterans_benefits_summit/Coordination_of_Benefits.pdf

The Indian Self-Determination and Education Assistance Act,[8] passed in 1975, gave tribes the option to take over the administration of federally funded programs through IHS and the Bureau of Indian Affairs, and tribes quickly took advantage of this opportunity. Today, half of the Indian health care system is managed by tribal governments, and the elected leaders in tribal governments have become active, experienced, and knowledgeable participants in health advocacy and planning for their own communities.[9] Community and local control have been recommended for the Indian health system since the earliest days of IHS as a federal department,[10] and today's decentralization goes even further in allowing tribes to design programs to match regional and tribal-specific needs.

Today, IHS presides over a diverse and widely spread health network composed of three different types of providers:

- **IHS facilities,** staffed and administered directly by the federal agency;
- **tribally operated health facilities**, financed at least in part by IHS funds, but planned and self-governed by tribes; and
- **urban Indian health organizations,** funded separately under IHS to meet the health needs of American Indians and Alaska Natives who live in urban areas, often at some distance from reservation-based IHS or tribal health facilities.

The Indian health system is highly complex and diverse in its own right, but because VA has recognized IHS and tribal health programs as partners in VA's network of community care providers, the Indian health system is also part of (and contributes to the complexity of) the current landscape of VA health care delivery. Understanding the diversity of the Indian health system informs the second consultation topic of 2016 on priorities for serving Veterans in Indian Country (page 9), as tribes from different regions and different types of programs (IHS, tribal, or urban) describe the specific needs and priorities they have for meeting the health needs of their Veterans. The background on how VA and IHS work together and the goals they have in common is also critical in understanding the third consultation topic of 2016 on care in the community (page 22) and tribes' responses to VA's proposed plan to consolidate the operations of VA's network of health providers.

The 2010 VA-IHS MOU: Collaborating to Deliver Health Care to Native Veterans

In 2010, VA and IHS made a shared commitment to work together in delivering health care to Veterans through a memorandum of understanding (MOU) signed by the two agencies. The 2010 VA-IHS MOU lays out a multitude of ways to increase coordination, collaboration, and resource sharing. The MOU has served as a policy document that supports enterprise-wide cooperation to advance care for Native Veterans.

8 Public Law 93-638. Because of the public law number of the authorizing legislation, tribal health facilities that are self-governed through a contract or compact with IHS are sometimes called "638" facilities.

9 IHS. (2006). Caring and Curing: *The First 50 Years of the Indian Health Service*, p. 28. Retrieved from https://www.ihs.gov/newsroom/factsheets/

10 IHS, p. 8.

Appendix B. Dear Tribal Leader Letters: Accreditation of Veterans Service Organizations

Department of Veterans Affairs
Washington DC 20420

March 3, 2016

Dear Tribal Leader:

We are writing to facilitate Tribal consultation on the Department of Veterans Affairs' (VA) effort to improve access of Native American veterans to VA-recognized organizations and VA-accredited individuals who may assist them on their benefit claims.

VA is considering issuing a proposed rule that would amend part 14 of title 38, Code of Federal Regulations (CFR), to expressly provide for the recognition of Tribal organizations so that representatives of the organizations may assist Native American claimants in the preparation, presentation, and prosecution of their VA benefit claims. The purpose of the proposed rulemaking would be to address the needs of Native American populations who are geographically isolated from existing recognized Veterans Service Organizations or who may not be utilizing other recognized Veterans Service Organizations due to cultural barriers or lack of familiarity with those organizations.

Cheyenne & Arapaho Memorial Wall

In June 2016, the Cheyenne and Arapaho Tribes honored their past and current Active Duty and Veteran members with a ceremony honoring their service to the country and to the tribe.

The proposed rulemaking would allow the Secretary of Veterans Affairs to recognize Tribal organizations in a similar manner as the Secretary recognizes State organizations. Specifically, the proposed rulemaking would consider applications from a Tribal organization that is established and funded by one or more Tribal governments to be recognized for the purpose of providing assistance on VA benefit claims. In addition, the proposed rulemaking would allow an employee of a Tribal government to become accredited through a recognized State organization in a similar manner as VA accredits county Veterans' Service Officers who may become accredited through a recognized State organization. Finally, the proposed rulemaking would extend office space opportunities already granted to employees of State organizations who are accredited to national organizations to similar employees of Tribal organizations. We are seeking Tribal consultation regarding VA's consideration of such proposed rulemaking.

VA is also seeking comment on the potential compliance costs. In order to become accredited as a Tribal organization, the organization must show that it meets the requirements in title 38 CFR 14.628(d). Pursuant to§ 14.628(d), an organization requesting recognition must: (i) "[h]ave as a primary purpose serving Veterans", (ii) "[d]emonstrate a substantial service commitment to Veterans either by showing a sizable organizational membership or by showing performance of Veterans' services to a sizable number of Veterans", (iii) "[c]ommit a significant portion of its assets to Veterans' services and have adequate funding to properly perform those services", (iv) "[m]aintain a policy and capability of providing complete claims service to each claimant requesting representation or give written notice of any limitation in its claims service with advice concerning the availability of alternative sources of claims service", and (v) "[t]ake affirmative action, including training and monitoring of accredited representatives, to ensure proper handling of claims." VA is seeking comment on the amount of time and the costs of persons' time to show that the organization meets these requirements. VA's Office of General Counsel accepts recognition requests via mail, fax, or email.

Written comments may be submitted to Tribalgovernmentconsultation@va.gov within 30 days from the date of this letter. For additional information regarding this effort, please contact Mr. Clay Ward, VA Office of Tribal Government Relations, at (202) 461-7445.

We appreciate your support and collaboration as we move forward to improve access of Native American Veterans to VA-recognized organizations and VA-accredited individuals who may assist them on their benefit claims.

Thank you for your continued support of our mission.

Sincerely,

Robert D. Snyder
Interim Chief of Staff

Appendix C. Dear Tribal Leader Letter: Priorities for Veterans

U.S. Department of Veterans Affairs
Deputy Assistant Secretary for Intergovernmental Affairs (075)

May 19, 2016

Dear Tribal Leader:

How the Department of Veterans Affairs (VA) delivers benefits and services for Veterans is growing and changing rapidly. In this environment of change, VA is more committed than ever to fulfilling its tribal consultation policy, which includes strengthening VA's relationship with tribes and consulting with tribal governments on all VA policies and actions that may impact tribes and Veterans across Indian Country.

VA wants to ensure that the needs of American Indian and Alaska Native Veterans and the priorities of tribal governments are part of these changes, now and in the future. To that end, VA is seeking input from tribal leaders **on the top 3 to 5 priorities that tribes have for serving Veterans in Indian Country.** Once identified, these priorities may be used to assist with the collaborative development of **an Indian Country Veterans Affairs policy agenda**, which will inform tribal governments, VA, members of Congress, and other Veteran-serving partners in coming years.

To gather this input, VA plans to hold two tribal consultation sessions in 2016.

> The first consultation will take place **Wednesday, June 29, 2016, at 5:15 p.m.** at the Spokane Convention Center, at 334 W. Spokane Falls Blvd., Spokane, WA 99201. This session is held **in conjunction with the National Congress of American Indians (NCAI) Mid-Year Conference**, taking place June 27-30, 2016, in Spokane, WA.
>
> The second consultation will be scheduled later this year. VA will send a second letter to confirm this session when the date and time are finalized.

VA also invites written comments on the consultation topics, particularly for tribal leaders and representatives who may be unable to attend the consultation meetings in person. Written comments may be submitted as follows:

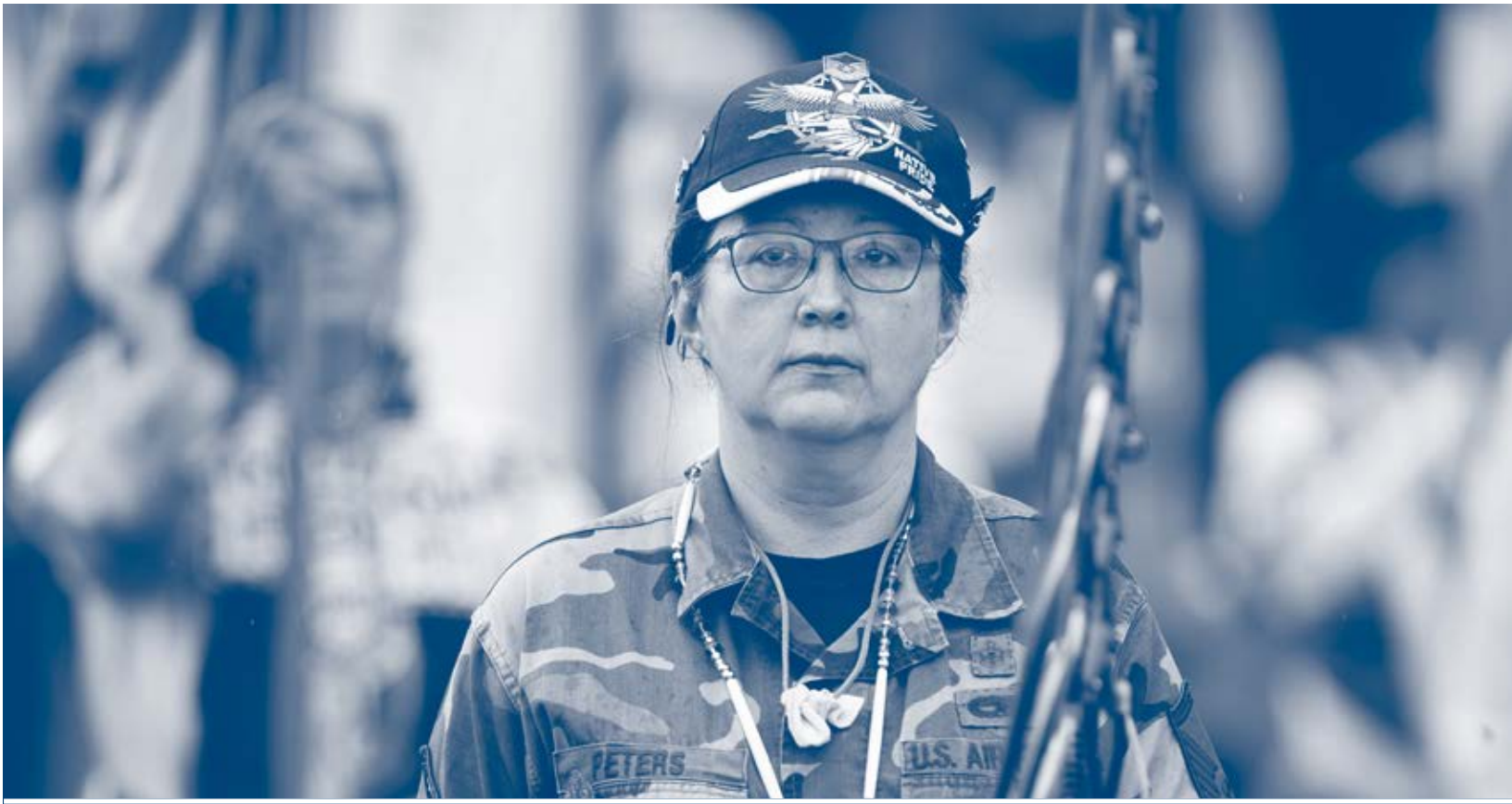
Email: tribalgovernmentconsultation@va.gov
Mail: U.S. Department of Veterans Affairs
Office of Intergovernmental Affairs (075F)
810 Vermont Avenue, NW, Suite 915G
Washington, DC 20420

Written comments should be submitted no **later than October 7, 2016.** For questions, please contact VA's Office of Tribal Government Relations at 202-461-7400 or at the email address above.

VA will compile all 2016 testimony received into a tribal consultation report to be disseminated in 2017. VA wishes to thank tribal leaders for their continued support, input, and engagement as we continue our work to honor and serve American Indian and Alaska Native Veterans.

Sincerely,
James Albino

Enclosures: Priorities for Veterans fact sheet (1 pg.)



Dr. Judy Peters

With KIA/MIA POW Veteran Memorial Eagle Staff in hand, Native American Indian Veteran, First Nations Women Warriors, Dr. Judy Peters, performs in the Formal Grand Entry ceremony during the Second Annual National Gathering of American Indian Veterans.

Priorities for Veterans Fact Sheet

VA | U.S. Department of Veterans Affairs

Office of Tribal Government Relations

What are your priorities for Veterans across Indian Country?

May 2016

VA wants to know the top 3–5 priorities that tribes have for serving and engaging Veterans. We are gathering input on your priorities for Veterans to help create an **Indian Country Veterans Affairs policy agenda**, which will inform tribal governments, VA, members of Congress, and other Veteran-serving partners in coming years.

This list shows the issues and priorities VA has worked to address in recent years.

What are your priorities for serving Veterans in your community? Use the list below to identify your top 3 5 priorities, or add new issues of your own.

Access to medical care

In Indian Country and for other rural areas, VA is using telehealth to expand access to care: **http://www.telehealth.va.gov/**

Suicide prevention

VA and IHS are continuing outreach to share resources and information about preventing suicide among Native Veterans.

VA and tribal or IHS facilities working together

The 2010 VA-IHS memorandum of understanding defined many ways VA and IHS can cooperate. VA has reimbursed almost $40 million to IHS and tribal health facilities for direct care to Veterans.

VA supporting traditional providers and treatments

Some VA medical centers have added traditional treatments, like sweat lodges, for Veterans.

Treatment for PTSD and mental health

VA is using telemental health care to reach Native Veterans with PTSD and other mental health care needs: **http://www.ruralhealth.va.gov/native/programs/telemental-services.asp**

Transportation

VA's Beneficiary Travel program reimburses mileage for travel to VA health care: **http://www.va.gov/HealthBenefits/vtp/highly_rural_transportation_grants.asp**

Housing

VA's Native American Direct Loan program helps Native Veterans get low-cost home loans: **http://www.benefits.va.gov/homeloans/nadl.asp**

Homelessness

VA implemented HUD-VASH, a housing voucher program, on tribal lands: **http://www.va.gov/homeless/hud-vash.asp**

Employment/vocational rehab

Homeless Veteran Reintegration Program grants are available to tribes: **http://www.benefits.va.gov/vocrehab/index.asp**

Tribal Veterans Representatives

Tribal Veterans Representatives (TVRs) help connect Native Veterans with VA and other community organizations: **http://www.ruralhealth.va.gov/native/programs/tribal-veterans.asp**

Understanding benefits

VA holds training summits, benefit fairs, and other events in Indian Country to help spread the word about benefits for Native Veterans.

Benefits for families

Some benefits are available for spouses, children, and survivors of Veterans: **http://explore.va.gov/spouses-dependents-survivors**.

Tribal consultation, listening sessions, town hall meetings

VA consults with tribes before any action that significantly affects tribal resources, rights, or lands. VA uses listening sessions and other meetings to supplement formal consultations

VA wants to hear from you. What do you think are the most important issues for Veterans living in Indian Country? Choose from the issues above, or add new priorities of your own.

My Priorities for Veterans

1. _____
2. _____
3. _____
4. _____
5. _____

Complete this form and email it back to **tribalgovernmentconsultation@va.gov** or send it to:

U.S. Department of Veterans Affairs, Office of Intergovernmental Affairs (075F)
810 Vermont Avenue, NW, Suite 915G, Washington, DC 20420

At a consultation, you can give it directly to any VA representatives.

Learn More About VA

Learn more about any of these programs at **va.gov/tribalgovernment** or **www.ebenefits.va.gov/ebenefits/**

Email the VA Office of Tribal Government Relations at **tribalgovernmentconsultation@va.gov**

Find the Office of Tribal Government Relations regional specialist for your state at **va.gov/tribalgovernment/locations.asp**

Appendix D. Dear Tribal Leader Letter: Care in the Community

Department of Veterans Affairs
Washington DC 20420

September 12, 2016

Dear Tribal Leader:

We are writing to facilitate tribal consultation on the Department of Veterans Affairs (VA) effort to improve continuity of care and health care access for Veterans by consolidating multiple community care, previously known as non-VA care, programs into one standard program with standard rates.

Today, VA uses multiple programs, including the Indian Health Service (IHS)/Tribal Health Program Reimbursement Agreement Program, to provide thousands of Veterans access to community care. Having multiple programs, each governed by its own set of requirements, with different payment schedules results in a complex and complicated landscape that Veterans and their caregivers must navigate. It causes confusion for Veterans, community providers, and VA staff.

In October 2015, VA submitted to Congress the *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, which lays out the vision for a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. The *Plan* incorporates feedback from key stakeholders, including VHA field leadership as well as clinicians, representing diverse groups and backgrounds. VA conducted tribal consultation in October 2015, regarding the inclusion of IHS and tribal health programs in the core provider network proposed in the *Plan*, prior to its submission to Congress.

As VA continues to move forward with implementing the vision of the *Plan*, we again seek tribal input to assist VA in developing the network of providers in a manner that would build on VA's existing relationships with tribal health programs and facilitate future collaboration to improve health care services provided to all eligible, VA-enrolled Veterans, regardless of whether they are eligible for IHS-funded health care or not. Future collaborations may focus on enhancing care options for all eligible Veterans using a single set of eligibility requirements; streamlining the manner in which VA engages with non-VA providers, including tribal health programs; standardizing clinical and business processes, including the referral process, care coordination, and health information exchange; and establishing standard reimbursement rates.

We are seeking tribal consultation regarding the tribal health programs participation in the core provider network, and potentially transitioning from the current reimbursement agreement structure to a model under which tribal health programs deliver care to all eligible, VA enrolled Veterans using a standard reimbursement rate. We would like your comments on the following questions:

1. What would be the impact of transitioning from the existing reimbursement agreement structure, which requires each tribe to enter into an individual reimbursement agreement with VA, to a standard arrangement for reimbursement of direct care services provided to eligible Veterans managed by a third-party administrator for VA?

2. Would tribal health programs be interested in expanding direct care services under this new structure to include reimbursements for care provided to all Veterans enrolled in VA health care, regardless of whether they are eligible for IHS-funded health care or not?

3. Would tribal health programs be interested in receiving standard reimbursement rates based on Medicare rates plus a feasible percentage of those rates that minimize improper payments and comply with industry standards?

4. Would tribal health programs be interested in extending existing reimbursement agreements between VA and tribal health programs through December 2018 and ensuring any new reimbursement agreements between VA and tribal health programs extend through December 2018, as VA works in collaboration with tribes and other VA stakeholders on implementing a consolidated community care program?

The in-person session of the Consultation is scheduled for Wednesday, September 28, between 9:00 AM and 11:00 AM at the Smithsonian - National Museum of the American Indian (NMAI), 4th Street & Independence Avenue, SW, Washington, DC 20560.

If you or a representative plans to attend the consultation, please RSVP to tribalgovernmentconsultation@va.gov to expedite processing through security at the NMAI and for venue planning purposes. Attendees should enter on the south doors marked "staff entrance" on 4th Street & Independence Avenue, SW.

Written comments may be submitted to tribalgovernmentconsultation@va.gov before November 5, 2016. For additional information regarding this effort please contact Majed Ibrahim at majed.ibrahim@va.gov.

We appreciate your support as we move forward to enhance and improve the experience for our Veterans.

Sincerely,
David J. Shulkin, MD

VA Community Care Fact Sheet

Tribal Health Programs—Collaborating Today for a Better Tomorrow Fact Sheet

August 2016

Since 2012, the Department of Veterans Affairs (VA) has worked closely with the Indian Health Service (IHS) and Tribal Health Programs (THP) to ensure that American Indian/ Alaska Native (AI/AN) Veterans can receive care paid for by the VA in a culturally sensitive environment. VA values these collaborations and looks forward _to working with IHS and THP as VA moves towards implementing a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff.

VA proposes to extend existing reimbursement agreements with IHS and THP through December 2018 and ensure any new reimbursement agreements between VA and THP extend through December 2018, so that we may conduct tribal consultation and work together to ensure VA's consolidated community care program builds on VA's existing relationships with IHS and THP.

Future Vision for VA Community Care

- Today, VA uses multiple programs to provide thousands of Veterans access to community care. Having multiple programs, each governed by its own set of requirements, with different payment schedules results in a complex and complicated landscape that Veterans and their caregivers must navigate. It causes confusion for Veterans, community providers, and VA staff.
- VA submitted the Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care (Plan) to Congress in October 2015. That plan outlines our vision to move towards an integrated health care network that delivers the best health care available through VA and community providers.
- VA collected feedback from Veterans, Veterans Service Organizations (VSOs), tribes, Federal partners, Health Care Industry Leaders, Congress, and VA Staff, and sought industry best practices to develop the Plan. Some key themes from this feedback included recommendations for:
    - ◊ Clarifying processes for accessing community care, as current processes are confusing today; and
    - ◊ VA to play an active role in care coordination for Veterans.
- Based on this feedback, the Plan proposes to simplify and consolidate all existing VA Community Care programs by rolling them into one program with a single set of eligibility requirements, streamlined clinical and business processes, and the establishment of a high-performing network of community providers and facilities.

- To successfully achieve the goal outlined in the Plan, VA is taking both a short-term and long-term approach to implement immediate fixes where we can today, while driving towards a better future state for community care.
- In creating our two-pronged approach, we looked at the Veteran's community care journey to identify five major touch points that would have the most impact on improving each Veteran's health care experience. Encompassing all of these touch points is a focus on Customer Service that aims to provide quick resolution of questions and issues.

    1. *Eligibility:* We want to provide easy-to-understand eligibility information to Veterans, community providers, and staff.
    2. *Referral and Authorizations:* We want to streamline referrals and authorizations, providing Veterans timely access to a community provider of their choice.
    3. *Care Coordination:* We want to solidify care coordination through seamless health information exchanges.
    4. *Community Care Network:* We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
    5. *Provider Payment (Claims):* We want to become better partners to our community providers by paying them promptly and correctly.

VA's Community Care Network

- As part of VA's *Plan*, VA is working to build a high-performing, integrated health care network to improve Veterans' access to high-quality care both in VA and in the community.
- Reimbursement agreements with IHS and **THP** are one of the many ways in which VA purchases care for Veterans. VA wants to continue our collaborations with IHS and **THP** and work together to determine the path forward towards an integrated health care network.
- Participation in the Community Care Network could allow **THP** to provide care to and receive reimbursement for all Veterans enrolled in VA health care and served by **THP,** regardless of whether they are eligible for IHS-funded health care or not.
- VA is incorporating lessons-learned from existing community care programs and industry best practices into the Community Care Network draft request for proposal **(RFP)**, which is scheduled to be out for bid in 2016. Many of these features will benefit tribal health programs, including:

    - ◊ Ensuring Veteran choice in provider selection.
    - ◊ Establishing direct communication channels between VA and community providers.
    - ◊ Standardizing and simplifying processes for sharing information between VA and community providers.

Next Steps

- Conduct Tribal Consultation regarding the tribal health programs participation in the core provider network, and potentially transitioning from the current reimbursement agreement structure to a model under which tribal health programs deliver care to all eligible, VA enrolled Veterans using a standard reimbursement rate.
- Continue to serve Veterans under the existing reimbursement agreements while VA engages in consultation and future planning with THP.
- Continue to work with key stakeholders to ensure that the future Community Care Network provides Veterans with a provider network that best meets their needs.

Charles Tailfeathers and Linda Woods

The Office of Tribal Government Relations co-sponsored a Native Veteran Summit/Fourth Annual Gathering of Warriors, along with the Confederated Tribes of Grand Ronde and the Native Wellness Institute during July 7-9, 2016.

Contacting VA's Office of Tribal Government Relations

Washington, DC – National Office

Stephanie Birdwell, Director
202–461–7400 | StephanieElaine.Birdwell@va.gov

David "Clay" Ward, Program Analyst
202–461–7445 | David.Ward@va.gov

Connecticut, Iowa, Maine, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New York, North Dakota, Rhode Island, South Dakota, Wisconsin, Wyoming

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651–405–5676 | Peter.Vicaire@va.gov

Alabama, Florida, Georgia, Kansas, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Texas

Mary Culley, Regional Specialist
405–456–3876 | Mary.Culley@va.gov

Arizona, Colorado, New Mexico, Utah

LoRae "HoMana" Pawiki, Regional Specialist
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Alaska, California, Idaho, Nevada, Oregon, Washington

Terry Bentley, Regional Specialist
541–440–1271 | Terry.Bentley@va.gov

VA

U.S. Department of Veterans Affairs
Office of Tribal Government Relations

www.va.gov

INDIAN HEALTH SERVICE PORTLAND AREA DIRECTOR'S UPDATE

Dean M Seyler - Area Director
October 10, 2017
Yakama Legends Casino & Hotel
NPAIHB Quarterly Board Meeting

Indian Health Service Portland Area

- **H.R. 601 Continuing Appropriations Act, 2018**
  - H.R. 601, the "Continuing Appropriations Act, 2018" was signed into law by the President on September 8, 2017.
  - The continuing resolution provides fiscal year 2018 appropriations through December 8, 2017, for the continuing projects and activities of the Federal Government.

Indian Health Service Portland Area

- **A.S.A.P Area Pool**
  - Letter to Tribes seeking comments to discontinue; sent 10-06 with 30 day comment
  - The number of referrals have declined
  - Not all tribes who have retained shares with ASAP utilize the funding.
  - The Affordable Care Act has provided extensive funding for substance use disorder treatment that was not been available in prior years.
  - Difficulty in increasing the number of substance use disorder treatment facilities as recognized IHS vendors. Facilities would rather negotiate treatment fees per each tribe.

Indian Health Service
Portland Area

- **IHS Awards $16.5 Million in Grants to Support Behavioral Health Programs**
  - Substance Abuse and Suicide Prevention (SASP)
    - Cow Creek Ban of Umpqua Tribe of Indians
    - Northwest Portland Area Indian Health Board
    - Port Gamble S'Klallam Tribe
    - Seattle Indian Health Board
  - Domestic Violence Prevention Program (DVPP)
    - Confederated Tribes of Siletz Indians
    - Nez Perce Tribe
    - Northwest Portland Indian Health Board
  - Behavioral Health Integration Initiative (BH2I)
    - Yellowhawk Tribal Health Center
  - Preventing Alcohol-Related Deaths (PARD)

Here is the link to the full release:
https://www.ihs.gov/newsroom/pressreleases/2017pressreleases/ihs-awards-16-5-million-in-grants-to-support-behavioral-health-programs/

Indian Health Service
Portland Area

- **CDC-IHS Healthcare Infection Control Training**
  - Date: Week of 1/22/18 (Dates TBD)
  - Portland, OR (Hotel TBD)
  - Open to all Portland Area IHS/Tribal/Urban
  - Register thru IHS Environmental Health Support Center
    - https://www.ihs.gov/ehsct/index.cfm?module=classes&catID=4

Who Should Attend:

- Clinic Leaders
- Clinic Medical Directors
- Clinic Healthcare Providers
- Infection Control Officers
- Clinic Risk Management
- Accreditation Managers
- Facility Managers

POC: LCDR Matthew Ellis, MPH REHS
matthew.ellis@ihs.gov / (503) 414-7788

Indian Health Service
Portland Area

Accelerated Model for improvement - Ami™ Waves

- **Colville Service Unit**
  - September 25-27, 2017
    - Billing Errors
    - Procurement Process
    - PRC Referrals
    - PRC Payments
- **Wellpinit Service Unit**
  - September 27-Oct 2, 2017
    - Infection Control Process
    - Optimizing access of patient care
- **Yakama Service Unit**
  - October 3-5,2017
    - Referral process (Direct Care)
    - Patient access to follow-up care and patient scheduling
    - Phone access for patients

Indian Health Service
Portland Area

Accelerated Model for improvement -Ami™ Waves

- **Warm Springs Service Unit**
  - October 17-19, 2017
    - Increase Patient Satisfaction
    - Medical Supply Management
- **Fort Hall Service Unit**
  - October 25-27 27-Oct 2, 2017
    - Increased Access to Care/Patient Satisfaction
    - Pharmacy Point of Sale (POS) Billing
- **Western Oregon Service Unit**
  - FY17
    - Health Information Management (HIM) Scanning
    - Lab Draw/Operations
    - Lab Inventory

Indian Health Service
Portland Area

- **FY17 CHEF**
  - $1,725,099 submitted for Portland Area
  - $650,606 has been returned
  - $24,484,022 current balance (as of September 25, 2017)

Indian Health Service
Portland Area

- **YRTC – NARA Update**
  - **24 bed license granted on 10-02-2017**
  - **Combining Services Under One Roof**
  - **Staffing of facility in process**
  - **Projected opening date – 10-16-2017**
  - **620 NE 2nd St. Gresham Oregon**

Indian Health Service
Portland Area

Indian Health Service
Portland Area

Indian Health Service
Portland Area

Indian Health Service
Portland Area

Indian Health Service
Portland Area

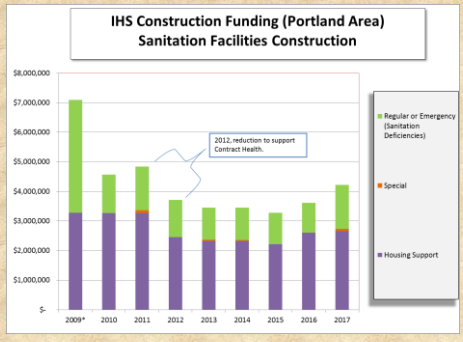
Indian Health Service
Portland Area

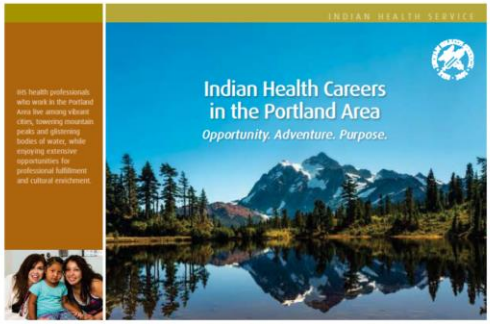
- **Small Ambulatory Program (SAP)**
  - IHS is Accepting Applications for this Health Facility Construction Funding Opportunity.
  - $5.0M Reserved / Max Award is $2.0M
  - 3-5 Awards Anticipated (Highly Competitive)
  - Applications Due: December 1
  - Download Application Kit: https://www.ihs.gov/dfpc
  - Portland Area IHS Will Provide Two Webinars on Application Process
    - October 31st and November 7th
  - If You Plan to Apply, Please Contact
    - CAPT Jason Lovett - jason.lovett@ihs.gov OR
    - Gene Kompkoff - gene.kompkoff@ihs.gov
    - Available to Answer Questions, Provide Facilities Data, and Webinar Information

Indian Health Service
Portland Area

- **Annual Combined Space Verification**
  - Will Be Sent to Tribes in Early November
  - Verify the Amount and Location of Facility Space Used for IHS PSFA's
  - Response Due Date: December 31, 2017
  - Please Review the Provided Data and Certify if is Accurate
    - Used to Calculate Share of Equipment and M&I Funds
    - Used to Update and Maintain the CMS Facilities List for Encounter Rate Billing
    - Used to Verify Facility Type and Other Statistical Items
  - If Data is Not Accurate, Please Follow Included Instructions to Update
  - Questions:
    - Jonathan McNamara – Health Facilities Engineering – jonathan.mcnamara.ihs.gov
    - Peggy Ollgaard – Business Office – peggy.ollgaard@ihs.gov
    - Mary Brickell – Statistics – mary.brickell@ihs.gov

Indian Health Service
Portland Area





Indian Health Service Portland Area

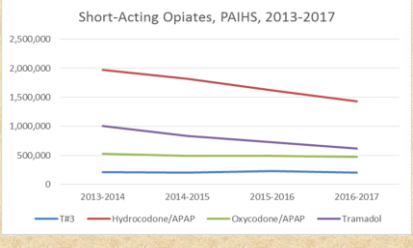
- Portland Area IHS Multi-Conference Series
- Nov. 13-17, 2017 at Spokane NATIVE Project.
  - **AAAHC Achieving Accreditation Workshop**
    - Nov. 13 (afternoon) - Nov. 14 (all day)
    - Currently all slots are filled
  - **Pain Skills Intensive Seminar** (HOPE Committee and UNM sponsored)
    - Nov. 15 (all day)
    - Medication Assisted Treatment (MAT) DATA waiver training Nov. 16 (morning)
    - Registration link- Access code psi11152017
  - **Portland Area Fall Clinical Director's Meeting**
    - Nov 16 (afternoon) – Nov 17 (morning)

Indian Health Service Portland Area

- Portland Area Opiate Procurement
  - 4th year of data collection for 6 Federal and 11 Tribal sites utilizing the VA Pharmacy Prime Vendor (PPV)
  - Assesses procurement of 9 commonly prescribed opiates
    - Codeine/acetaminophen, hydrocodone/acetaminophen, oxycodone/acetaminophen, fentanyl, hydromorphone, methadone, morphine, oxycodone, tramadol
  - Also tracking procurement of associated drugs:
    - Naloxone- utilized to reverse opiate overdose
    - Naltrexone, buprenorphine/naloxone- used to treat opiate use disorders
  - Individualized reports with analysis and recommendations for best practices on appropriate and judicious opiate prescribing are provided to each included Federal and Tribal clinic.

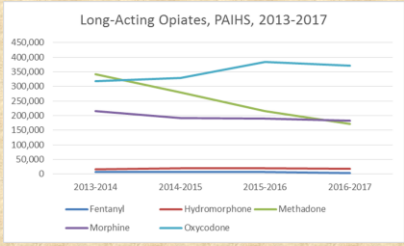
Indian Health Service Portland Area

- Key trends:
- Procurement of hydrocodone/APAP is down 27.3%



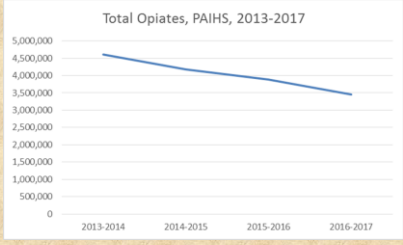
Indian Health Service Portland Area

- Key trends:
- Procurement of methadone is down 50.0%



Indian Health Service Portland Area

- Key trends:
- Overall procurement is down 25.0%



Indian Health Service Portland Area

- Key Recommendations:
  - Utilize a facility policy on chronic opioid therapy (COT)/chronic pain management.
  - Assure policies are congruent with the IHS Chronic Non-Cancer Pain Management policy.
  - Assure all prescribers of Controlled Substances have had training on appropriate pain management.
  - Conduct at least annual peer review among your prescribers to assure compliance with facility policies on COT.
  - Implement a First Responder and Take-Home Naloxone (co-prescribing) program, esp. for those prescribed methadone.
  - Transition as many patients as possible off of methadone.
  - Develop local capacity for Medication-Assisted Therapy for opioid dependence.
  - Follow CDC recommendations to limit acute opiate prescriptions to 3 days, rarely more than 7 days, of therapy.
  - Obtain a Prescription Drug Monitoring Program (PDMP) report on all new patients receiving controlled substances, all patients receiving more than 7 days of medication for acute pain, and at each visit for patients on chronic opioid therapy.

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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

PORTLAND AREA
INDIAN HEALTH SERVICE
1414 NW NORTHRUP, Suite 800
PORTLAND, OREGON 97209

OCT 0 5 2017

Dear Tribal Leaders:

I am writing to seek your input on the Portland Area Office Alcohol and Substance Abuse Program (ASAP) Pool. Established in the late 1990's this pool was developed between multiple Portland Area Tribes. The original purpose pool was to offer Tribes access to this pool for substance use disorder inpatient treatment. Currently, there are 18 Tribes who are contributing to the ASAP Pool at the Portland Area Office for this purpose.

Tribes who have participated have not been accessing the pool at the same rate as in subsequent years due to the inception of the Affordable Care Act. Since the funds have not been fully expended for the last few years the Area has sent the participating Tribes their proportional shares left here via non-recurring contract modifications.

While I can appreciate the initial intent of a local ASAP Pool, the annually recurring ASAP funding has been underutilized due to ACA expansion. I believe this is why these funds remain at the Area Office unspent/untouched. Starting in Fiscal Year 2018, the ASAP funds are single year appropriations. Which means that any remaining funds will be sent to the Tribes as non-recurring at the end of the fiscal year. I feel it may be more efficient for the Tribes to manage on their own. I am considering to dissolve the pool in fiscal year 2018 and distribute to the Tribes as recurring in future years.

Please provide your comments regarding the continued establishment of this pool by November 3, 2017, at the below address. I plan on making a decision on this within 30 days after the comment closing period.

Portland Area ASAP Pool
Attn: Jonathan Merrell
Director, Office of Clinical Support
1414 NW Northrup St., Suite 800
Portland, OR 97209

Sincerely,

/Dean M. Seyler/

Dean M. Seyler
Director

8B

Indian Health Careers in the Portland Area

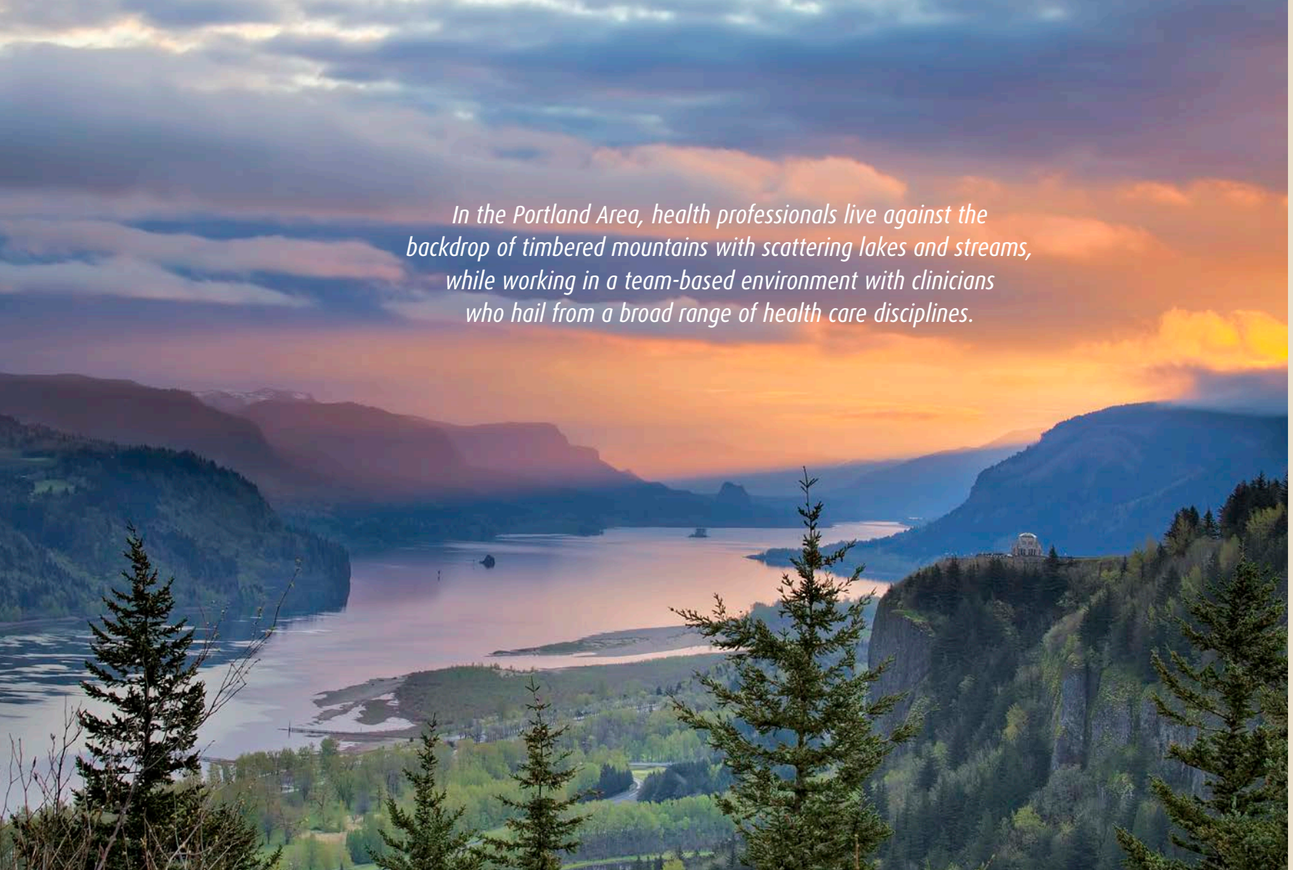
Opportunity. Adventure. Purpose.

IHS health professionals who work in the Portland Area live among vibrant cities, towering mountain peaks and glistening bodies of water, while enjoying extensive opportunities for professional fulfillment and cultural enrichment.

Canoe Journey – Paddle to Squaxin landing in Olympia, WA. Right photo: A canoe journey necklace. The beads represent how many canoe journeys one has attended. The copper circle represents the circle of life. Cover photo: Mt. Shuksan in North Cascades National Park, Washington state. Cover inset photo: IHS doctor with mother and daughter.

Tribes of Oregon, Washington and Idaho

Burns Paiute Tribe • Confederated Tribes of the Chehalis Reservation • Confederated Tribes of the Colville Reservation • Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians • Confederated Tribes of Grand Ronde • Confederated Tribes of Siletz Indians • Confederated Tribes of the Umatilla Indian Reservation • Confederated Tribes of Warm Springs • Confederated Tribes and Bands of the Yakama Nation • Coquille Indian Tribe • Coeur D'Alene Tribe of Indians • Cow Creek Band of Umpqua Tribe of Indians • Cowlitz Indian Tribe • Hoh Indian Tribe • Jamestown S'Klallam Tribe • Kalispel Tribe of Indians • Klamath Tribes • Kootenai Tribe of Idaho • Lower Elwha Klallam Tribe • Lummi Nation • Makah Tribe • Muckleshoot Indian Tribe • Nez Perce Tribe • Nisqually Indian Tribe • Nooksack Indian Tribe • NW Band of Shoshone Nation • Port Gamble S'Klallam Tribe • Puyallup Tribe of Indians • Quileute Tribe •Quinault Indian Nation • Samish Indian Nation • Sauk-Suiattle Indian Tribe • Shoalwater Bay Indian Tribe • Shoshone-Bannock Tribes • Skokomish Indian Tribe • Snoqualmie Tribe • Spokane Tribe of Indians • Squaxin Island Tribe • Stillaguamish Tribe of Indians • Suquamish Tribe • Swinomish Indian Tribal Community • Tulalip Tribes • Upper Skagit Indian Tribe



In the Portland Area, health professionals live against the backdrop of timbered mountains with scattering lakes and streams, while working in a team-based environment with clinicians who hail from a broad range of health care disciplines.

Providing Care in Oregon, Washington and Idaho

The Portland Area IHS provides health care for an estimated 150,000 American Indian and Alaska Native residents of Oregon, Washington and Idaho. Health delivery services are provided by a mix of health centers, health stations, preventative health programs and Urban Indian Programs.

The Portland Area encompasses a rich and diverse Native culture and meets the needs of a population that requires an equally diverse health care system. Direct service health centers operated by a combination of Tribal facilities, Urban Indian organizations and Area IHS facilities, ensure comprehensive, coordinated care delivery to more than 40 Tribes in the Pacific Northwest.

The Portland Area operates six federal health facilities in five Tribal communities and one at Chemawa Indian School in Salem, OR. There are also three Urban Indian Programs, which offer services ranging from community health to comprehensive primary health care. Overall, Tribes administer more than 74 percent of the IHS Portland Area budget authority appropriation.

In an effort to combat the rising trend of health disparities in the Portland Area, Indian health facilities there place extensive emphasis on improving health outcomes, particularly in the areas of infant health, high-risk maternal and child health, tobacco use intervention, domestic violence, diabetes care, women's health care and cancer screenings.

In addition, the Northwest Portland Area Indian Health Board works closely with the Portland Area, operating a variety of health-related programs on behalf of their member Tribes, including the Northwest Tribal Epidemiology Center.

◀ Sunrise over Crown Point at Columbia River Gorge, OR. Right photos top to bottom: Traditional fancy dancers in colorful regalia at the Shoshone-Bannock Indian Festival Pow Wow, Fort Hall, ID. IHS health professional with a young patient and his family. A couple learn about Native basketweaving in Washington state.

IHS offers a wide range of health profession opportunities in the Portland Area. Enjoy a unique work/life balance that provides rich rewards and ample time for family and recreational activities.

A World of Opportunities

The Portland Area IHS is seeking dedicated health professionals for its state-of-the-art facilities in Oregon, Washington and Idaho. You will not only have an opportunity to care for patients from culturally diverse backgrounds, but also be a part of a motivated and highly competent health care team serving a vital mission. IHS offers competitive salaries, a full range of benefits and, in some cases, signing bonuses. Many positions also offer relocation incentives and opportunities for government housing.

Health Profession Openings by Discipline

- Dentists
- Dietetic Services
- Environmental Health Staff
- Infection Control
- Medical Technologists
- Mental Health Staff
- Nurses
- Pharmacists
- Physicians
- Physician Assistants
- Public Health Nurses
- Public Health Nutritionists
- Quality Management Staff
- Radiologic Technologists
- Social Workers

IHS Career Options

IHS offers clinicians a choice of three options to practice their specific health profession discipline: working as a federal civil service employee, as an Officer in the Commissioned Corps of the US Public Health Service (USPHS) or directly for a Tribal or Urban Indian Program. Each of these options offers career flexibility, competitive salaries and benefits and ample opportunity for advancement.

Federal Civil Service

Professionals who choose to work in the federal civil service earn competitive salaries and are eligible for comprehensive federal and retirement benefits. They also enjoy significant career flexibility, eligibility for advancement and can transfer throughout IHS facilities while still maintaining their benefits.

US Public Health Service (USPHS) Commissioned Corps

One of the seven uniformed services of the United States, the Commissioned Corps offers the opportunity to serve our nation in uniform as a health professional in certain disciplines. The Commissioned Corps is comprised of highly qualified public health professionals protecting, promoting and advancing the health and safety of the nation. Approximately 2,000 Commissioned Corps officers currently serve within IHS. Commissioned Corps officers are eligible for military retirement benefits.

Tribal or Urban Indian Programs

Individuals interested in working within Tribal or Urban Indian Programs negotiate compensation and benefits directly with the program or Tribe with whom they seek to work. Openings are available in both urban and rural areas.

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

◀ You can join the IHS team as a civil service employee, an officer of the USPHS Commissioned Corps or as a direct hire for a Tribal or Urban Indian Program. Above right: Young health professionals are attracted to the financial freedom of the IHS LRP.

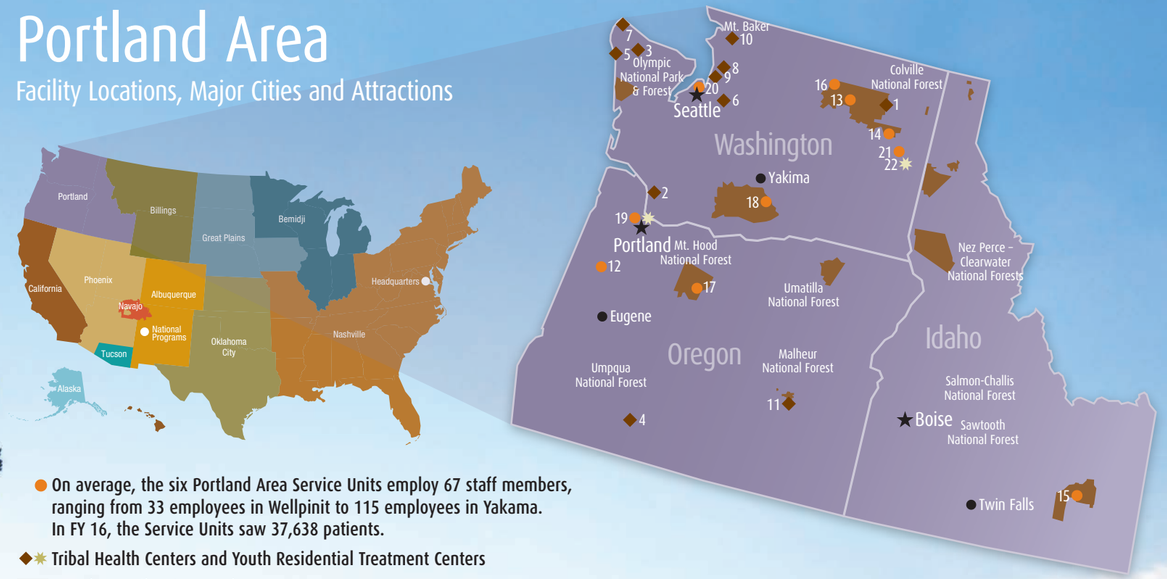
Did you know that you can pay off your health profession loans through our Loan Repayment Programs?

The IHS Loan Repayment Program (LRP) offers health professionals practicing at IHS facilities an opportunity to pay off all of their eligible health education student loans in addition to receiving competitive salaries and benefits. Participants are eligible to receive up to $20,000 per year and can extend their contract annually until all of their loans are paid off. Pursue the opportunity to build your career with IHS and work as part of an interdisciplinary team of health professionals, while gaining the financial freedom to live and work within some of the most picturesque settings in the country.

Additionally, the National Health Service Corps (NHSC) Loan Repayment Program (LRP) offers primary care providers up to $50,000 for a two-year service commitment to work at an approved NHSC site in a high-need, underserved area. Like IHS, NHSC LRP recipients can obtain additional loan repayment by extending their service.

Portland Area

Facility Locations, Major Cities and Attractions



- On average, the six Portland Area Service Units employ 67 staff members, ranging from 33 employees in Wellpinit to 115 employees in Yakama. In FY 16, the Service Units saw 37,638 patients.
- ◆✳ Tribal Health Centers and Youth Residential Treatment Centers
- American Indian Reservation

Learn more about health profession opportunities in the Portland Area, visit **www.ihs.gov/Portland**.

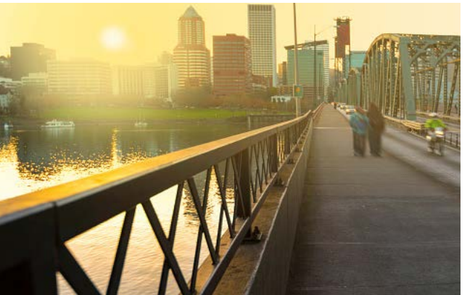
1	◆ Colville Tribes Community Health Center	Keller and Inchelium, WA	Tribal Health Center
2	◆ Cowlitz Family Health Center	Longview, WA	Tribal Health Center
3	◆ Hoh Tribe Health Clinic	Forks, WA	Tribal Health Center
4	◆ Klamath Tribal Wellness Center	Chiloquin, OR	Tribal Health Center
5	◆ Quileute Health Center	LaPush, WA	Tribal Health Center
6	◆ North Bend Family Clinic	Snoqualmie, WA	Tribal Health Center
7	◆ Sophie Trettevick Indian Health Center	Neah Bay, WA	Tribal Health Center
8	◆ Stillaguamish Tribal Health Clinic	Arlington, WA	Tribal Health Center
9	◆ Tulalip Health Clinic	Tulalip, WA	Tribal Health Center
10	◆ Upper Skagit Tribal Clinic	Sedro-Woolley, WA	Tribal Health Center
11	◆ Wadatika Health Center	Burns, OR	Tribal Health Center
12	● Chemawa Indian Health Center (Western Oregon Service Unit)	Salem, OR	Health Center
13	● Colville Indian Medical Health Center (Colville Service Unit)	Nespelem, WA	Health Center
14	● David C. Wynecoop Memorial Clinic (Wellpinit Service Unit)	Wellpinit, WA	Health Center
15	● Not-Tsoo Gah-nee Indian Health Center (Fort Hall Service Unit)	Fort Hall, ID	Health Center
16	● Omak Clinic (Colville Service Unit)	Omak, WA	Health Center
17	● Warm Springs Health & Wellness Center (Warm Springs Service Unit)	Warm Springs, OR	Health Center
18	● Yakama IHS Clinic (Yakama Service Unit)	Toppenish, WA	Health Center
19	●✳ Native American Rehabilitation Association (NARA) of the Northwest Inc.	Portland, OR	Urban Indian Health Center and Youth Residential Treatment Center
20	● Seattle Indian Health Board	Seattle, WA	Urban Indian Health Center
21	● The NATIVE Project	Spokane, WA	Urban Indian Health Center
22	✳ Healing Lodge of the Seven Nations	Spokane Valley, WA	Youth Residential Treatment Center

Attractions/State Parks in Oregon, Washington and Idaho

- 367 State Parks
- 26 State Recreation Areas
- 12 State Forests
- 15 State Fish Hatcheries
- 7 State Wildlife Areas
- 2 State Wildlife Management Areas
- 1 State Preserve
- 4 State Natural Areas
- 1 State Nursery
- 4 National Parks
- 33 National Forests
- 3 National Historic Sites
- 4 National Historic Parks
- 37 National Wildlife Refuges
- 6 National Recreation Areas
- 1 National Memorial

Learn more about the Portland Area state parks and attractions, visit **www.stateparks.com**.

◀ Panorama of Mt. McGown Peak on a clear morning in Stanley, ID. Above photo: Kayaks beached on the shore of Trillium Lake with Mt. Hood in the distance in Oregon.



Discover a Work/Life Balance

The Portland Area provides clinicians a unique opportunity to serve American Indians and Alaska Natives while enjoying a fulfilling career and an active lifestyle. Located in the evergreen Pacific Northwest, health clinicians in the Portland Area find themselves surrounded by scenic panoramas of the high desert, while still living near urban hubs such as Seattle, Spokane, Portland and Vancouver, BC.

For those interested in cultivating an outdoor lifestyle, the Portland Area offers salmon fishing, camping, hiking, boating, rafting, skiing and golfing. For skiers, top-notch slopes and majestic mountains, such as Mount Rainier, Mount Bachelor, Mount St. Helens and Mount Hood, are just a drive away. Other outdoor landmarks include Silver Falls Park, Columbia River Gorge, Timberline Lodge, Multnomah Falls, the Deschutes River and the Lewis and Clark Trail.

The Portland Area boasts a vibrant food scene and its location on the water means fresh seafood only requires visiting a local fish market. The Northwest is consistently recognized for its wines, craft breweries, delicious coffee and abundance of local farmers' markets.

Many health professionals who relocate to the Area find serving this unique patient population to be a rewarding long-term career option and a culturally enriching experience for the whole family. This includes opportunities for attending traditional Pow wows and activities, such as the Shoshone-Bannock Indian Festival Pow Wow in Ft. Hall, ID; the Gathering of the Falls Pow Wow in Spokane, WA; and Pi-Um-Sha Treaty Days in Warm Springs, OR.

And with the growth of the technology industry and the number of companies headquartered in Seattle and Portland — Nike, Boeing, Intel, Pendleton Woolen Mills and Starbucks, to name a few — the Portland Area offers tremendous opportunities for spousal employment. Likewise, families thrive with a variety of educational options and the accessibility to local amenities and businesses, family-friendly activities and places of worship.

◂ Photos top to bottom: Hiking in Mt. Rainier National Park, Washington state. IHS clinician with patient. Strolling along a Portland bridge with a view of the skyline at sunset. Opposite: Smith Rock and the Crooked River, Smith Rock State Park, Terrebonne, OR.

With its abundant orchards, pristine shores and famous mountain peaks, the Portland Area offers countless outdoor activities for health clinicians and their families.

Contact a recruiter to learn more about Indian health opportunities in the Portland Area

Portland Area Indian Health Service
1414 NW Northrup Street, Suite 800
Portland, OR 97209
(503) 414-5555

por_aorecruiter@ihs.gov

Indian Health Service
Health Professions Recruitment

Indian Health Service

@IHS_Jobs

Indian Health Careers in the Portland Area

Opportunity. Adventure. Purpose.

October 2017 PORBRO004

Native American Rehabilitation Association of the Northwest, Inc.
YOUTH RESIDENTIAL TREATMENT CENTER

REQUIRED ADMISSION APPLICATION DOCUMENTS

Youth Name: _____ Date of Birth: _____

Please submit all applicable documents with the completed application form.

_____ Copy of signed consent form to disclose information under Title 42, Part 2, Code of Federal Regulations to NARA.

_____ History and physical (within the last 30 days) documenting the patient is medically stable. History to include vision and hearing tests as well as PHQ-9 screening.

_____ Immunization record (TB test within the last 12 months required).

_____ Most recent treatment/discharge plans (if applicable).

_____ Pending and past court hearing documentation.

_____ Chemical dependency evaluations (any within the last 6 months).

_____ Educational Records/assessments (including IEP and 504, if applicable).

_____ Documents verifying Indian status for IHS eligibility (e.g., CIB, documentation of tribal enrollment).

_____ Copy of health insurance card(s).

_____ Copy of birth certificate.

_____ Copy of signed admission agreement regarding medical care.

Additional documentation will be required prior to admission:

_____ Urine drug screen (within 48 hours of admission to NARA)

_____ Pregnancy test (within 48 hours of admission to NARA)

_____ Activity Agreement & Release Form (upon admission)

All documents must be submitted to:

YRTC
620 NE 2nd Ave.
Gresham OR 97030
Phone: 971-274-3757 / Fax: 503-912-5740

Native American Rehabilitation Association of the Northwest, Inc.
YOUTH RESIDENTIAL TREATMENT CENTER

YOUTH REFERRAL & INTAKE FORM

Date of Application:

YOUTH INFORMATION		
Last Name:	**First Name:**	**Middle Name:**
Other names (aliases):		**Date of Birth:**
I identify my gender as: Choose an item.	**Preferred Gender Pronoun:** Choose an item.	
Religious Preference:	**Ethnicity:**	
Marital Status:	**Primary Language:**	
Race:	**Place of Birth (city/state):**	
Tribal Affiliation:		
Medicaid/OHP: ☐ Y ☐ N **Policy Number:** **Effective Date:** Click here to enter a date.		
Other Health Insurance: ☐ Y ☐ N **Name of Insurance:** **Policy Number:** **Effective Date:** Click here to enter a date.		
FAMILY INFORMATION		
Father's Name:	**Phone Number:**	
Father's Address:		
Mother's Name:	**Phone Number:**	
Mother's Address:		
YOUTH'S CURRENT PLACEMENT		
☐ Home ☐ Other Family ☐ Hospital ☐ Foster setting ☐ Juvenile detention		
Name of Legal Guardian:		
Relationship to Youth:	**Phone Number:**	
Legal Guardian Address:		
EDUCATIONAL HISTORY		
Name of last school attended:		
City/State:		
Grade in School:	**Attending special education class?** ☐ Y ☐ N	
Has youth ever been suspended or expelled from school? ☐ Y ☐ N		
If yes, please explain why:		
Other school related comments:		
LEGAL HISTORY		
Current and/or pending legal charges? ☐ Y ☐ N		
If yes, please describe:		
Social Service involvement:		
Indian Child Welfare Act Involvement:		

EMOTIONAL / BEHAVIORAL			
History of physical violence/aggression toward others? ☐ Y ☐ N If yes, please describe:			
History of suicidal ideation/attempt: ☐ Y ☐ N If yes, please describe:			
Diagnosis:			
Describe current course of treatment for substance use disorder:			
Co-morbid mental health conditions:			
Clinical indications for residential care (reason cannot be treated in less restrictive environment). Please cite applicable ASAM criteria:			
Current/past substances:			
Primary:	Last use:	Amount?	Frequency:
Other:	Last use:	Amount?	Frequency:
Other:	Last use:	Amount?	Frequency:
Other:	Last use:	Amount?	Frequency:
Other:	Last use:	Amount?	Frequency:
MEDICAL			
Medical conditions for which youth is currently receiving care:			
Currently prescribed medications:			
Medication:	Dose:	Medical condition:	
REFERRING PROVIDER INFORMATION			
Referred by:		Title:	
Phone Number:		Email Address:	
Agency name:			
Agency address:			
Presenting concerns/problems:			
Systems youth is involved with:			
Does youth approve NARA contacting referent, parent/guardian, system partners? ☐ Y ☐ N			

PLEASE NOTE

Any specialty medical care needed while at NARA's YRTC that is not available through the Oregon Health Plan or the youth's insurance provider MUST be funded through the youth's home clinic, tribe or IHS.

Native American Rehabilitation Association of the Northwest, Inc.
YOUTH RESIDENTIAL TREATMENT CENTER

PARENT/LEGAL GUARDIAN - CONSENT AND ACKNOWLEDGEMENT

As parent or legal guardian of:

_____
Youth's Full Legal Name (print)

I consent to have NARA's Youth Recovery Treatment Center:

- Use the positive discipline and behavior management system, if necessary;
- Restrict contact of the youth by persons outside the program, including visits, telephone communication, electronic mail and postal mail, if necessary for the youth's safety;
- Apply the Reasonable and Prudent Parent Standard to determine whether the youth is allowed to participate in age-appropriate or developmentally appropriate activities, including extracurricular, enrichment, cultural and social activities;
- Impose a dress code, as needed.

I acknowledge that I have:

- Received information and/or had explained to me and understand the process and procedures of personal or room searches and protocols for confiscation of contraband items, including notification of law enforcement if illegal contraband is discovered;
- Received a copy of, had explained to me and understand, the Rights and Responsibilities of all individuals in treatment at NARA;
- The right to ask for, and have made available to me and the youth listed above, any written policies and procedures for review that pertain to the program.

I understand that I am responsible for:

- Providing written authorizations for the exchange of information for the care of the youth listed above;
- Providing written authorization/approval of all visitors for the youth listed above (except those approved by law and regulation);
- Pre-approving visitation resources for the youth listed above (contingent on verification by the agency);
- Approving and providing written authorizations for the youth to participate in activities, as required;
- Approving and providing any other authorizations as needed.

_____
Name(s) of parent/legal guardian (print)

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of Staff Member Date

Native American Rehabilitation Association of the Northwest, Inc.
YOUTH RESIDENTIAL TREATMENT CENTER

YOUTH MEDICAL TREATMENT AUTHORIZATION FORM

Youth Full legal name: _____

Home address: _____

Date of birth: _____ Gender: ◯ Male ◯ Female ◯ Other

Parent/Legal Guardian Name (print): _____

This form grants temporary authority to NARA's Youth Residential Treatment Center (YRTC) to provide and arrange for medical care for the youth named above. I/we grant authorization and consent for NARA to administer general first aid treatment for any minor injuries or illnesses experienced by the youth. If an injury is life threatening or in need of emergency treatment I authorize NARA to summon any and all professional emergency personnel to attend, transport and treat the youth and to issue consent for x-rays, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment or hospital care deemed advisable by, and rendered under, the general supervision of any licensed physician, surgeon, dentist, hospital or other medical professional or institution duly licensed to practice in the State of Oregon.

I/we understand this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of NARA in the exercise of their best judgment upon the advice of any medical or emergency personnel.

◯ I/we rely on prayer/spiritual means for healing in accordance with the creed and tenets of our religion and do not authorize medical treatment. Please understand, if the youth is old enough to consent to any medical procedures/processes and does consent, we are bound by law to proceed as the youth wishes. We will not coerce the youth to consent.

This authorization is effective _____ through _____.

_____ _____
Parent/legal guardian signature Date

_____ _____
Parent/legal guardian signature Date

_____ _____
Witness Signature Date

What You May Bring With You for Your Stay at YRTC

- 7 days of casual clothing –
  - Pants, shorts, blouses, shirts, t-shirts. No rips, holes, cut-offs or tight clothing. No skirts or dresses. Straps on blouses must be 3 fingers wide;
  - Seasonally appropriate and outdoor activity clothing. Be prepared for both hot and cool conditions.
  - Suitable underwear, no thongs;
  - Pajamas, robe, slippers (no drawstrings);
  - Bras (no underwire, sports bras recommended);
  - 1 pair of gym shoes without laces (Velcro closures recommended).
- Eyeglasses, if needed (no contacts);
- Sunglasses;
- Prescribed medications – all medications must be in their original bottles or containers with prescription labels. Liquid medications must be new and sealed;
- Over-the-Counter (OTC) medications – new, unopened OTC medications are allowed. Nighttime OTC medications are prohibited. OTC medications with pseudoephedrine ingredients and weight control supplements are not allowed.
- Alarm clock;
- Electric razor;
- Stationary, envelopes, stamps for writing to family and friends.

What Not to Bring

- Alcohol or drugs;
- Sample medications;
- Weapons of any kind;
- Electronic equipment (cell phones, TV's, laptops, iPads, iPods, tablet computers, radios, cameras, gaming systems, computers, CD/DVD players, smart watches, fitbits, etc.);
- Makeup;
- Jewelry;
- Tobacco products (chewing tobacco, cigars, cigarillos, pipes, electronic cigarettes, vaping devices, etc.) and any associated paraphernalia, including matches and lighters;
- Clothing with alcohol, drug (including nicotine), sex or gang themes, terms or innuendos is not allowed;
- Bandanas or clothes that could be perceived as gang-affiliated are not allowed;
- Belts;
- Hats/caps;
- Clothing with drawstrings;
- Money;
- Safety/disposable razors, scissors, needles, hooks, pins, paperclips, thumbtacks;
- Curling irons, hair dryers, hair straighteners;
- Products containing alcohol (mouthwash, hairspray, breath spray, astringent, etc.);
- Glue, whiteout, spray cans;
- Candles;
- Vehicles.

YRTC DRESS CODE

- Clothing cannot be revealing or inappropriate. Questionable apparel will be determined at the discretion of the staff.
- Shirts must meet the waistband of pants. No exposed midriffs. Shirts may not show excessive cleavage.
- See through clothing must be worn with appropriate undershirts. This applies to men and cut off/sleeveless shirts. An appropriate undershirt must be worn.
- Visible underwear is not appropriate. Pants must cover hips. No underwear showing. No sagging pants.
- Shorts must be mid-thigh or longer when standing (your shorts should be no shorter than your fingertips when arms are at your side when standing).
- No clothing or accessories with alcohol, drug (including nicotine), sex or gang themes, terms or innuendos.
- Shoes or socks are to be worn at all times in the house. Shoes must be worn at all times outside the building.
- Shirts must be worn at all times in the house and on the property.
- Sleeping attire may not be worn outside the bedroom.
- Leggings may only be worn if appropriately covered by shirts that fall below the buttocks.
- Sunglasses will be worn outside only.
- Hats or caps will be worn outside only.
- Any other clothing that is not specifically mentioned in these rules but is deemed inappropriate by staff must be changed.

Heritage University
Garrett Lee Smith Suicide Prevention grant

Principle Investigators (PI's)
Maxine Janis, Associate Professor & President's Liaison for Native American Affairs
Corey Hodge, Chair, Social Work
Interns: Sasha Longee, Social Work
Brenda Lewis, Business

Nax̱shsim Natash Wa (We Are One) Project

Nax̱shsim Natash Wa (pronounced like Nahhh-ka-shh-him Nahhh-Tahh-shh-Wà) is the Ichishkiin Sinwit language phrase that translates as

"We are one."

THRIVE Suicide Prevention Project

- Through the GLS funding streams, THRIVE is able to provide funding each year for Heritage to coordinate and implement suicide early intervention and prevention strategies targeting their students, faculty, and AI/AN youth in their local community (Yakama Nation).
- SP Training and Technical Assistance
- SP Resources:
  - Educational Materials
  - Media Campaigns
    - Lived Experience Videos

Heritage University (HU)Suicide Prevention

- Strength- based approaches
- Cultural Protective Factors
- Cultural Responsiveness
- HU Initiatives

Strength-Based approaches

Cultural Protective Factors

HU- Culturally Responsive

Advisory Board

HU Suicide Prevention Initiatives

- Question, Persuade, Refer (QPR) Gatekeeper Training
- Applied Suicide Intervention Skills (ASIST) Training
- Internships
- Crisis Response Plan
- Campus-Community Collaborations

HU Suicide Prevention Initiatives

- Tepee/Lodge – Cross-Cultural Learning space, Talking Circle
- Native American Heritage Month
- All Nations Powwow – Stand Strong Special
- Wellness Through Laughter Comedy Show
- Gun Lock Safety event
- Comfort Care packages

Questions

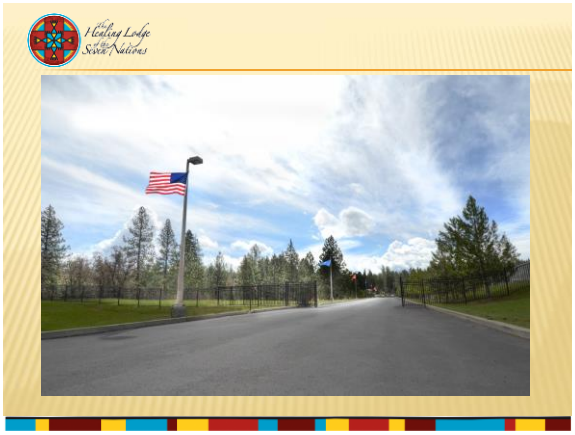
The Healing Lodge of the Seven Nations

RESIDENTIAL TREATMENT FOR ADDICTED YOUTH

The Healing Lodge of the Seven Nations

SEVEN TRIBAL NATIONS CAME TOGETHER

- Vision and Foresight of Tribal leaders.
- Spokane, Kalispel, Colville, Nez Perce, Kootenai, Coeur D'Alene and Umatilla Tribe.
- Addressed concern of sending "our children" to far away places for help.
- Central site was selected (Spokane)
- Created through Public Law 93.638.
- Evolved, continued to grow and dream facility was opened in 1996.




OUR FACILITY

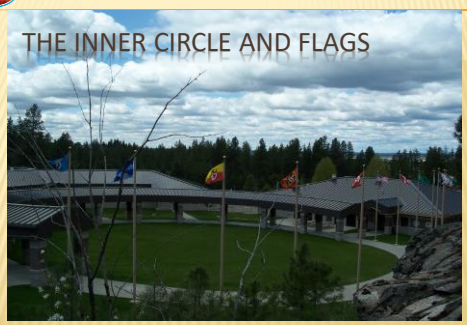

ENTRANCE

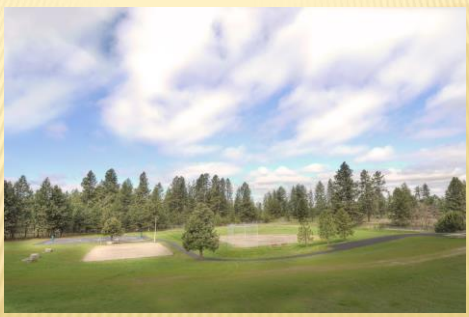
SCHOOL AND CAFETERIA

THE MEDICINE WHEEL

THE TALKING CIRCLE

THE INNER CIRCLE AND FLAGS





OUTDOOR RECREATION

WILDLIFE AT THE LODGE

OVERALL COMPLIANCE STANDARDS

- Washington State Administrative Code (WAC): 203
- Department of Health (DOH): 593
- Indian Health Service (Food Service): 45
- USDA (Food Service): 300 pages of standards
- CARF International: 1200
- FIRE MARSHALS (state and local)
- FINANCIAL OMB A-133: Federal Single Audit Act
- Spokane Public Schools Contract
- Behavioral Health Organizations (BHO)
- OSHA Audit

RESIDENT PROFILE

- Average number of residents served/yr: 190+
- Serve youth ages 13-17 years old
- Serve approximately 70% native youth, serve all.
- We serve more males than females
- We have 45 beds: 29 male and 16 female
- Top three drugs of choice: 1)Marijuana, 2)Alcohol, and 3) Amphetamines
- Top three mental health diagnosis: 1)ADHD, 2)Depression/Anxiety and PTSD

HOLISTIC AND THERAPEUTIC COMMUNITY

- Voluntary Program (not lock down)
- Hands-Off Facility
- Multi-Disciplinary Team Approach
- Treating Youth with Respect and Dignity at all times.
- Create a Safe Place

PROGRAM COMPONENTS



Chemical Dependency Treatment
- Social Justice CD Curriculum
- CD Education (group/1:1)
- **Expressive Arts/ Music**
- Sports, Weight Lifting and Running

Cultural Program
- Root Digging
- Rights of Passage
- Guest Speakers, Dancers, Drummers
- Sweat Lodge Ceremonies
- Cultural Projects
- Groups

Education Program
- GEDs
- High school credit
- High school credit retrieval

PROGRAM COMPONENTS (CONT'D)



Mental Health
- Mental Health Counselors
- 1 on 1's
- Groups

Recreation
- Basketball
- Softball
- Running
- Hiking
- Volley Ball
- Weight lifting
- Disc Golf

Food Service
- 3 meals per day with 3 snacks per day.
- Sugar-free Diet
- Caffeine-free Diet

CULTURAL PROJECTS

ANIMAL TEACHINGS

Teachings through stories
Teachings through skits
Discussing traits
Bring self-awareness

RITES OF PASSAGE

MUSIC PROGRAM

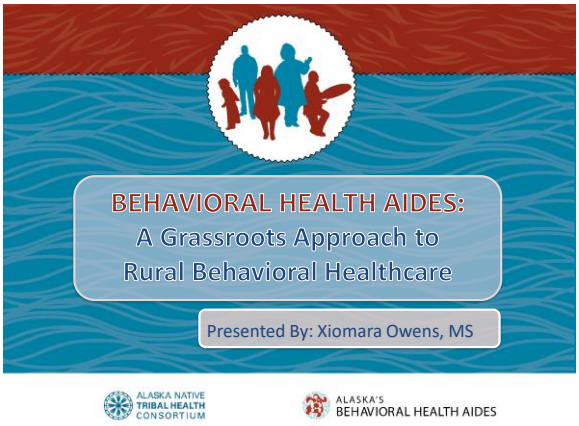
The Music Program records hundreds of songs by our young residents. Many of those songs have been selected to be on a featured album.

The Music Program has become a core therapeutic tool for the clinical team in addressing trauma and addiction.

CALENDAR PROJECT

CALENDAR PROJECT

A RAINBOW OF HOPE FOR OUR YOUTH



Objectives

- **Describe key elements of BHA program**
  - Context
  - Certification program
- **Describe BHA scope of work**
  - Across the continuum of care
- **Identify factors related to program implementation and sustainability**

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Overview

- **Context**
  - History & current events
  - Stakeholders and partners
- **AK Health Aides Programs**
  - Certification Board
  - Standards & Procedures
- **Behavioral Health in Alaska**
  - BHA scope of practice
  - BHA billing & reimbursement
- **BHA Training & Resources**
  - Behavioral Health Aide Manual

DENTEX
BHA

PROGRAM CONTEXT: GEOGRAPHY, CULTURE, STATE

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

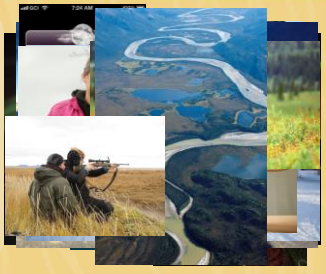
Population Demographics

- Alaska's area: **570,641 miles²**
- Total Alaska population: **737, 354**
  - Alaska Native/American Indian population: **143,367**
  - Median age: **26.8 years**
- Diverse Alaska Native cultural groups
  - **11** distinct cultures
  - **11** different languages, **22** different dialects

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

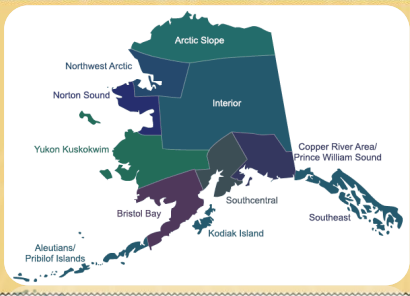
Alaskan Context

- Geography
- Weather
- Seasons
  - Hrs. of daylight
- Culture
- Natural resources
  - Subsistence
- Community



ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Alaska's Tribal Health System



ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

A Statewide System

- Village-based
- Sub-regional
- Regional
- Statewide
- Contract health

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Alaska Native Health Care Referral Patterns

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Partners and Partnership

- Indian Health Services
- Alaska Native Tribal Health Consortium
  - Community Health Aide Program
  - Dental Health Aide Program
  - Behavioral Health Department
- Community Health Aide Certification Board (CHAPCB)

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Partners and Partnership

- Tribal Health Organizations
  - Tribal Behavioral Health Directors
- State of Alaska, Dept. of Behavioral Health
- Alaska Behavioral Health Association
- Local, regional, and statewide providers
- Training partners

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Key Contextual Factors

- Alaska is REALLY big (and extreme)
- Alaska is like a village
- Tribal Sovereignty and the Tribal Health System
  - Coordinated access to higher levels of care
- Cultural identities and practices
- $$$
  - Funding, cost of living, travel, billing/revenue
- Autonomy and Partnership

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Who are YOU serving?

- **Demographics**
- **Cultural identity & practices**
- **Where are they located?**
  - Rural, remote, urban
- **Issues related to access?**
  - Including stigma and/or familiarity with MI/SA
- **Are you investing in prevention and early intervention?**

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Who are YOUR partners?

- **Similarities and differences between communities, regions, organizations?**
  - Where is the common ground?
- **What systems need to be in place/ coordinated?**
  - Levels of care and provider types
  - Billing systems and sources of revenue
- **What is your vision for integrating BHAs?**
  - In your healthcare system? Communities?
  - Who needs to have a seat at the table?

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

PROGRAM HISTORY: HEALTHCARE CLOSE TO HOME

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

CHAP History

1950s	Chemotherapy Aides (Volunteers) Direct Observed Therapy for TB patients
1960s	Formal Training/Federal Funding 1968
1976	Indian Health Care Improvement Act (IHCIA) (PL 94-437)
1992	IHCIA amended to add § 119 that provided for the Alaska Community Health Aide Program under authority of the 25 U.S.C. § 13 and required a Certification Board (PL 102-573)

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

Health Aide History

1998	Alaska Area Director appoints a CHAP Certification Board (CHAPCB)
2002	Standards amended to address Dental Health Aides and Therapists (DHA/T)
2005	First DHA/Ts Certified
2008	Standards amended to address Behavioral Health Aides and Practitioners (BHA/P)
2009	First BHA/Ps Certified

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

www.akchap.org

- Standards & Procedures
- Summary of Certification requirements
- Application Forms

Certification Board Members

- Training Center Regions (4)
- CHA Training Centers (1)
- CHAP Directors' Association (1)
- CHA Association (1)
- Medical Director (1)
- Federal [Alaska Area Native Health Service] (1)
- State of Alaska (1)
- Dental Health (1)
- Behavioral Health (1)

Standards and Procedures

- Certification requirements
- Program oversight
- Supervision requirements
- Scope of practice
- Competencies *(Knowledge & Skills Checklist)*
- Training & related curriculum
- Practicum
- Continuing education
- Approved training sponsors

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

CHAPCB Program Operations

- Ongoing review of applications & granting certification
- Maintain database and applicant files
- Facilitate 3 Board meetings per year
- Travel and support for Board Members
- Billing, budget projection & reconciliation
- Correspondence, newsletter & website

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

Why Certification?

- Quality services
- Standards of care
- Recognized provider type

Individuals who are certified as a BHA/P…

- Completed Board-specified training and work requirements
- Have knowledge and skills specific to their scope of practice
- Stay updated on best practices (Continuing Education)

How will YOUR BHAs get certified?

- **Why certification?**
  - What is it? Why is it important? What does it represent?
- **Structure for certification**
  - Interdisciplinary Certification Board
    - Committed, detail oriented, collaborative, informed
  - Board staff
  - Staff at organization
    - Commitment to model, supervision, integration of BHAs into service model

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

How will YOUR BHAs get certified?

- **Standards and Procedures**
  - Establish requirements to meet and maintain a standard
  - Designed to honor context and culture
  - Scope of work
- **Consider and/or align with other systems**
  - Other providers' scope of practice
  - Local and regional resources

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

BEHAVIORAL HEALTH:
BHA SCOPE OF PRACTICE

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Behavioral Health in Alaska

- Adverse Childhood Events
  - Historical trauma
- Unintentional injury
- Suicide
- Substance abuse
  - Binge drinking
  - Alcohol abuse mortality
- Domestic violence

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Alaska's BHA/Ps

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Standards and Procedures: Behavioral Health Aide Program

- Employed by tribe or tribal organization
- Administrative oversight (*Licensed*)
- Clinical supervision (*Licensed or unlicensed*)
- Four levels of certification
  - BHA-I, BHA-II, BHA-III, BHP

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Standards and Procedures: Behavioral Health Aide Program

- Scope of practice
  - Culturally-informed, community-based, clinical services
  - Behavioral health prevention, intervention, aftercare, and postvention
- Certification requirements
  - Training
  - Practicum
  - # of work hours
  - 40 CEUs every 2 years

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

BHA Scope of Practice

BHA-I
- Screening
- Initial intake process
- Case management
- Community education, prevention, early intervention

BHA-II
- Substance abuse assessment & treatment

BHA-III
- Rehabilitative services Quality assurance case reviews

BHP
- Team leadership
- Mentor/support BHA-I, II, and III

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Aligning systems CHAPCB / State of Alaska

Clinical Associate

- Behavioral health screening/ client status review
- Short-term crisis stabilization
- Case management
- Peer support services
- Screening and brief intervention

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Aligning systems
CHAPCB / State of Alaska

Clinical Associate *(continued)*

- Comprehensive community support services *(adults)*
  - Individual & Group
- Therapeutic behavioral health services *(children)*
  - Individual & Group
  - Family (with & without patient)

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Aligning systems
CHAPCB / State of Alaska

Substance Abuse Counselor

- Assessments
- Treatment

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Who do BHAs Serve?


Elders

Youth

Families

Individuals

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

BHAs Serve Their Communities

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

Domestic Violence: Prevention & Intervention

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

Substance Abuse: Prevention and Intervention

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ALASKA'S BEHAVIORAL HEALTH AIDES

Suicide, Grief, and Loss: Prevention, Intervention, Postvention

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ALASKA'S BEHAVIORAL HEALTH AIDES

Defining Your BHA Scope

- **What is your vision for the BHA program?**
  - In your healthcare system? Communities?
- **Prevalence of behavioral health problems**
- **Current providers and scope**
  - Within behavioral health
  - Interdisciplinary team
- **Clear distinction between certification levels**
  - Scope of practice
  - Competencies

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

BEHAVIORAL HEALTH AIDE: TRAINING TOWARDS CERTIFICATION

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

- THO Employment
- Supervised by Master's level clinician

- Work experience hours
- Training curriculum
- 100 hour Practicum

- Competency evaluation
- Employee development plans

BHA Training

- Related to scope of work
  - Specific to cert. level
- Specific courses and curriculum (CHAPCB)
  - Curriculum builds upon itself
- Two pathways to certification
  - Non-academic *(Specialized)*
  - Academic *(Alternative)*
- Must be CHAPCB approved

BHA Training: **Two Pathways**

Specialized

- Based on CHAPCB curriculum
- Blended delivery
  - Online LMS
  - Distance and OJT
  - In-person
    - Intensives
    - Annual BHA Forum

Alternative

- Industry certificate/ degree
  - Not be specific to CHAPCB curriculum
    - Add'l courses required to meet cert. requirements
  - Pipeline to career

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

BHA-I Courses

- General Orientation (28)
- Orientation to Village-based BH Services (8)
- Ethics & Consent (6)
- Confidentiality & Privacy (6)
- Intro to Behavioral Health (24)
- Intro to Counseling (12)
- Intro to Documentation (12)
- Survey of Community Resources & Case Mngmt (8)
- Working with Diverse Populations (12)
- Intro to Group Counseling (8)

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA'S BEHAVIORAL HEALTH AIDES

BHA-II Courses

- Psycho-physiology & Behavioral Health (16)
- Intro to Co-Occurring Disorders (8)
- Tobacco Dependency Treatment (8)
- DSM Practice Application (12)
- Advance Interviewing Skills (16)
- ASAM Practice Application (12)
- Case Studies & Clinical Case Management (8)
- Traditional Health Based Practices (8)
- Intermediate Therapeutic Groups Counseling (16)
- Applied Crisis Management (8)

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

BHA-III Courses

- Treatment of Co-Occurring Disorders (12)
- Advanced Behavioral Health Clinical Care (40)
- Documentation & Quality Assurance (16)
- Intro to Case Management Supervision (16)
- Applied Case Studies in Alaska Native Culture Based Issues (8)
- Behavioral Health Clinical Team Building (12)
- Intro to Supervision (8)

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

BHP Courses

- Issues In Village-Based BH Care (40)
- Special Issues in BH Services (16)
- Competencies for Village-Based Supervision (16)
- Principals & Practice of Clinical Supervision (40)

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

BHA Training: **Resources**

- CHAP and DHAT training programs
- Existing training partners
  - In-house
  - Online Learning Management System
  - Local substance abuse counselor training program
  - University certificate and degree programs
- Developing model of training delivery
  - Blended delivery
  - Maximize distance-delivery
  - Course blocks
  - Find a partner who honors/prioritizes YOUR curriculum

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

BHA Training: Current Events

Training includes:
- Course work
- Practical application
- Integrating current events into training
- OJT with supervision
- Evaluation of competencies

Training should:
- Be thoughtful
- Prepare skilled providers
- Offer career opportunities

- AAS Degree Program at Iḷisaġvik College
  - Meets BHA-I and BHA-II cert. reqs
  - Certificate (yr. 1), AAS (yr. 2)
- Registered Apprenticeship (RA)
  - Model for workforce training and development
  - Recognized nationally, earn and learn, wage increases
  - Meets BHA-I and BHA-II cert. reqs
- Billing/revenue
  - BHA State Plan Amendment
    - Certified BHAs as a billable provider
    - Encounter rate for specific services
    - Reduced documentation requirements

Behavioral Health Aide Manual **eBHAM**

- Introduction
- Professional Orientation
- Clinical Skills for Client Care
- Overlapping BH Concerns
- Client Care Chapters

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

BHA Knowledge & Skills *(Competencies)*

- Working with Others
- Screening and Assessment
- Planning Services
- Providing Services
- Linking to Community Resources
- Community Education and Advocacy
- Cultural Competency and Individualizing Care
- Documenting
- Professional and Ethical Practice
- Professional Development

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

How Will You Train YOUR BHAs?

Standards and Procedures

- **What is their scope of practice?**
- **Knowledge, skills, abilities (competencies)**
  - BHAs
  - BHA supervisors
  - Process for evaluation
- **Curriculum and training tied to competencies**
  - Teamwork: BHAs, Supervisors, Instructors

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

How Will You Design Your Model of Training?

- **In-house & Partners**
- **Staff & Community expertise**
- **Instructional designers**
- **Distance & In-Person**
- **Synchronous & Asynchronous**
- **Competencies and evaluation**
- **OJT and Supervision**
- **Industry certificate & career opportunities**

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALASKA'S BEHAVIORAL HEALTH AIDES

Key Factors to Grow a BHA Program

- **Partnerships and resources**
  - Certification Board
  - Training
- **Consistency / fidelity**
- **Integration**
  - Into BH system
  - Included in tx plan
  - Train other providers how to work with BHAs
- **Sustainability**
  - Training
  - Billing systems and revenue potential

Quyana!

ANTHC: www.anthc.org
CHAPCB: www.akchap.org

BHA program
email: behavioralhealth@anthc.org
web: anthc.org/behavioral-health-aide-program/

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Specialized Training Matrix for BHA/P Certification

Level of Practice	BHA I	BHA II	BHA III	BH Practitioner
BHA Program Oversight	The BHA/P may only practice in a program in which clinical oversight of the behavioral health program is provided and responsibility is taken by a licensed behavioral health clinician (LBHC).			
Employment	Must be employed by Indian Health Services, a tribe, or tribal health organization that operates a community health aide program.			
Work Related Experience Providing village-based behavioral health services.	❑ 1000 hours under supervision of a licensed behavior health clinician or behavioral health professional.	❑ 2000 hours under supervision of a licensed behavior health clinician or behavioral health professional.	❑ 4000 hours under supervision of a licensed behavior health clinician or behavioral health professional.	❑ 6000 hours under supervision of a licensed behavior health clinician or master level behavioral health person.
BHA/P Specialized Training Requirements	❑ CB 8.20.050 General Orientation (28) ❑ CB 8.20.100 Orientation to Village-based Behavioral Health Services (8) ❑ CB 8.20.110 Ethics & Consent (6) ❑ CB 8.20.115 Confidentiality & Privacy (6) ❑ CB 8.20.125 Intro to Behavioral Health (24) ❑ CB 8.20.135 Intro to Counseling (12) ❑ CB 8.20.140 Intro to Documentation (12) ❑ CB 8.20.145 Survey of Community Resources & Case Management (8) ❑ CB 8.20.150 Working with Diverse Populations (12) ❑ CB 8.20.155 Intro to Group Counseling (8) ❑ CB 8.20.160 Crisis Intervention (16) ❑ CB 8.20.165 HIV/AIDS & Blood-Borne Pathogens (8) ❑ CB 8.20.170 Community Approach to Promoting Behavioral Health (8) ❑ CB 8.20.175 Family Systems I (16) ❑ CB 8.20.180 Recovery, Health, Wellness, & Balance (8)	❑ CB 8.20.220 Psycho-physiology & Behavioral Health (16) ❑ CB 8.20.225 Intro to Co-Occurring Disorders (8) ❑ CB 8.20.228 Tobacco Dependency Treatment (8) ❑ CB 8.20.230 DSM Practice Application (12) ❑ CB 8.20.235 Advance Interviewing Skills (16) ❑ CB 8.20.240 ASAM Practice Application (12) ❑ CB 8.20.245 Case Studies & Clinical Case Management (8) ❑ CB 8.20.250 Traditional Health Based Practices (8) ❑ CB 8.20.255 Intermediate Therapeutic Groups Counseling (16) ❑ CB 8.20.260 Applied Crisis Management (8) ❑ CB 8.20.270 Community Development Approach to Prevention (12) ❑ CB 8.20.275 Family Systems II (16)	❑ CB 8.20.325 Treatment of Co-Occurring Disorders (12) ❑ CB 8.20.335 Advanced Behavioral Health Clinical Care (20) ❑ CB 8.20.340 Documentation & Quality Assurance (16) ❑ CB 8.20.345 Intro to Case Management Supervision (16) ❑ CB 8.20.350 Applied Case Studies in Alaska Native Culture Based Issues (8) ❑ CB 8.20.370 Behavioral Health Clinical Team Building (12) ❑ CB 8.20.385 Intro to Supervision (8) ❑ CB 8.20.390 Child Development (20)	❑ CB 8.20.400 Issues In Village-Based Behavioral Health Care (20) ❑ CB 8.20.425 Special Issues in Behavioral Health Services (16) ❑ CB 8.20.485 Competencies for Village-Based Supervision (16) ❑ CB 8.20.490 Principals & Practice of Clinical Supervision (40) ❑ CB 8.20.495 Child-Centered Interventions (20)
Prerequisites	None	Must satisfy all of the requirements of a BHA I	Must satisfy all of the requirements of a BHA II	Must satisfy all of the requirements of a BHA III

Specialized Training Matrix for BHA/P Certification

Level of Practice	BHA I	BHA II	BHA III	BH Practitioner
Supervised Practicum Hours	Practicum hours 100	Practicum hours 100	Practicum hours 100	Practicum hours 100
Supervised Practicum Requirements	❑ Providing initial intake or client orientation to services, including screening and initial intake paperwork, with appropriate case documentation (25); ❑ Providing case management & referral with appropriate case documentation (25); ❑ Providing village-based community education, prevention & early intervention with appropriate case documentation (35). ❑ Balance of hours must be related to practicum components listed above.	❑ Providing client substance use assessment and treatment planning using DSM & ASAM patient placement criteria with appropriate case documentation (35); ❑ Providing rehabilitative services with appropriate case documentation (30); ❑ Providing rehabilitative services with appropriate case documentation (25). ❑ Balance of hours must be related to practicum components listed above.	❑ Providing behavioral health clinical assessment, treatment planning & rehabilitative services for clients with issues related to co-occurring disorders (45); ❑ Providing quality assurance case review with documentation of review activity (20); ❑ Providing clinical team leadership by leading clinical team case reviews (20). ❑ Balance of hours must be related to practicum components listed above.	❑ Engaging, mentoring, and supporting, as well as participating in supervision and evaluation of BHA-Is, BHA-IIs, and BHA-IIIs based on their understanding of supervisee's level of knowledge and skills, professional goals, and behavior (45) ❑ Providing clinical team leadership by leading clinical team case review (25). ❑ Balance of hours must be related to practicum components listed above.
BHA/P Knowledge & Skills Checklist. The applicant has demonstrated the knowledge of the BHA competencies.	❑ Complete and sign the signature page.	❑ Complete and sign the signature page.	❑ Complete and sign the signature page.	❑ Complete and sign the signature page.
BHA/P Cultural Competency Checklist	❑ The applicant has demonstrated the ability to provide culturally competent services.	❑ The applicant has demonstrated the ability to provide culturally competent services.	❑ The applicant has demonstrated the ability to provide culturally competent services.	❑ The applicant has demonstrated the ability to provide culturally competent services.
Application Fee	❑ $500	❑ $500	❑ $500	❑ $500
Recertification	❑ Recertify every 2 years	❑ Recertify every 2 years	❑ Recertify every 2 years	❑ Recertify every 2 years
Continuing Hours **CE is needed only when an applicant is renewing their certification	❑ 40 hours	❑ 40 hours	❑ 40 hours	❑ 40 hours
Continuing Education Training Requirements ** A minimum of 20 CEUs must be attended via face-to-face instruction.	❑ Ethics & Consent (4); ❑ Confidentiality & Privacy (4); ❑ Cross Cultural Communication & Understanding and Working with Diverse Populations (4); ❑ The remaining (28) hours must be a balance of the hours related to the knowledge & skills competencies.	❑ Ethics & Consent (4); ❑ Confidentiality & Privacy (4); ❑ Cross Cultural Communication & Understanding and Working with Diverse Populations (4); ❑ The remaining (28) hours must be a balance of the hours related to the knowledge & skills competencies.	❑ Ethics & Consent (4); ❑ Confidentiality & Privacy (4); ❑ Cross Cultural Communication & Understanding and Working with Diverse Populations (4); ❑ The remaining (28) hours must be a balance of the hours related to the knowledge & skills competencies.	❑ Ethics & Consent (4); ❑ Confidentiality & Privacy (4); ❑ Cross Cultural Communication & Understanding and Working with Diverse Populations (4); ❑ The remaining (28) hours must be a balance of the hours related to the knowledge & skills competencies.

Nak Nu We Sha
(NNWS)
"We Care"

June Adams, MSW
Yakama/Cherokee
Yakama Nation NNWS Program Manager
Laretta Smiscon, NNWS Social Worker Supervisor
Yakama Nation

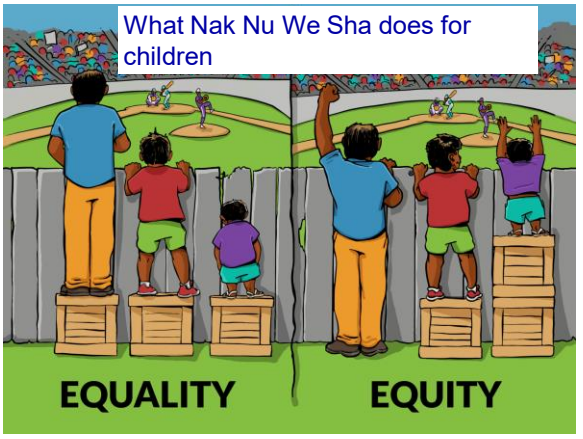
Nak Nu We Sha Staff

- Program Manager
- SW Supervisor
- 12 Social Workers
- 2 Office Asst.
- 1 Bookkeeper
- 1 Foster Care Licensor

Nak Nu We Sha Mission and Vision Statement

- **Vision Statement**—Nak Nu We Sha envisions children raised within their community, culture and tradition, protected by exercising Yakama Nation Sovereignty.
- Mission Statement—The mission of the Yakama Nation Nak Nu We Sha Program is;
  - **the prevention of the disintegration of our Indian Families;**
  - **Through early intervention and remediation services.**

What Nak Nu We Sha does for children



What does Nak Nu We Sha do?

- Child Abuse Prevention Activities (Tule Gathering, Pow Wow) One time emergency assistance, clothing donations, car seats
- Independent Living Classes (cooking classes)
- Kinship Services-Respite, gas vouchers, electricity, vouchers, Food, Clothing, Personal Hygiene, diapers, etc.
- Foster Care Licensing
- Child Placement Agency-Places dependent children, Basic and Intensive Case Management for Dependent Children (transportation, visits, referrals, family reunification)

Who Nak Nu We Sha Services

Enrolled Yakama Children and Indian Children Living on the Yakama Reservation under 21

Dependent Children of Nak Nu We Sha are victims of child abuse or neglect

Nak Nu We Sha receives notice of Approx. 35 Child Abuse and Neglect Intakes

Title IVB Population 5,605 (3,419 Yakama)

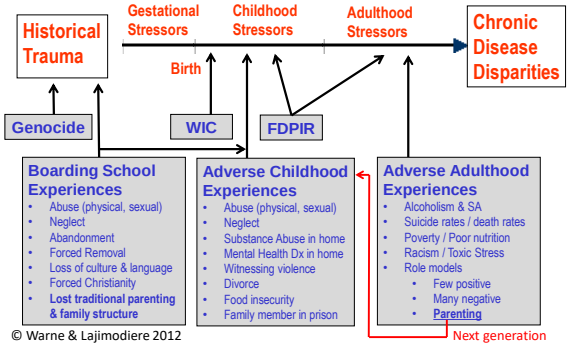
Serves 209 to 225 Dependent Children

Serves 197 Kinship Children (Children living with relatives)

***Historical trauma** is the collective emotional wounding across generations that results from massive cataclysmic events – Historically Traumatic Events (HTE)**

- The trauma is held personally and transmitted over generations. Thus, even family members who have not directly experienced the trauma can feel the effects of the event generations later

Inter-Generational Basis for Chronic Disease Disparities Among American Indians and Alaska Natives



Funding Sources and Contracts

1. Title IV B- Part I-Child Welfare Services
2. Title IV B-Part II –Promoting Safe and Stable Families
3. BIA ICWA Federal Funding
4. State Foster Child Placing Agency
5. State ICWA
6. Independent Living Services
7. Kinship Services-Tribal
8. Kinship Services-State

Behavioral Health Referrals

- NNWS will do a Mental Health CAN Screen on all dependent children they case manage.
- Initial referral will be sent to Yakama Nation Behavioral Health until client resides out of area or has exceptional circumstances.
- Immediate Suicidal Clients will be referred to Comprehensive Mental Health 575-4200 or taken to the Hospital for immediate treatment.

Case Closures (1 Year as 7/17)

- 50 Case Closures (19% of cases closed last year)
- 40% of the cases Children Returned back to parents
- 40% of the cases Children went into Guardianship (non-Indian or Indian)
- 16% of the cases Aged Out
- 4% of the case child deceased
- 89% (186 cases) Need Permanency

Future Directions

Prevention

- Intervene before a child is abused or neglected
- Reduce Riske Factors-Parenting Skills
- Embrace Traditions

"To be yourself in world that is constant trying to make you something different"

80 Percent of Nak Nu We Sha's Resource are focused on Tertiary Prevention

The Levels of Prevention

	PRIMARY Prevention	SECONDARY Prevention	TERTIARY Prevention
Definition	An intervention implemented before there is evidence of a disease or injury	An intervention implemented after a disease has begun, but before it is symptomatic.	An intervention implemented after a disease or injury is established
Intent	Reduce or eliminate causative risk factors (risk reduction)	Early identification (through screening) and treatment	Prevent sequelae (stop bad things from getting worse)
NAS Example	Prevent addiction from occurring Prevent pregnancy	Screen pregnant women for substance use during prenatal visits and refer for treatment	Treat addicted women Treat babies with NAS

Adapted from: Centers for Disease Control and Prevention. A Framework for Assessing the Effectiveness of Disease and Injury Prevention. MMWR. 1992; 41(RR-3):1-501. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/00021443.htm

TENNESSEE DEPARTMENT OF HEALTH

Blackfeet Saying

A child is sacred. And when that child comes into the home, the family must welcome it. And if the child is happy and feels the want, he will come into this world very, very strong. And not to know this is to know nothing.

June Adams

June_Adams@Yakama.com

Strategies to Reduce Diabetes > Sugary Drinks

Presented at the Northwest Portland Area Indian Health Board Quarterly Meeting
October 11, 2017 – Yakama Nation

Sara Soka
Vice President of Policy
ssoka@hfamerica.org

HEALTHY FOOD AMERICA
Moving Science to Action

HEALTHY FOOD AMERICA
Moving Science to Action

Our Mission

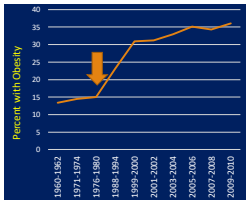
Healthy Food America acts on science to drive change in policy and industry practice so that all people can live in places where nutritious food is easy to obtain and exposure to unhealthy products is limited. We collaborate with other advocates to knock added sugar back to healthful levels.

healthyfoodamerica.org

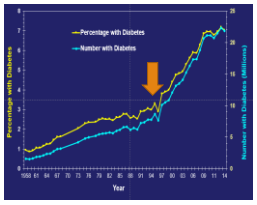
Epidemics of diabetes and obesity

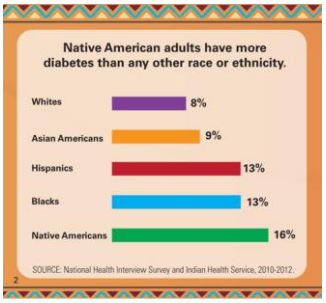
1 out of 3 children born in the year 2000 will develop diabetes

Prevalence of Obesity - US Adults
1960 - 2010



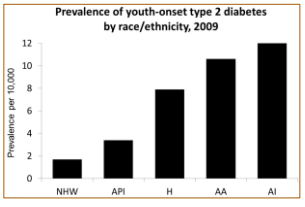
Prevalence of Diagnosed Diabetes - US Adults
1958 - 2014



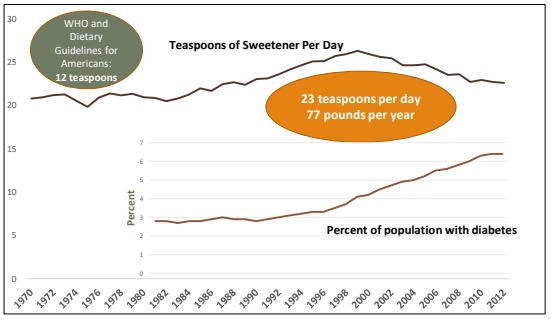


The rate of diagnosed diabetes varied by region from 6.0% among Alaska Natives to 24.1% among American Indians in southern Arizona.

American Indian youth most vulnerable

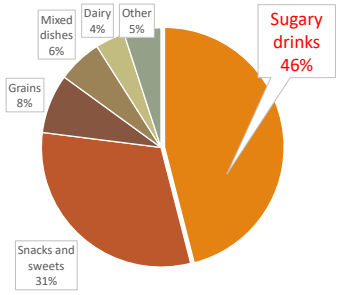


Driving diabetes – too much sugar



Almost half of added sugars comes from sugary drinks

- Among youth, 2-18, 60% of total added sugar calories come from beverages
- Americans gulp 150 calories per day from sugary drinks



Sugary drinks

How much sugar is in that drink?

20 oz
15 tsp

32 oz
13 tsp

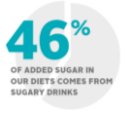
11 oz
8 tsp

And for a bonus:

- What is the recommended daily limit for sugar intake?
  Less than 12 tsp/day for adults and 6 tsp for children

Why focus on sugary drinks?

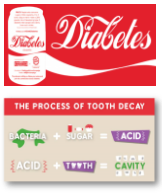
- Primary source of added sugar in U.S. diet
- Major source of added calories fueling the obesity epidemic
- Heavily marketed (youth and communities of color targeted by drink industry, like commercial tobacco)
- Consumption higher among communities of color and people with lower incomes
- Cause obesity, diabetes, dental decay, liver, and heart disease
- Do not affect appetite
- No nutritional benefits



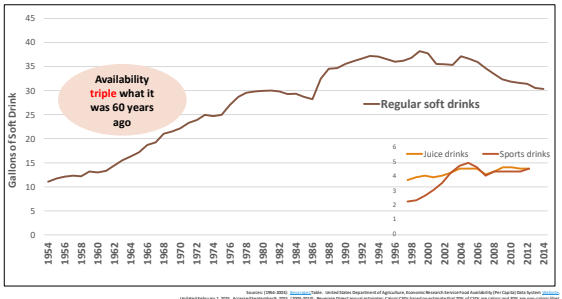
Sugary drinks cause chronic diseases

1 soda/day:

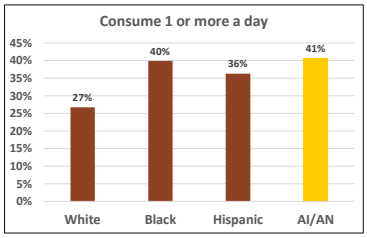
- ↑ Risk of overweight/obesity by 55% (children).
- ↑ Risk of diabetes by 26%.
- ↑ Risk of dying from heart disease by almost 1/3.
- ↑ Risk of stroke by 22%.
- ↑ Risk of tooth decay by 30% with daily consumption (adults).



Dramatic increase in sugary drink availability



AI/AN consume sugary drinks often



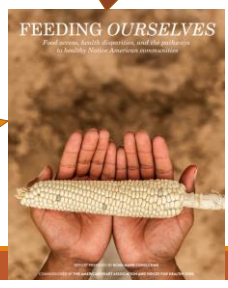
US adults – 2013 - BRFSS

It wasn't always this way…

"When we were strong in our foods on this continent, we were stronger people – we were healthier. And for Indigenous peoples it all starts with the food."

"Reservation stores often only sell foods high in fat, calories and sugar."

"Ultimately, the foods of the settlers and rationed foods replaced the foods of the communities. Dramatic shifts occurred in the span of a relatively short period of time and the health of American Indian peoples throughout the United States has never fully recovered."



Imagine if you were in charge of drinks and not them

Instead of this…

This…

What to do about it?

"Food can either empower us and make us strong, or it can kill us."

- Denisa Livingston, Diné Community Advocacy Alliance Organizer, MPH

DenisaWorldwide@gmail.com

Healthy Diné Nation Initiatives

- Eliminate 5% sales tax on healthy, cultural foods
- Place 2% sales tax on unhealthy foods, effective April 2015 (Healthy Diné Nation Act of 2014)
  - $1.8 M per year
  - $3.5 million to date
- Community Wellness Development Projects
  - Community-based and directed health and wellness projects to create healthier physical and social community environments

Community Wellness Projects

- Wellness and exercise equipment, supplies
- Trails and recreation facilities
- Health classes, workshops and coaching
- Food system: farming and vegetable gardens, greenhouses, farmers' markets, agricultural projects, equine therapy, healthy food preparation classes, food processing and storage facilities, health food initiatives, community food cooperatives
- Recreational, health, and youth clubs
- Library, health education materials
- Healthy convenience store improvements
- Clean water initiatives, clean communities initiatives, recycling initiatives
- Emergency preparedness
- Other community-based wellness projects

Taxed foods and beverages

- Beverages
  - Artificially sweetened, naturally sweetened, or sugar-sweetened drinks
- Sweets
  - Candy, frozen desserts, pastries, pudding, gelatin based desserts, or fried or baked goods.
- Chips and Crisps
  - Crispy type snack foods that are fried, baked, or toasted, such as potato chips, tortilla chips, pita chips, or cheese puffs.
- Fast Food
  - Ready to eat, quickly served foods, including any canned, precooked, or potted meats.
- Flavor enhancers
  - Salt, sugar, and sweeteners.

- **Preparing the ground:** Diné Community Advocacy Alliance (DCAA)
  - Grassroots community health advocates raise awareness and mobilize community to combat obesity and diabetes
  - Community advocacy trainings: how to advocate, making policy change in Navajo Nation, and the diabetes and obesity epidemics on the Navajo Nation
- **Funding**
  - Self-financed
  - Donation from American Heart Association for media
- **What to expect from industry**
  - Hired Navajo lobbyist to oppose efforts at Council meetings
  - Met with President just before he vetoed initial bills

2012	2013	2014	2015	2016-17
Launch Alliance	Introduce bills to tax unhealthy foods and remove tax on healthy foods	Both bills pass President vetoes Override healthy food veto Reintroduce, pass and sign unhealthy food tax	Pass Project Funds Management Plan	Distribute funds to chapters

What to do about it?

We the people, the grassroots people, have the solutions to our own problems in our hands.

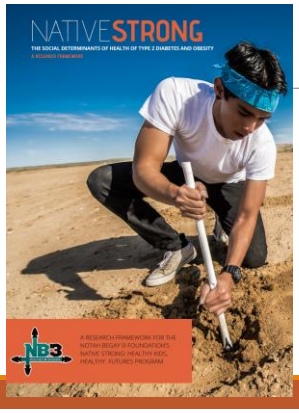
We have to create a space and opportunity to allow our tribal citizens to get involved. We have been the first community-led referendum in the U.S. to succeed at this level.

As volunteers, we are operating from passion and compassion to defeat our epidemics because we see so much suffering in our communities.

Philadelphia Mayor Jim Kenney

"What we're looking to do is to take some of that profit, to put it back into the neighborhoods that have been their biggest customers, to improve the lives and opportunities for the people who live there."

2) http://www.npr.org/sections/thesalt/2016/04/08/473548273/philly-wants-to-tax-soda-to-raise-money-for-schools



Notah Begay III Foundation

nb3foundation.org/our-work/native-strong/

What to do about it?

At every level we are still advocating to ensure these laws and policies are implemented and enforced.

As we are facing challenges, we are also moving forward in monumental steps working with the Navajo Nation Executive Branch and Office of Navajo Tax Commission to create a formal partnership with the grassroots people, our organization, to provide guidance and assistance.

I am signing some documents that will create another successful step and will be an example for other tribal governments.

What to do about it?

Denisa Livingston, Diné Community Advocacy Alliance Organizer, MPH

DenisaWorldwide@gmail.com

Acceptability & Appeal

Include health information at point of purchase

Consumers lack information on the health effects of sugary drinks.

- Require health warnings on sugary drinks
- Post health information signs on shelves where sugary drinks are sold

http://www.rwjf.org/en/library/articles-and-news/2016/01/health-warning-labels-sweetened-beverages.html

Media campaigns

Tradition educates the community

David is the Edible School Garden Instructor for a FoodCorps site in Tuba City, Arizona

Kelly Concho-Hayes, Navajo and Acoma, emphasizes her heritage: "I'll speak in my language; I'll dress in the traditional [attire] of my tribes."

Availability

Kids meals

A third of all US children and adolescents aged 2–19 consumed fast food on a given day.

- Ban soda as default beverage option or ban completely.
- Nutritional standards for kids meals.

Healthy retail

- Replace sugary drinks with healthier products
  - Endcaps and displays
  - Shelf location
  - Checkout aisles
- Promote healthier beverages
- Sell healthier beverages
- Offer incentives like tax credits
- Small-scale healthy food stores that are appropriate to the constrained infrastructures existing in tribal communities

Procurement

- Vending
- Cafeterias
- Government programs
  - Parks and Recreation Sites.
  - Child care and before/after schoo programs.
  - Meetings
- Government contracts

Community Centers

Minneapolis American Indian Center

At all Minneapolis American Indian Center sponsored and/or coordinated gatherings, meetings, and events, including rental space, beverage offerings must be in accordance with the Center's Healthy Beverage Policy. The Minneapolis American Indian Center will promote access to free, safe drinking water at all times and provide only healthy beverages, as specified by beverage standards (see below), during all meetings (internal and external), events, and programming. The purpose is to combat the epidemics of obesity and diabetes.

What Beverages are Allowed?	***What Beverages are <u>Not</u> Allowed?***
• Water (free, safe drinking water through fountains and similar outlets; unsweetened, 100% fruit-infused, plain or naturally flavored sparkling/seltzer).	• Soda Pop
• Tea/coffee (unsweetened with only naturally occurring caffeine).	• Sugar-added or added caffeine coffee/tea drinks, including Energy Drinks
• 100% fruit juice (no more than ½ cup or 4-8 ounces per serving.	• Sugar-added Fruit juices
• Milk (plain low-fat [1%] or fat-free [skim], or other unsweetened non-dairy milk alternatives).	• Flavored, sugar-added milk, like chocolate or strawberry milk

Employees and visitors will continue to have personal choice of beverage(s) they purchase outside of the organization and bring to work; however, because we serve community members, we encourage all staff to model healthy choices by choosing not to consume sugary drinks or conceal consumption around community members.

Schools

NO SUGARY DRINKS AT SCHOOL

- USDA bans full sugar drinks during class hours for elementary and middle schools
- Allows drinks with <40 cal/8 oz in high schools
- Eliminated from cafeterias
- Permitted off hours, special events, trips, and fundraisers
- Work remains:
  - Assure implementation
  - Seek total elimination from schools
  - Address in-school marketing

Child care

- No sugary drinks at child care.
- Availability can be reduced through:
  - Distributing information about nutrition.
  - Licensing and regulation.
  - Offering technical assistance to implement healthy practices and policies.
- CA AB 2084 (2010) – no sweetened beverages allowed

Hospitals and health care

- In 2006, 99% of hospital cafeterias sold SSBs
- **Partnership for a Healthier America**: 150 hospitals now serve healthier drinks
- **Healthier Hospitals**: 500 hospitals committed to healthier foods
- **University of California, San Francisco** Eliminated sale of sugary drinks in 2015

Increase water availability

Affordability

Sugary drink tax

- Reduces consumption
- Reduces disease
  - Diabetes: 2.6% decrease in new cases over 10 years
  - Obesity:
    - 1% decrease (adults)
    - 1.4% decrease (children)
- Increases awareness about adverse health effects
- Generates revenue to support community health and well-being
- Reduces US health care costs by $23 billion over 10 years

Philadelphia Mayor Jim Kenney

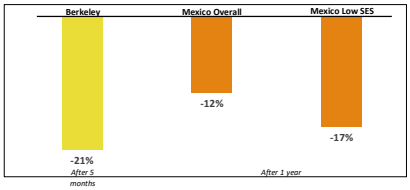
"What we're looking to do is to take some of that profit, to put it back into the neighborhoods that have been their biggest customers, to improve the lives and opportunities for the people who live there."

2) http://www.npr.org/sections/thesalt/2016/04/08/473548273/philly-wants-to-tax-soda-to-raise-money-for-schools

Sugary Drink Taxes

Taxes decrease sugary drink consumption

Impact of taxes in Berkeley and Mexico



Other impacts

Berkeley

- Based on retail scanner data:
  - **Store revenue**: no decrease in Berkeley relative to comparison cities
  - **Grocery bills**: No increase for consumers
- Based on data from Berkeley's Office of Economic Development:
  - **Food jobs**: increased by 7%
  - **Food sector revenue**: increased by 15%

Silver et al. *PLoS Med*, 2017. Silver L, PHI NCDHub, 2017 courtesy Kris Madsen

Building the base for change

"Establishment of Tribal food policy councils has been one of the central actions that embeds and encourages a broader array of follow-on actions that improve food and nutrition. "

- Muskogee Creek Nation - The first Tribe to pass a tribal government resolution establishing a 'food and fitness policy council" in 2010
- The Mvskoke people launched its Food Sovereignty Initiative in 2009

- Tribal Health and Wellness Committees
- Resolution supporting increased availability of healthy traditional foods

- Youth committee developing policies to present to schools and tribal college
- Marketing campaigns promoting healthy foods and drinks

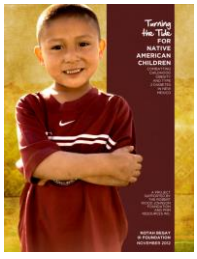
Sugary drinks - not part of healthy eating

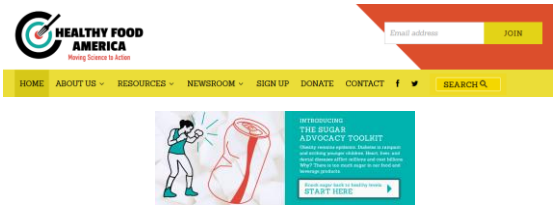
[We] used to have a healthy, sacred relationship with food and with each other. [We] literally ate out of one bowl. That was a healthy best practice.

We need to figure out how to restore this. Underlying all this is to return to the values.

Our elderly blessed themselves with the foods they ate. They asked for good health, strength, and asked that the food nourish their bodies and mind.

Now in this day and age, we have gone away from that practice.





Contact us!

- **Get answers to your questions**
- **Technical assistance and support**
- **Tools and resources**
- **Media and communications help**

healthyfoodamerica.org

ssoka@hfamerica.org

Diné Community Advocacy Alliance (DCAA)

History

A Strong Voice for the Diné Communities: DCAA formed in March 2012 as a response to the high rates of obesity, diabetes, and the complications of these health issues among children, youth, families, adults, and elders living in the Navajo communities.

Mission

DCAA is comprised of grassroots level community health advocates from various communities to raise awareness, inform, educate, and mobilize community members to combat obesity, diabetes, and other chronic health issues.

Imagine:

- Our Navajo Nation being a leader in health.
- Having the highest life expectancies in the world.
- Reclaiming our traditional healthy lifestyles.
- Returning to our traditional food sovereignty.
- Promising healthy generations.

Healthy Diné Nation Initiatives

1. **Elimination of 5% Navajo Nation Sales Tax on Healthy Foods:**
   Enacted: April 22, 2014 | Effective: October 1, 2014
   1. Fresh Fruits
   2. Fresh Vegetables
   3. Nuts
   4. Nut Butters
   5. Seeds
   6. Water
   7. Special ethnic foods: sumac berries, yucca, juniper, blue corn, yellow corn, white corn, frozen or dry hominy, posole, dried beans, and wild rice.

2. **The Healthy Diné Nation Act of 2014 / Unhealthy Foods 2% Sales Tax** in addition to the current Navajo Nation sales tax(es):
   Enacted: November 21, 2014 | Effective: April 1, 2015
   1. Beverages: any artificially sweetened, naturally sweetened, or sugar-sweetened drinks including powders, gels, drops, sparkling drinks, alcoholic-free and alcoholic drinks, excluding unsweetened hot tea, unsweetened hot coffee, unflavored milk, and unsweetened, unflavored water.
   2. Sweets: candy, frozen desserts, pastries, pudding and gelatin based desserts, or fried or baked goods.
   3. Chips and Crisps: crispy type snack foods that are fried, baked, or toasted, such as potato chips, tortilla chips, pita chips, or cheese puffs.
   4. Fast Food: ready to eat, quickly available, quickly served foods, including any canned, precooked, or potted meats.
   5. Flavor enhancers: salt, sugar, and sweeteners.
3. **Community Wellness Development Projects Fund Management Plan:** a special *Unhealthy Foods Tax* revenue account to fund Navajo Nation Chapter *Community Wellness Projects*.
   - Effective: April 13, 2015
4. **Navajo Nation Chapter Project Guideline and Distribution Policy:** allows all 110 Navajo Chapters to access the *Unhealthy Food Tax* revenue to create Diné community-based and community-directed health and wellness projects to address improvements to the physical and social environment of the community.
   - Effective: June 21, 2016
   - First Chapter Disbursement Estimation: Fall 2016

Shánah Daniidlį́įgo As'ah Neildeehdoo: *Let's Live a Long Life!*

We are hungry for change.

A Movement Towards Healthier Lifestyles.

#HealthyDinéNation
#SaveOurTribe
#ChampionsOfChange

#CutTheCRAP
(**C**arbonated, **R**efined, **A**rtificial, **P**rocessed foods)

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FEEDING *OURSELVES*

Food access, health disparities, and the pathways to healthy Native American communities

REPORT PREPARED BY **ECHO HAWK CONSULTING**

COMMISSIONED BY **THE AMERICAN HEART ASSOCIATION AND VOICES FOR HEALTHY KIDS**

FEEDING OURSELVES

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COMMISSIONED BY

American Heart Association. TAKING ACTION TO PREVENT OBESITY | Robert Wood Johnson Foundation | Voices for Healthy Kids

PREPARED BY

ECHO HAWK CONSULTING

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For a subject worked and reworked so often in novels, motion pictures and television, American Indians remain probably the least understood and most misunderstood Americans of us all.

President John F. Kennedy
1963

"When we were strong in our foods on this continent, we were stronger people – we were healthier. And for Indigenous peoples it all starts with the food. When Indian Country lost its ability to feed itself, through whatever means, we lost that part of ourselves that supports our ability to thrive. It is only by regaining our foods will we be able to restore our health, our resilience as peoples and secure the stability and diversification within our own communities and local economies. But the challenges to secure that future require different approaches than those used in other communities and in predominately urban settings, if for no other reason than our unique legal status, the remote location of our lands upon which foods can be found, and the language, cultural traditions, and legal status of our communities."

Janie Hipp
Director, Indigenous Food and Agriculture Initiative,
University of Arkansas School of Law

EXECUTIVE SUMMARY

The loss of Native American lands and purposeful destruction of Native cultures is ink on the fabric of American history. Now-repudiated federal policies that forcibly separated Native peoples from our historical lands and traditional sources of food are manifesting in our bodies today. Separation from healthy foods has been one of the most pernicious health problems we endure. The epidemics of obesity and diabetes in Native communities, even among our children, are direct consequences of limited access to healthy food. In many tribal communities, poverty, inequality, the lack of access to capital, and myriad and complex bureaucratic barriers undermine our current capacities to reestablish strong and vibrant Indian Country food systems.

This report, *Feeding Ourselves: Food Access, Health Disparities, and the Pathways to Healthy Native American Communities*, explores the complex historical and contemporary challenges to Native American healthy food access, childhood obesity, and health disparities. Looking first at the historical context of colonization, the treatment of Native Americans as sovereign Tribal Nations, and the evolution of Federal Indian policy, *Feeding Ourselves* frames the work ahead to engage and assist Native communities in moving beyond this condition.

Feeding Ourselves encourages its readers to take the first step toward a solution – becoming aware of the extent of the problem of Native health disparities and its deep interconnections to U.S. Indian policy, poverty, historical trauma and food systems. This includes building awareness of the complex historic and present-day situations of Native peoples, innovative models, and how systemic and long-term changes may be supported by policy changes at the tribal, federal, and philanthropic levels.

The goal of *Feeding Ourselves* is to inform and inspire tribal leaders, grassroots activists, philanthropists, and policymakers to identify mutual goals and opportunities to invest in strategies to create lasting systems and policy change that will strengthen Native American food systems, increase access to healthy and affordable foods, revitalize Native cultures and economies, and improve the health outcomes of Native American children and families.

Momentum is already underway by a number of tribes, Native communities, nonprofits, educational institutions, advocates and non-Native champions to create meaningful change to the food systems, diet, health, lives and wellbeing of Native peoples. This report presents some case studies of and lessons learned from Native-led innovations that are creating positive change.

The scope of the report is focused primarily on Tribal (rural and reservation) food access and health issues. While many Native peoples now reside in urban centers, the deep social, political, spiritual, cultural connections with the land base that is defined as Indian Country can not only provide the impetus for improving food systems within remote and reservation communities, but can become inextricably linked to improving the health and wellbeing of urban Indian citizens.

Feeding Ourselves challenges philanthropy, public health experts and policymakers to partner with Native leadership and stakeholders to create a framework for racial and health equity as we move forward together. There is no shortage of opportunity to make a profound difference through strategic partnership, respect for Tribal sovereignty, Native American knowledge, cultures and community-driven solutions.

OVERVIEW OF CHAPTERS

The first two chapters, “An Historical Overview: Colonization, The Evolution of U.S. Federal Indian Policy and Contemporary Indian Country” and “Indian Country Food Systems: An Historical Overview and Contemporary Challenges of Native Food Systems, Diet and Health” present the evolution of U.S. Indian policy and its impact on the political, socio-economic and cultural realities of Native peoples that underpin the immense challenges that Native peoples face today. This includes highly negative consequences on Native food systems, diets and health.

The next chapter, “Indian Country Food Systems Today: Native Agriculture, Federal Feeding Programs, Markets and Healthy Food Financing,” features where food is coming from in Native communities, the role of markets in crafting sustainable solutions to healthy food access and the challenges of financing food-related ventures.

The “Healthy Food Access in Indian Country: Innovations, Investment and Stakeholders” chapter highlights how Native communities are creating their own solutions from the ground up, the invaluable role played by Native intermediary funders and technical assistance providers, and support provided by some federal programs.

Case studies of grassroots advocacy, a Native intermediary funder, and a federal program are featured in “Indian Country Healthy Food Access Case Studies: Lessons Learned by Grassroots, Nonprofit and Federal Agencies.”

“We Stand On the Solution: Recommendations to Empower Indian Country Food Systems and Health” offers an outline of market-driven and policy-driven

(at the tribal, federal and philanthropic levels) solutions that, if implemented, will begin to create change within institutions that will have lasting and positive effects on Native food systems.

And finally, "Steps toward Increased and Strategic Partnership with Indian Country: Recommendations for Funders, Stakeholders and Policymakers" concludes this report by encouraging a deeper level of understanding of this issue and how diverse partners may engage and move forward together.

It is with a sense of urgency and hope that the authors offer Feeding Ourselves. Not only are Native health disparities threatening the very future of tribal communities, but concurrently, the time is ripe for opportunities to make a profound difference through strategic partnership, respect for Tribal sovereignty, Native American knowledge, cultures and community-driven solutions. The futures of Native children and Tribal Nations are at stake. The time to come together and act is now.

SUMMARY OF RECOMMENDATIONS: "WE STAND ON THE SOLUTION"

There are roles for all concerned who strive to provide every Native American family and individual with increased access to healthy foods and address the health disparities experienced by Native communities. Partnership and collaboration between various entities and stakeholders is of paramount importance.

In presenting recommendations for tribes, philanthropic funders, federal government agencies, educational institutions, community development financial institutions (CFDIs), service providers and Native food producers, one recurring central theme is increased tribal control of assets related to food production and purchasing for and by Native communities. Placing decision-making power within Native hands will best benefit the health of their community members also will have positive economic, social, cultural, environmental and infrastructure effects.

Below is a summary of recommendations that is further detailed in the chapter, *"We Stand on the Solution: Recommendations to Empower Indian Country Food Systems and Health."*

FOR TRIBES:

- Advocate for and secure tribal control of federally-funded feeding programs for tribal communities, with the accompanying ability to infuse purchasing decisions to emphasize Native locally produced healthy foods and healthy foods traditional to tribal culture;
- Support agricultural and natural resources with tribal policies that mandate sustainable management of water, community member access to land for food production and for subsistence hunting and gathering;
- Prioritize the production and marketing of healthy foods by financially supporting Native food producers' transition to production of crops with improved nutritional value, establishing a lending preference for healthy food production, incentivizing healthy food outlets and small-scale health food stores, financially supporting market-based linkages such as farm-to-school and other similar programs, and encouraging healthy food labelling and marketing;
- Adopt a policy preferring the purchase of healthy foods produced by tribal citizens at tribally-run institutions;
- Discourage the purchase and consumption of unhealthy foods by taxing "junk" foods and prohibiting the purchase of unhealthy foods at tribally-run institutions;
- Support a pipeline of Native healthy food producers and food-centered entrepreneurs through academic scholarships, internships, mentorship and apprenticeships and through development of successful food business models;
- Engage the tribal community in conducting community food assessments and planning to enhance control of the local food system;
- Encourage the implementation of tribal-level policies that address the full range of food and agriculture needs and encourage intertribal coordination of food and agriculture activities; and
- Partner with local, regional and national allies to develop and implement an integrated approach to food system management, enhancing health, the economy, the environment and the preservation of tribal cultures.

FOR FEDERAL AGENCIES:

- Study the feasibility of placing management of all feeding programs within USDA Food and Nutrition Service's jurisdiction under direct tribal government management;
- Ensure greater use of traditional foods within federal feeding programs and as donated food product in all public institutional settings in Indian Country;
- Recalibrate federal feeding programs to better support the local use of Native lands and tribal ability to solve local food access problems;
- Ensure that all agencies at USDA, BIA, and all other federal agencies commit the necessary support and resources to strengthen, support, build and grow healthy food alternatives in Indian Country;
- Create funding programs that will support Native consumers' healthy food access through small-scale, "self-help" grocery stores and financially supporting healthy foods incentive programs in Indian Country; and
- Enhance tribal control of and participation in the local food system by supporting local and regional food processing and packaging infrastructure development.

FOR FOUNDATIONS:

- Fund Native community engagement strategies around the local food system; demonstration models and networks related to healthy food production and/or marketing; capacity building technical assistance for service providers; Native intermediary funders that provide on-the-ground expertise; support for grassroots organizers and organizations; CDFIs that support healthy food businesses; and Native-controlled educational institutions that help to launch the careers of Native food entrepreneurs and that conduct supportive research and policy analysis.
- Convene tribes, public agencies, philanthropic players, public health experts, and Native and non-Native nonprofit organizations to develop consensus, identify expertise and roles, and create plans for local and systemic change; and
- Partner with grantmaking tribes and tribally-led nonprofit organizations to leverage larger-scale joint programs and networks.

AMERICAN HEART ASSOCIATION AND VOICES FOR HEALTHY KIDS

This report was commissioned by the American Heart Association (AHA) and its Voices for Healthy Kids®, a joint initiative of the Robert Wood Johnson Foundation (RWJF) and AHA. Voices for Healthy Kids works to help all young people eat healthier foods and be more active. Nearly one in three kids and teens are overweight or obese. By engaging, organizing and mobilizing people in communities across the United States, Voices for Healthy Kids will help make the

healthy choice the easy choice in the places where children live, learn, and play.

AHA and Voices for Healthy Kids have established a commitment to further their own knowledge and that of the larger fields of public health, philanthropy and healthy food access about Native Americans and "Indian Country," in order to better understand how they can engage and partner with Tribes and Native Americans to improve access to healthy and affordable food, reduce childhood obesity and address health disparities.

CONTRIBUTORS AND APPRECIATION

The authors of this report are deeply appreciative not only of AHA/Voices for Healthy Kids' investment in commissioning this report but to the numerous contributors, research and work of various organizations that informed its content and recommendations. We would like to extend our deep gratitude to:

- University of Arkansas School of Law's Indigenous Food and Agriculture Initiative;[1]
- First Nations Development Institute;[2]
- The Notah Begay III (NB3) Foundation;[3]
- The Praxis Project's Communities Creating Healthy Environments (CCHE) Program;[4]
- The Native Organizers Alliance (NOA), a project of the Alliance for a Just Society (CCHE Indian Country technical assistance partner);[5]
- The W.K. Kellogg Foundation;[6]
- The Robert Wood Johnson Foundation;[7] and
- The Diné Policy Institute.[8]

Echo Hawk Consulting also wishes to thank the external reviewers of this report who contributed invaluable advice, guidance and recommendations:

- NB3 Foundation;
- The Praxis Project;
- Food Trust; and
- Voices for Healthy Kids.

ABOUT ECHO HAWK CONSULTING AND THE AUTHORS

CRYSTAL ECHO HAWK

President & CEO, Echo Hawk Consulting

Crystal Echo Hawk is a member of the Pawnee Nation of Oklahoma. For more than 18 years, Crystal has served as an advocate for the health, wellbeing and rights of Tribes, Native American children and families. Crystal and her firm, Echo Hawk Consulting, provide expert consulting services in executive leadership, fundraising, philanthropic giving, community development, program design, partnership development, evaluation and

communications. Clients include Tribes, dynamic grantmakers, businesses, nonprofit organizations and philanthropic individuals focused on supporting culturally appropriate and community-driven social change, strategic partnerships and increased investment in Native American communities.

Prior to leading Echo Hawk Consulting, Crystal served as the Executive Director for the Notah Begay III (NB3) Foundation from 2009-2014. The NB3 Foundation is a national Native American nonprofit organization established by 4-time PGA TOUR winner and NBC Sports/ Golf Channel TV Analyst Notah Begay III. During her tenure, Crystal helped to grow the NB3 Foundation from a small grassroots organization to an organization that reinvested more than $9.7 million to fight the grave health issues facing Native children through strategic grantmaking, health and wellness programming, technical assistance, research and advocacy that benefitted more than 50 Native American communities, tribes and 24,000 Native children and families in 13 states.

Before her work with the NB3 Foundation, Crystal served as the Assistant Development Director for the Native American Rights Fund and Tribal Planner for the Pawnee Nation of Oklahoma. Crystal received both her Master's Degree in Social and Political Thought and Bachelor's Degree in European History from the University of Sussex at Falmer, England.

JANIE HIPP

Director of the Indigenous Food and Agriculture Initiative, Visiting Assistant Professor of Law

Professor Janie Hipp serves as the Director of the Indigenous Food and Agriculture Initiative and has the companion title of visiting professor of law. She is a member of the Chickasaw Nation of Oklahoma.

The Indigenous Food and Agriculture Initiative encompasses multi-disciplinary research, services, and education opportunities. The Initiative is the first of its kind nationally, and seeks to directly support Indian Country by providing strategic planning and technical assistance, education and professional development, in:

- Tribal Governance Infrastructure to Enhance Business and Economic Development Opportunities;
- Financial Markets and Asset Management, including Banking, Risk Management, and Stewardship of Land and Natural Resources; and
- Health and Nutrition Policy for Tribal Community Wellness,
- Intellectual Property Rights and Protection of Traditional Knowledge.

Prior to joining the Indigenous Food and Agriculture Initiative, she was the senior adviser for tribal relations to Thomas Vilsack, Secretary of the U.S. Department of Agriculture. She is the founder of the USDA's Office of Tribal Relations in the Office of the Secretary, is a former

National Program Leader at the USDA National Institute of Food and Agriculture, and served two terms on the USDA Secretary's Advisory Committee for Beginning Farmers and Ranchers.

She is an LL.M. graduate of the University of Arkansas School of Law's Agricultural and Food Law program. In 2014, she was named a Distinguished Alumni by the University of Arkansas Alumni Association and a Distinguished Member of the American Agricultural Law Association. She holds a J.D. from Oklahoma City University and a B.A. in Social Work from the University of Oklahoma.

WILSON PIPESTEM

Founder, Pipestem Law and Ietan Consulting

Wilson Pipestem's professional career has been dedicated to advocacy on behalf of American Indians and tribal governments. His advocacy in the federal courts led to the largest settlement in U.S. history between an Indian tribe and the federal government in Osage Nation v. United States. His advocacy before the Congress and federal agencies has led to the recovery of lost tribal lands, reaffirmation of inherent sovereign rights to determine tribal governmental and individual identity, and return of tribal criminal jurisdiction over non-Indians who commit domestic and dating violence crimes against Native women.

Wilson is a frequent speaker on developments in federal law and policy. He has taught Federal Indian Law at two law schools and appeared on MSNBC, NPR, and other media regarding tribal sovereignty and Native rights. He serves as a Director of the NIKE N7 Fund and served for six years as Chair of the Notah Begay III Foundation, organizations focused on addressing diabetes and obesity in Native communities through sport and nutrition.

He is a graduate of Stanford Law School and Oklahoma State University (OSU). In 2013, he was named a Distinguished Alumni by the OSU Alumni Association and OSU American Indian Alumni Society. Pipestem is an enrolled member of the Otoe-Missouria Tribe and an Osage Headright holder.

AN HISTORICAL OVERVIEW

Colonization, The Evolution of U.S. Federal Indian Policy and Contemporary Indian Country

> *"We stand at the beginning of a new era for Indian Country and for tribal relations with the United States. Previous eras were defined by what the federal government chose to do: the Indian removal period when tribes were forcibly removed from their homelands to reservations, the reorganization and termination era, the allotment era, even the recent promise of the self-determination era. But this new era is defined by what we, as Indian nations, choose to do for ourselves."*
>
> National Congress of American Indians, Jefferson Keel (Chickasaw), State of Indian Nations Address, January 2011

NATIVE AMERICANS AND ALASKA NATIVES IN THE UNITED STATES

Tribal nations have survived unfathomable hardship and maintained their distinctly separate tribal identities and cultures from the arrival of European colonists until today, engaging in war, trade, and treaty-making, and inspiring the principles of freedom and democracy enshrined in the U.S. Constitution. As the Founders shaped the Constitution, they specifically acknowledged the status of tribal nations as sovereign, along with the states and foreign nations.[9] Today, tribal nations continue to exercise power as governments over their lands and people.

Federal policies toward Indian tribes and Native peoples have changed radically over the history of United States. The condition of tribal governments and Natives today reflects each of these federal policies.

PRE-CONTACT

Before the establishment of the United States, tens of millions of Indigenous peoples inhabited North America and governed their distinct, complex societies long before European potentates sent explorers to colonize new territories and seize lands and resources from the continent and its inhabitants.

COLONIAL TIMES (1492 TO 1828)

During the colonization of America, the proliferation of European colonies created a dominant presence on the East Coast of North America. These colonies acquired some Indian lands under the Doctrine of Discovery – the legal concept that title to Native lands belongs to the European government whose subject "discovered" it because the inhabitants were not subjects of a European Christian monarch – as well as signed treaties with the tribes for additional land. Colonial governments treated Indian tribes as foreign governments, setting the precedent for future relations. Following the Revolutionary War, the new United States worked to maintain peace and diplomatic relations with neighboring tribes.

REMOVAL, RESERVATION AND TREATY PERIOD (1828 -1887)

As the U.S. population and military strength grew, so did pressure by the U.S. government on eastern tribes to move west, resulting in forced migration such as the Cherokee Trail of Tears. Seeking to obtain more Indian land, the U.S. government embarked on an aggressive military campaign throughout the West, relocating tribes to Indian reservations. In general, reservations were established through treaties, which required Indians to trade large tracts of land for the continued right of self-governance under the protection of the United States.

ALLOTMENT AND ASSIMILATION PERIOD (1887- 1934)

The demand for the land and resources within reservations and the push to assimilate Indians into mainstream American life led to the General Allotment Act of 1887 and tribe-specific land allotment acts. Allotment and assimilation forced conversion of communally-held tribal lands into small parcels for individual Indian ownership. More than 90 million acres - nearly two-thirds of reservation land - were taken from tribes and given to settlers as "surplus," usually without compensation to the tribes. The Allotment era resulted in the loss of over two-thirds of tribally entrusted lands from 138 million acres (558,000 km²) in 1871 to 48 million acres (190,000 km²) in 1934. The Bureau of Indian Affairs was tasked with the goal of "civilizing" Natives, discouraging or outlawing expressions of the various tribal cultures, such as speaking a tribal language, participating in tribal ceremonies, or practicing a Native religion.

THE ALLOTMENT ERA RESULTED IN THE LOSS OF OVER TWO-THIRDS OF TRIBALLY-ENTRUSTED LANDS FROM 138 MILLION ACRES (558,000 KM²) IN 1871 TO 48 MILLION ACRES (190,000 KM²) IN 1934.

INDIAN REORGANIZATION PERIOD (1934-1945)

The federal government, under the Indian Reorganization Act of 1934 and the Oklahoma Indian Welfare Act of 1936, ended the discredited policy of allotment. It established procedures to begin to restore lost lands to tribes and attempted to help tribes reconstitute their governments. The federal government created programs and projects to rehabilitate Indian economic life. These efforts were critical in re-establishing tribal economies and formed

a basis for renewed tribal autonomy, but too often forced European values and government structures upon tribes, thereby damaging traditional values and governance.

TERMINATION PERIOD (1945-1968)

Congress decided that the formal relationship between some tribes and the United States, and the federal assistance associated with it, should end. Further Public Law 280, passed in 1953, imposed state criminal and civil jurisdiction over tribes in California, Minnesota, Nebraska, Oregon and Wisconsin. Termination of federal assistance created economic disaster for many tribes, resulting in millions of acres of valuable natural resource land being lost through tax forfeiture sales. Federal policy emphasized the physical relocation of Indians from reservations to urban areas.

SELF-DETERMINATION PERIOD (1968-PRESENT)

A resurgence of tribal government involvement in Congress and in the federal courts ended the termination era and prompted the development of a policy of self-determination and self-governance. Laws like the Indian Self-Determination and Education Assistance Act of 1975 emerged that favored tribal control over federal programs that benefit tribes and Indians. Tribes have made great strides toward reversing economic hardships that resulted from previous federal policies, and have in many cases revived their cultures and societies.

The modern federal policy of self-determination also embraces the concept of tribal sovereignty, the power of Indian tribes to govern and enhance the health, safety, and welfare of tribal citizens within tribal territory. Although tribal nations are located within the geographic borders of the United States, each tribal nation exercises its own sovereignty over its territory and people. Hundreds of treaties, along with the Supreme Court, the President, and Congress, have repeatedly affirmed that tribal nations retain their inherent powers of self-government.

Today, tribal governments maintain the power to determine their own governance structures and enforce laws through police departments and tribal courts. The governments exercise these inherent rights through the development of their distinct forms of government, determining citizenship, establishing civil and criminal laws for their nations, taxing, licensing, regulating, and maintaining and exercising the power to exclude wrongdoers from tribal lands. In addition, tribal governments are responsible for a broad range of governmental activities on tribal lands, including education, law enforcement, judicial systems, health care, environmental protection, natural resource management, and the development and maintenance of basic infrastructure such as housing, roads, and bridges.

> *"My fellow tribal leaders, we've learned that together, united, we are greater than the sum of our parts. My fellow government officials, we've learned that together, working beyond the boundaries of party and state, we can improve countless lives and generate shared prosperity. Together, we can build a strong partnership between all of our nations... one that will secure a brighter future for all our people."*
>
> NCAI President Brian Cladoosby (Swinomish)
> State of Indian Nations Address,
> January 2014

NATIVE AMERICA TODAY

There are 566 federally-recognized Indian tribes, bands, nations, pueblos, rancherias, communities and Native villages in the United States. Two-hundred and twenty-nine of these are located in Alaska; the rest are located in 33 other states. Tribes are ethnically, culturally and linguistically diverse.[10] American Indian reservation and trust land areas, also known as "Indian Country," comprise approximately 56.2 million acres.[11] Alaska Native corporations and villages control 44 million acres as fee simple land under the Alaska Native Claims Settlement Act.[12] The total landmass under American Indian or Alaska Native control is about 100 million acres and would make Indian Country the fourth largest state in the United States.[13] The Navajo Nation would be the 42nd-largest state in the Union. The Navajo Nation is larger than each of the following states: Maryland, New Hampshire, Vermont, Massachusetts, Hawaii, New Jersey, Connecticut, Delaware, and Rhode Island. 19 tribal nations are each larger than the state of Rhode Island. 12 tribal nations have a land base larger than the state of Delaware.[14] *[Fig. 1]*

DEMOGRAPHIC TRENDS

In 2010, 5.2 million people, or 1.7% of the U.S. population, identified as American Indian/Alaska Native alone or in combination with other races, while 0.9% identified as American Indian/Alaska Native alone. While the overall U.S. population grew about 9.7% between 2000 and 2010, the percentage of the U.S. population identifying as American Indian/Alaska

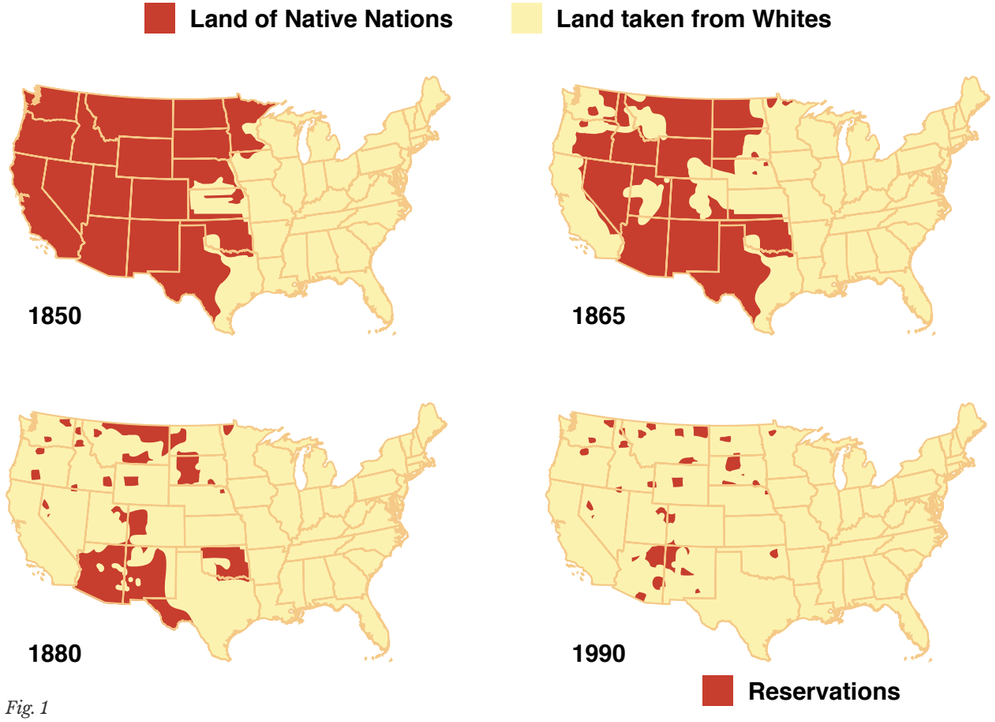


Fig. 1

Native alone or in combination with other races, grew by 27% since the 2000 census.[15] After enormous loss of life since contact with non-Indians, the Indian Country population is growing again.

- In 2013, there were 14 states with more than 100,000 American Indian and Alaska Native residents: California, Oklahoma, Arizona, Texas, New Mexico, Washington, New York, North Carolina, Florida, Alaska, Michigan, Oregon, Colorado and Minnesota;[16] and
- In 2013, the states with the highest percentage of American Indian and Alaska Native population were Alaska (14.3%), followed by Oklahoma (7.5 %), New Mexico (9.1%), South Dakota (8.5%), and Montana (6.8%).[17]

And Native people are getting younger. About 32% of Natives are under the age of 18 compared to only 24% of the total U.S. population. Some states have even higher proportions of young Native people. For example, in South Dakota nearly 40% of the 71,817 American Indians are under 18 years old.[18]

POVERTY & SOCIO-ECONOMIC CHALLENGES

Poverty continues be a hard truth in many Native communities. About one in four American Indians and Alaska Natives (AI/AN) were living in poverty in 2012.[19] The median income of AI/AN households is $35,062, compared to $50,046 for the nation as a whole. Of the ten poorest counties in the United States, eight are located entirely within Indian reservations or have reservations within them, or have 90% or more Native population within the county. 28.4% of Native peoples lived in poverty in 2010, while the corresponding rate is 15.3% for the nation as a whole.[20]

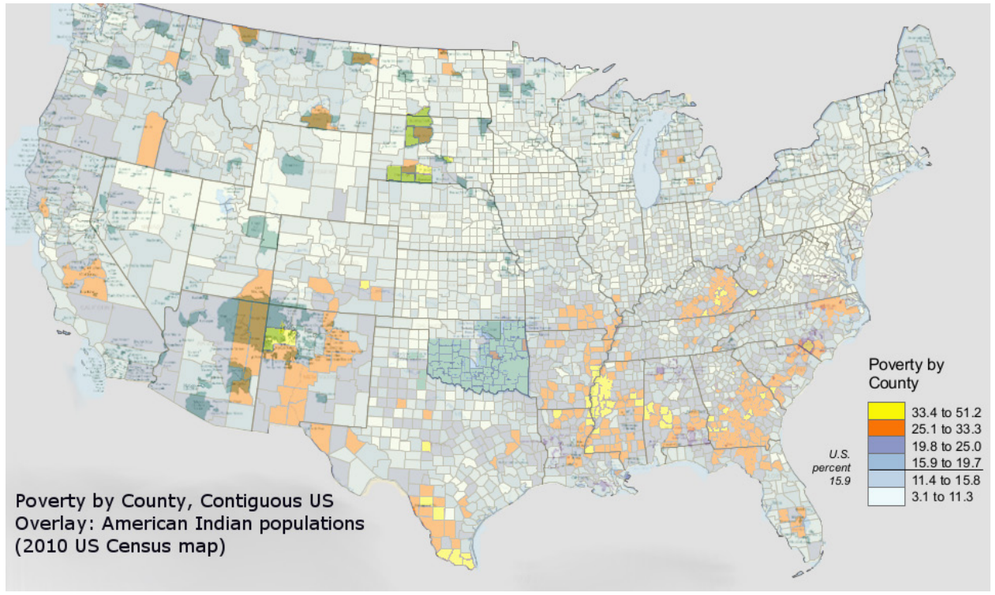


Fig. 2

The map below illustrates the intersection of poverty levels in Indian Country.[21] The green areas of the map represent on-reservation or trust lands, and the sections where those lands meet with yellow or orange areas indicate counties suffering severe widespread poverty. *[Fig. 2]*

Some of the poorest counties in the U.S. are home to the Standing Rock Sioux Tribe (ND); Cheyenne River Sioux Tribe, Oglala Lakota Nation, Rosebud Sioux Tribe, as well as portions of the Crow Creek (SD); Lumbee (NC); Navajo (AZ/NM) and Hopi (NM); San Carlos Apache (AZ); portions of the Mississippi Choctaw (MS); and Muscogee Creek and Cherokee Nations (OK);[22]

Federal policy of relocating American Indians to urban centers throughout the period of the 1950s through the 1970s resulted in additional pressures on families and individuals. Tribal populations live in poverty in cities in greater proportions than any other group and the federal funding to meet communities needs did not follow the population to its new location;[23] Unemployment is higher in rural American Indian communities (in some communities 57% or higher) than in non-American Indian communities;[24] and Tribal nations own significant assets but cumbersome federally-imposed bureaucratic barriers often undermine their capacity to fully utilize and benefit from those resources.

LACK OF BASIC INFRASTRUCTURE

- Over 14% of reservation homes lack electricity, ten times the national average;[25]
- One-fifth of reservation households lack running water;[26]
- Nearly 20% of reservation homes lack basic kitchen facilities, including piped-in water, a range or a cook stove, and a refrigerator;[27]

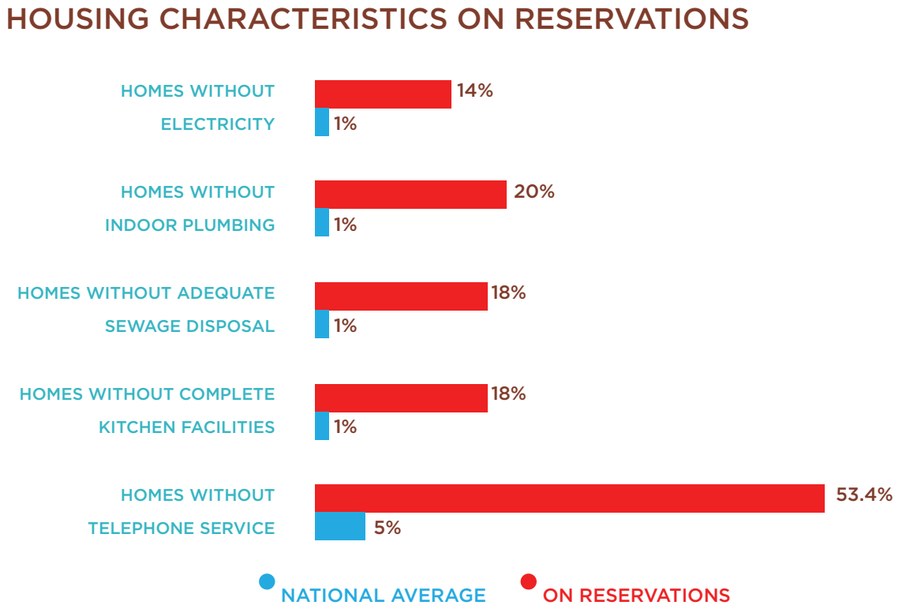


Fig. 3

- More than half of households on reservations do not have phone service;[28] and
- Fewer than 10% of reservation residents have Internet access.[29] *[Fig. 3]*

HOUSING

- Over 90,000 American Indian families are homeless or under-housed;[31] and
- Over 30% of American Indian families live in overcrowded housing and 18% are severely overcrowded with 25-30 individuals sharing a single home. These rates are over six times the national average.[34]

INSUFFICIENT EDUCATION RATES

- About three out of every ten American Indian students drop out before graduating from high school both on reservations and in cities[33];
- American Indian adults achieve lower levels of education than the national average;[34] and
- In 2012, 39% of American Indian students started in 2005 as first-time, full-time students at 4-year institutions graduated, compared to 60% of White students.[35]

MYTHS OF INDIAN GAMING

Tribal gaming has recently brought significant revenues to some tribes. Tribal gaming revenues totaled $28.3 billion dollars in fiscal year 2013.[36] Tribal gaming revenue is generated at 479 gaming facilities operated by 244 Indian tribes in 28 states.[37] These facilities range from a few slot machines in tribally-owned convenience stores to large scale enterprises that rival Las Vegas casinos.

In 2013, tribal gaming generated over $13.6 billion for federal, state and local government budgets through compact and service agreements, indirect payment of employment, income, sales and other state taxes, and reduced general welfare payments.[38] Although many of the most prosperous tribes act generously toward their less fortunate brothers and sisters, tribal gaming primarily benefits the tribal members who are citizens of the tribes whose lands are near sizable populations. In addition, those tribes whose lands and communities are the farthest from urban populations may well be among those whose continuing access to healthy foods will be most challenged, unless utilization of those lands in new ways is achieved for the benefit of those communities. More research and analysis is needed to fully answer that question.

INDIAN GAMING FACTS IN BRIEF

- Poverty is not countered, in contrast to popular belief, by Indian gaming operations;
- Of the 244 tribes that have casinos, only 25% give per capita payouts to individual members based on gaming revenues. Most tribes' membership is too large to provide per capita payments based on revenue and/or their gaming revenue is not significant enough for individual payments;[39]
- 75% of gaming Tribes devote all of their revenue to Tribal governmental services, economic and community development, neighboring communities and charitable purposes;[40] and
- According to ABC News, only 23 casinos are deemed highly successful in profit generation.[41]

HEALTH DISPARITIES

Natives continue to suffer from serious health problems. The average life expectancy for American Indians has improved yet still trails that of other Americans by almost 5 years.[42] Health disparities in Indian Country outpace other populations in the U.S. Current data from the National Congress of American Indian's Center for Diabetes Research and Policy Research Center, in addition to other relevant sources, reflects the following:

- According to the Indian Health Clinical Reporting System, over 80% of American Indian and Alaska Native (AI/AN) adults ages 20 to 74 are overweight or obese; among children and youth, between 45 % and 51 % are not at a healthy weight;[43]
- Childhood obesity rates often exceed 50% in tribal communities;[44]
- Obesity rates are twice as high for American Indian preschoolers than other race and ethnic populations;[45]
- 30% of AI/AN individuals are estimated to have pre-diabetes;[46]
- According to these trends, 1 out of 2 American Indian children will develop type 2 diabetes;
- There was a 110% increase in diagnosed diabetes from 1990 to 2009 in AI/AN youth aged 15-19 years;[47]
- The issues related to poor health, diabetes and obesity translate into oral health, maternal and child health and mental health concerns, and also translate into higher incidence of cancer, heart disease and chronic diseases related to obesity and diabetes, including amputations, strokes, and related health trauma;[48]
- AI/AN death rates nearly 50 % greater than those of non-Hispanic whites;[49]
- Among AI/AN people, cancer is the leading cause of death followed by heart disease. Among other races, it is the opposite;[50] and
- Death rates from lung cancer have shown little improvement in AI/AN populations. AI/AN people have the highest prevalence of tobacco use of any population in the United States.[51]

THE U.S. COMMISSION ON CIVIL RIGHTS FOUND THAT NATIVE AMERICANS LAG 20-25 YEARS BEHIND THE GENERAL POPULATION IN HEALTH STATUS, REPRESENTING THE MOST SEVERE UNMET HEALTH CARE NEEDS OF ANY GROUP IN THE U.S.

The Indian Health Service is the primary and largest health care provider for many American Indians, yet its resources are unable to meet the immense needs of the people as indicated above by these alarming statistics. About 55% of American Indians rely on the Indian Health Service for medical care.[52] Yet, the Indian Health Care Improvement Act only meets about 60% of their health needs.[53] Due to underfunding, Indian Health Service facilities are crisis-driven and leave a wide gap in adequate and preventative health care for many American Indians on the reservations. Pharmacies and doctor's offices outside of hospitals are completely non-existent in some communities.

HISTORICAL TRAUMA AND RACISM: CONNECTIONS TO HEALTH DISPARITIES

- Leading researchers increasingly point to the role of historical trauma and racism as significant factors in the health of Native peoples and current status of Native Americans;[54]
- Historical trauma has manifested through the

displacement from ancestral homelands, loss of spiritual ties to the land, population loss, "cultural genocide" including the mass killing of millions of Native peoples through colonization, forced relocation of tribes and the removal of Native children forced to attend Boarding Schools where they were assimilated in mission schools mandating that they eradicate their traditional languages, cultural and spiritual lifeways;

- The suicide rate is 25% higher among Native Americans than the overall national rate and is ranked as the second leading cause of death for those aged 10 to 34;[55]
- Native youth suffer from higher rates of mental health disorders related to suicide, anxiety, substance abuse, and depression than other groups;[56] and
- The U.S. Commission on Civil Rights has found that Native Americans lag 20-25 years behind the general population in health status, representing the most severe unmet health care needs of any group in the U.S. Further study is needed to understand the socio-economic, cultural and human costs of these disparities to Indian Country.[57]

"NATIVE PEOPLE ARE INCLUDED IN THE SAME CATEGORY AS OTHER PEOPLE OF COLOR WITH LITTLE RECOGNITION OF THE FACT THAT NATIVE PEOPLE ARE POLITICALLY SITUATED DIFFERENTLY BECAUSE OF SOVEREIGNTY AND TREATY RIGHTS."
-LORI POURIER, PRESIDENT, FIRST PEOPLES FUND

GOVERNMENT FUNDING AND PHILANTHROPY

FUNDING FOR TRIBES AND NATIVE AMERICANS

- Numerous treaties and laws have created a fundamental contract or "trust responsibility" between tribal nations and the United States: Tribes ceded millions of acres of land that made the United States what it is today, and in return tribes have the right of continued self-government, and to exist as distinct peoples on their own lands;
- Part of this trust responsibility includes basic governmental services in Indian Country, funding for which is appropriated in the discretionary portion of the federal budget. As governments, tribes must deliver a wide range of critical services, such as education, workforce development, and first-responder and public safety services to their citizens. The federal budget for tribal governmental services reflects the extent to which the United States honors its promises to Indian people;[58]
- Across all federal funding authorities, there are only a few specific funding programs with set-asides for Tribes or created specifically for Tribal members; the rest are of a general focus. While funding levels have improved under the Obama Administration, government funding levels to address unmet needs in Indian Country are still woefully inadequate;
- During the first term of the Obama Administration, the "Let's Move in Indian Country" initiative was launched as a component of the First Lady's Let's Move national focus on children's health. While important to drawing focus and impetus to improving children's health, the initiatives lack dedicated funding to significantly change access to healthy foods at a comprehensive level and rapid rate across Indian Country in ways that would match resources to the dramatic health challenges facing Native youth. In order to follow through on the promise created in early achievements of "Let's Move in Indian Country," more attention and more funding investment will be needed to scale up from early successes and deeply embed healthy food access

in all communities. More is needed;

- In January 2015, President Obama has announced that his administration will seek $1 billion for his "Generation Indigenous Initiative" that seeks to improve opportunities and wellbeing of Native youth. While this historic investment should be applauded, it is only is a fraction of what is needed to address the significant challenges Native youth face today as they experience the highest rates of obesity, suicide, drop-out rates and poverty of any youth population in the U.S.;
- A 2011 report by Native Americans in Philanthropy and the Foundation Center revealed that only 0.3% of all foundation giving in the U.S. is invested in Native Americans. However, in grants awarded, the majority of these dollars go to non-Native organizations working on "Native American issues." Total grantmaking benefitting Native Americans by foundations in 2009 was approximately $68 million. Giving is not widespread across all foundations; rather is it generated consistently from a small group of large, midsize and small funders;[59]
- Tribal Philanthropy is on the rise due in large part to the success that some Tribes have achieved through Indian gaming. For example, the Shakopee Mdewakanton Sioux Community has provided more than $325 million in charitable giving and loaned more than $500 million to fellow tribes since the 1990s;[60] and
- While it is believed other gaming tribes have contributed over $200 million in philanthropic donations to Native and non-Native nonprofits organizations across the United States[61], the majority of tribes do not have significant enough gaming revenues to warrant large amounts of charitable giving.

TRIBAL SOVEREIGNTY, GOVERNMENTS, ADVOCACY AND POLICY CHANGE

The modern federal policy of Tribal Self-Determination has ushered in more opportunities for tribal governments to address longstanding problems in their communities. Supported by tribal governments, innovation and a return to traditional tribal knowledge are taking hold. These grassroots movements among tribal citizens are making vast improvements to lives of Natives in their territories.

These good works usually come through the tribal political systems that vary from reservation to reservation. Innovation sometimes has basic costs to thrive, and some tribal governments are able to respond and support such innovation. Some models from other tribal communities are adapted by tribal leaders or citizens who incorporate best practices to improve their communities.

National Native organizations such as the National Congress of American Indians provide forums for tribal leaders and citizens to exchange and support ideas, and keep abreast of national issues that could impact all tribes. Federal law and policy sometimes differentiates between tribes or groups of tribes, but more often than not federal policies apply across the board in Indian Country.

But to continue to promote this innovation and progress, federal and state laws and policies need to catch up to the realities of modern tribal life. States have traditionally been enemies of the tribes, constantly in competition for access to tribal lands and resources. In many places, this is changing, with states learning to work with tribes, and vice versa, to address their common interests. In others, the states and tribes continue to battle over tribal and individual Indian rights.

Working together, tribal governments have become a political force in Washington, D.C. Understanding that federal policies disproportionately impact tribal communities because of the status of Indian lands and the promise of health care, education, housing, and other programs for Indians, tribal leaders have become increasing more engaged in the federal political and policy processes. Several U.S. Senators, including Jon Tester from Montana and Maria Cantwell from Washington, credit the newly activated Indian vote as a reason for winning their elections. More and more members of Congress understand the place of tribal governments in the U.S. federal system and acknowledge that tribes and Natives play an increasing role in the political process, and are reacting to this change. Natives are seen less as a special category of recipients of special entitlements and more as active citizens with rights embedded in the U.S. Constitution.

INDIAN COUNTRY FOOD SYSTEMS

An Historical Overview and Contemporary Challenges of Native Food Systems, Diet and Health

HISTORICAL OVERVIEW: INDIAN COUNTRY FOOD SYSTEMS AND THEIR IMPACT ON FOOD, DIET AND HEALTH

Native communities have centuries-old, deeply connected histories of and connections with food. These robust and comprehensive traditional food systems sustained Native peoples and communities well before settlement of this continent by Europeans. Known agriculture production systems and historical relationships of Native peoples with food are well-established history. These traditional food systems were woven deeply into Native peoples' cultures and traditions and were connected to language, cultural and spiritual lives, families and communities. Food was sourced locally and regionally, and if unavailable, the people moved toward the food.

These complex relationships developed over millennia with food systems began to wane as what would become America's first immigrants came to these lands. Native communities began to be disengaged and disconnected from their original homelands and original food sources, which only deepened over time. As Native communities were removed to reservations and their original food systems were strained, new food sources had to be found. In many communities, the lack of foods was replaced by rations provided by the federal government. In most cases, those rations were made up of totally unfamiliar foods that not only had no cultural context to the people, but were also damaging to the physiology of the peoples themselves. These rations were mentioned in historical accounts from the period and in many cases within treaties entered into between these Native communities and the new country to be known as the United States.

In most cases, government rationed foods were of substantially lower nutritional value (flour, lard, and other products not normally within the historic diet of Native peoples) or in other cases, the foods were altogether rancid or rotten when received. Through ongoing periods of federal policy of relocation, reservation, assimilation, and termination the impact on social relationships and personal health has resulted in the circumstances we find today in Indian Country.

TRANSFORMATION OF NATIVE PEOPLES' RELATIONSHIPS WITH FOOD AND THE IMPACT ON HEALTH

As federal policy toward Indian Country has changed over time, what has not changed is the provision of "rations" to Native communities. In the beginning, those "rations" were provided during removal and relocation and the movement of Native peoples to new locations. Gradually, the provision of "rations" gave way to the provision of food stamps or other foods provided either directly through food distribution or donation programs, or through federal feeding programs such as SNAP, WIC, the Food Distribution Program on Indian Reservations (the "commodities" program), and many others.

THE SHEER LACK OF ACCESS TO TRADITIONAL FOOD SOURCES AND THE ADJUSTMENT TO NEW FOOD SOURCES, THE IMPACT OF STRESS AND TRAUMA ASSOCIATED WITH FEDERAL POLICIES OF REMOVAL, RESERVATION, AND ASSIMILATION ON THE INDIVIDUAL CANNOT BE UNDERSTATED AS A CONTRIBUTING FACTOR TO GENERATIONAL HEALTH DETERIORATION IN NATIVE COMMUNITIES.

Ultimately, the foods of the settlers and rationed foods replaced the foods of the communities. In short, these communities were forced to adjust to inaccessible traditional food sources, loss of historic relationships to the environment that provided traditional foods, a changing economic and social pattern and the introduction of food products into their communities that were unfamiliar and not well-suited to the physical needs of the peoples. Dramatic shifts occurred in the span of a relatively short period of time and the health of American Indian peoples throughout the United States has never fully recovered. In addition to the sheer lack of access to traditional food sources and the adjustment to new food sources, the impact of stress and trauma associated with federal policies of removal, reservation, and assimilation on the individual cannot be understated as a contributing factor to generational health deterioration in Native communities.[62]

For example, there was no word for diabetes in traditional Native languages when the Europeans arrived on this continent. In 1933, a physician for the Indian Health Service (IHS) reported just one case in the entire state of Arizona.[63] Researchers have also stated that in 1940 the occurrence of diabetes among Native Americans was almost unknown.[64] Diabetes began appearing in 1950, until during the 1960s, it became a common condition. The incidence of diabetes exploded in the 1970s, becoming an epidemic.[65] Beginning in the 1990s and through present day, nearly every Native American is involved either personally with diabetes, or with family and friends with diabetes. It has been called the new smallpox. Researchers point to dramatic changes in the traditional diet of Native Americans, the rise in sedentary lifestyles, poverty, loss of culture, trauma and other factors as contributing to this epidemic and public health crisis that faces Indian Country.

"From what I'm reading and hearing from the American Indian medical community, diabetes is

being framed by those on the front lines as a type of genocide and perhaps the final one for American Indians," said University of Kansas visiting associate professor in journalism and social scientist Dr. Teresa Trumbly Lamsam, Osage. "It's already an epidemic. We're not affecting the trajectory fast enough."[66]

These significant lifestyle and cultural changes that have impacted Native American diets and health are directly related to less healthy, low cost, western foods that have replaced traditional foods. Moreover, many Native Americans themselves believe their own people's attitudes toward food have changed, as evidenced by project participants in a 2012 research project conducted by the Notah Begay III (NB3) Foundation, funded by the Robert Wood Johnson Foundation:

[We] used to have a healthy, sacred relationship with food and with each other. [We] literally ate out of one bowl. That was a healthy best practice. Now we no longer have a healthy, sacred relationship with food. We need to figure out how to restore this. Underlying all this is to return to the values...our elderly blessed themselves with the foods they ate. They asked for good health, strength, and asked that the food nourish their bodies and mind. Now in this day and age, we have gone away from that practice."[67]

One participant interviewed by the NB3 Foundation pointed to the loss of culture due to forced change and outside development as a major reason for the health and social issues Cochiti Pueblo in New Mexico faces.

"In last 30 years, Cochiti [Pueblo] is a classic example of forced impositions of change that came by way of construction of the dam. [Things] changed overnight from an agriculture community and production of our own food. That kind of disruption was both drastic and traumatic in [our] ability to produce our own foods which was an important part of the cultural environment and which had highest value because it was so closely associated with a spiritual way of life."[68]

THE CUMULATIVE EFFECT OF FEDERAL POLICY AND POVERTY

The disruption of traditional Native American systems of governance, cultural and spiritual lifeways, and economies has led to disheartening statistics that represent families, children, and entire Nations living in Third World conditions, while paradoxically inhabiting one of the world's most powerful economies. Years of genocide, isolation, economic and social disempowerment, and the stripping of assets and wealth have caused overwhelming poverty, lack of basic infrastructure, insufficient education rates and poor health.

VIRTUALLY *ALL* OF INDIAN COUNTRY RESIDES WITHIN A "FOOD DESERT" AS DEFINED BY THE UNITED STATES DEPARTMENT OF AGRICULTURE.

Poverty is a central root cause to the food access and health issues that American Indian children and families face today. Poverty and hunger are twin evils, and it is rare to find one without the other.

This fact was illustrated by the Diné Policy Institute when it published its food sovereignty assessment research findings in 2014 regarding the Navajo food system and its negative health, community, economic, cultural, and environmental impacts, in order to identify strategies and recommendations for creating positive change for the Diné (Navajo) people. Poverty was a central and underlying factor identified regarding food insecurity and access issues. Among those Navajo residents surveyed, approximately seventy-three percent (73%) of participants made $29,999 or less in annual income. More than half of the total respondents made $19,999 or less per year and close to one third made less than $4,999 per year.

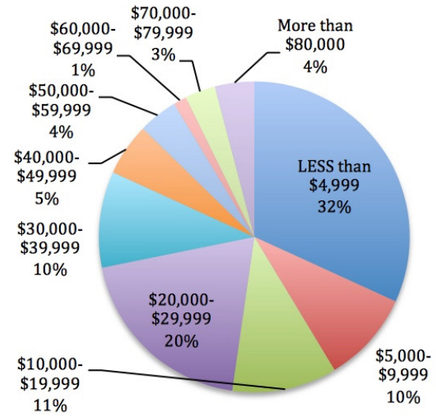


Figure 2.4 Income Level of Participants - Consumer Survey, Community Food Assessment

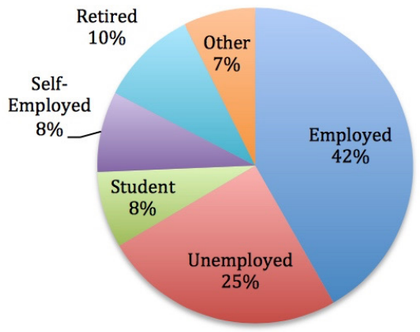


Figure 2.5 Employment Status of Participants - Consumer Survey, Community Food Assessment

Fig. 4

Less than a third of respondents made $30,000 per year or more.[69] *[Fig. 4]*

FOOD DESERTS IN INDIAN COUNTRY

Virtually **ALL** of Indian Country resides within a "food desert" as defined by the United States Department of Agriculture.[71] A community needs a grocery store every ten miles to ensure some measure of food security, yet there are only ten full service grocery stores in the entirety of the Navajo Nation,[72] which sprawls over 27,413 square miles—and the Navajo Nation is not alone in this problem. Almost the entirety of Indian Country resides in a food desert. This term is best clarified by saying that almost the entirety of Indian Country resides in a "retail food desert" as the important access to a food production land base creates unique opportunities for successful policy intervention.

In addition to lack of food vendors, food access in Indian Country is often made more difficult due to lack of vehicle access. In a food desert (or retail food desert), vehicle access is food access. For example, the

TABLE 2.1
ROUND TRIP DISTANCE TO OFF-NATION FOOD STORES FROM PROJECT AREA COMMUNITIES

	TO GALLUP, NM	TO FARMINGTON, NM
TSAILE, AZ	155 MI	174 MI
ROUND ROCK, AZ	240 MI	236 MI
LUKACHUKAI, AZ	173 MI	155 MI
CHINLE, AZ	183 MI	225 MI
MANY FARMS, AZ	210 MI	218 MI

Fig. 5

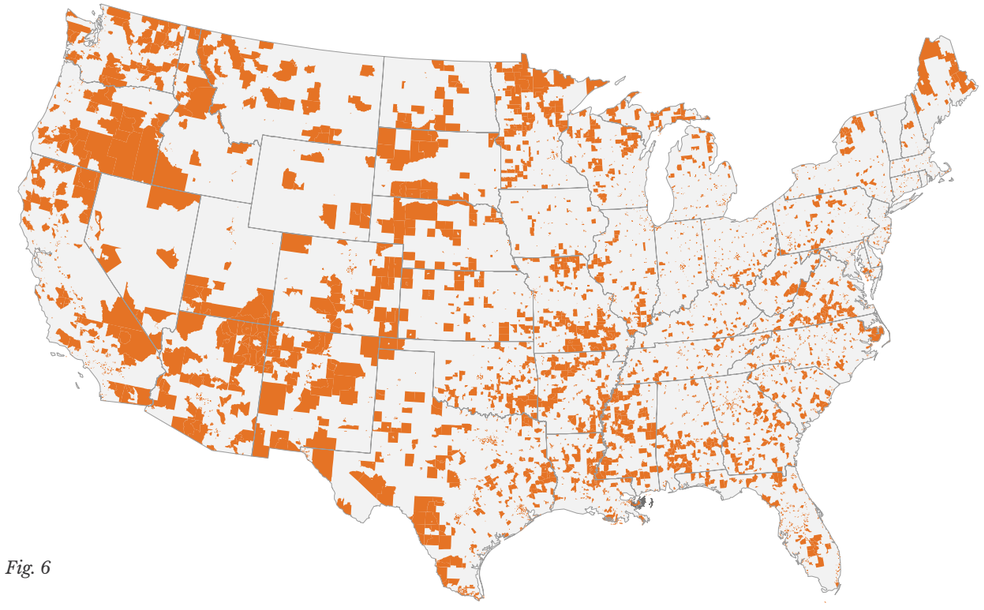


Fig. 6

FOOD DESERTS: 1 AND 10 MILES

Date: 12/3/2014 source usda economic research service, ESRI

LILA AT 1 IN 10

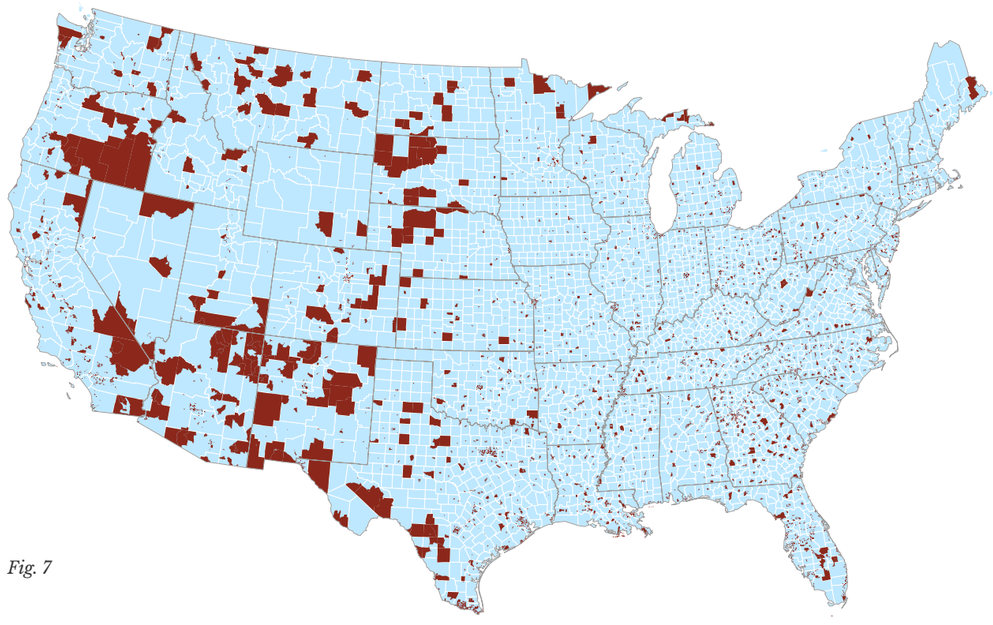


Fig. 7

FOOD DESERTS: 1 AND 20 MILES

Date: 12/3/2014 source usda economic research service, ESRI

LILA AT 1 IN 20

Diné Policy Institute found that to access an off-nation grocery store with a better supply of fresh, inexpensive food items, Navajo Nation residents were driving a minimum of 155 miles round trip.[73] Some residents remarked during the study that they would make a 400-mile trip.[74] The chart below provided by the Dine Policy Institute documents driving distances for residents surveyed in five Najavo communities.[75] *[Fig. 5]*

This is not unique to Navajo.[77] Similar statistics could be documented for reservations across the country and many urban Indian populations are situated within food deserts as well.[78] This particularly impacts Native people who rely on programs like the Supplemental Nutrition Assistance Program (SNAP) for their monthly food supply, because SNAP food can only be purchased at an authorized SNAP vendor—and those vendors are in short supply in Indian Country.[79]

The following maps show food deserts throughout the United States.[80] In the first map, the green areas represent urban communities where grocery stores are more than a mile away, and rural communities where grocery stores are more than ten miles away.[81] *[Fig. 6]*

The second map below is similar, but here the rural measure has changed—in this map, rural areas in orange represent communities where the nearest grocer is twenty miles away. Both maps show the difficulty of accessing food in much of Indian Country; the Navajo, Hopi, Standing Rock Sioux, Oglala Lakota Sioux and Cheyenne River Sioux among many others are all in areas where grocery stores may be twenty miles away by vehicle, if residents are able to access transportation. Even tribal communities throughout much of Oklahoma experience food deserts. *[Fig. 7]*

Problems accessing a consistent supply of healthy foods lead to widespread food insecurity across Indian Country. Food security is typically defined in terms of access to food itself, but also access to time to acquire that food coupled with access to knowledge and tools to prepare the food. The additional housing crisis throughout Indian Country can also impact the ability of people to prepare what foods they are able to access. The cumulative effect of insufficient housing options in Indian Country coupled with insufficient food vendors and chronic unemployment in rural and remote communities is often debilitating, leaving the

communities and tribal leadership to triage solutions to complex and interrelated problems.

HEALTH DISPARITIES: FOOD ACCESS AND CONTRIBUTING FACTORS

Diet goes hand in hand with food insecurity as a key contributor to chronic diseases and conditions.[82] Overall, Native Americans are twice as likely as the rest of the U.S. population to experience some manner of nutrition-related health problem.[83] In Indian Country, obesity-related disorders, particularly type 2 diabetes, are widespread, with the prevalence of diabetes rising dramatically over the past three decades.[84]

For example, as of 2009 16% of the adult American Indian and Alaska Native population had been diagnosed with diabetes.[85] On the Navajo Nation reservation alone 45,000 Navajo citizens have been diagnosed with type 2 diabetes and another 75,000 are pre-diabetic according to the Navajo Area Indian Health Service.[86] Alarmingly, 59% (10,407) of the total Navajo Nation children ages 1 to 4 years old participating in the Women, Infant and Children (WIC) Program in 2013 were obese.[87] Moreover, 38.7% of Navajo Head Start students enrolled in 2013-2014 school year were overweight/obese and two students were diagnosed as diabetic.[88] When taken into context with the issues of food access and poverty highlighted in the Diné Policy Institute's findings, it becomes increasingly clear there are links between these issues and the high rates of obesity and type 2 diabetes on Navajo Nation.

This example of the high rates of obesity and type 2 diabetes within the Navajo Nation are not unique to the Navajo people. It is demonstrative of the reality that most reservations and urban Indian populations increasingly face. Indian Country now faces nothing short of a public health crisis with regard to obesity and type 2 diabetes.

Tribal and public health advocates increasingly agree that the lack of access to healthy affordable food and poor diet are major contributing factors to chronic diseases and conditions that increasingly impact Native Americans -- especially children and youth.[89] However, the root causes of these health disparities are not limited to the challenges within Native food systems. In order to address and ultimately eliminate Native health disparities, it is important to understand how various factors, including socioeconomic, behavioral, social inequality, racism, culture, historical trauma and environment in conjunction with food deserts and poor nutrition contribute to these disparities.[90] It is imperative to build an understanding of not only how specific and unique conditions in which Native Americans are born, grow, live and work impact their health, but these factors must also be examined and understood within the context of the historical legacy of colonization and more than 200 years of failed and destructive U.S. federal policies. Fostering this understanding through more research and empowering tribal public health and food advocates are all important factors in creating pathways toward strengthening Native food systems and eliminating Native American health disparities.[91]

> "GOOD DATA LEADS TO GOOD SOVEREIGNTY…THE LACK OF GOOD DATA ABOUT U.S. AMERICAN INDIAN AND ALASKA NATIVE POPULATIONS HINDERS TRIBES…WITH MORE MEANINGFUL DATA, TRIBAL POLICYMAKERS CAN MAKE INFORMED DECISIONS ABOUT WHICH POLICIES AND PROGRAMS ARE RIGHT FOR THE TASK AT HAND…TRIBES CAN BE STRATEGIC… RESPONSIVE, INITIATING PROJECTS TO ADDRESS EMERGING NEEDS." *-NATIVE NATIONS INSTITUTE*

PUBLIC PERCEPTION VS. SOCIAL DETERMINANTS OF HEALTH

The lack of access to healthy and affordable food, historical trauma, poverty and the underdevelopment of Native food and health care systems are among the central drivers of the poor health of Native peoples. Despite this, researchers conducting a study of media coverage regarding Native American health issues and diabetes found that journalists have depicted Native Americans as being responsible for their diabetes because of their poor eating habits, obesity, and sedentary lifestyles.[92] This is one of the many negative perceptions and stereotypes that researchers have found repeated in media, movies and popular culture.[93] However, researchers have noted the important role of poverty and the lack of access to healthy and affordable food have played a profound role in health disparities among Native Americans. For example, reservation stores often only sell foods high in fat, calories and sugar. The same can be said for convenience stores in urban areas where an increasing share of Native Americans live today. Studies have shown a direct relationship to significantly higher obesity and diabetes in those living near convenience stores rather than grocery stores and fresh produce markets.[94] However, this side of the equation is often not widely known and reported on in coverage of Native American health in mainstream media. "How mainstream journalists tell the story influences public policy," Dr. Lamsam says. "Negative portrayals affect public opinion, and that can determine how policymakers act." [95]

If policy and systems change efforts are to be successful regarding food access issues and health disparities in Indian Country, there must be a clear understanding of the interrelated roles that U.S. government treatment and policies toward Native Americans, their unique political status, the current challenges inherent in contemporary Native American food systems and social determinants of health all play in the health disparities Native Americans face today. Poverty, racism, underdevelopment, historical trauma and the complex political and legal relationships between tribes and the federal government are primary factors.

In looking specifically at the issue of improving food access and health outcomes for children in Indian Country, all of these influences must be taken into account. "When [we] can show the social and institutional factors that help shape the choices that an individual or community are able to make, then we give the public more context and better tools for policy-making," stated Professor Sally Lehrman of Santa Clara University Journalism and Public Interest Department.[96]

FOOD ACCESS, DIET AND HEALTH: MORE DATA AND RESEARCH NEEDED

In order to dispel negative stereotypes as well as better inform both public and tribal policy making, additional studies such as the Diné Policy Institute's food sovereignty assessment cited above are critically needed to better understand the challenges that Native people face from reservation to reservation with regard to access to healthy food. There is a significant lack of this published research available.[97] Research that does exist is often increasingly outdated. Beyond published research, Tribes also sometimes struggle

internally to access data and analysis on their own reservations to better understand issues they may be facing regarding the connections between tribal food systems, socio-economic realities, the lack of healthy food access and health disparities.[98]

The issue of lack of data on American Indians and Alaska Natives is a longstanding and critical issue -- not only pertaining to food and health, but across the board. According to Jennifer Lee Schultz, senior researcher, and Stephanie Carroll Rainie, tribal health program manager, of The Native Nations Institute for Leadership, Management, and Policy (NNI), of the University of Arizona's Udall Center for Studies in Public Policy:

"It's no secret that the current data environment for tribes needs improvement. Because of the small size of Native populations, statistics rarely are reported in the findings of national surveys. When Native peoples and populations are reported, the data are not dependable, even on a matter as fundamental as who should be counted as a Native person. Nearly every tribal program and enrollment office holds a substantial amount of undigested data. Most of this information has been collected to comply with funders' reporting requirements. Afterward, it is stashed away in separate offices, stored in increasingly outdated formats. Some Tribal councils and program managers may not have a comprehensive view of available data that could help them make decisions. The challenge for tribes is to convert program data into a strategic resource. This means making better use of what they already have and shifting to more proactive and strategic collection of new data." [99]

The lack of resources and capacity for Tribes to collect and analyze data and the fact that Native peoples more often than not are not showing up consistently in state and national data sets means in this specific context that the depth of the interconnections between tribal food deserts and health disparities is not always fully known to even Tribes themselves. This also means these issues can be virtually invisible to non-tribal public health and food access advocates. A deeper investment in Native-led data collection and analysis could be a game changer for Native communities that seek to address food access and health issues.

"Good data leads to good sovereignty," stated Schultz and Rainie. "Armed with dependable and relevant information, Tribes can be strategic…They can be responsive, initiating projects to address emerging needs. As tribes meaningfully engage with data, quantitative information about Native populations will enhance—rather than detract from—the vibrancy and resiliency of tribal communities." [100]

INDIAN COUNTRY FOOD SYSTEMS TODAY

Native Agriculture, Federal Feeding Programs, Markets and Healthy Food Financing

INDIAN COUNTRY FOOD SYSTEMS TODAY

In the effort to chart interventions, policy change and solutions to food access issues and health disparities in Indian Country, it is imperative to understand the complexities and sources of Indian Country food systems today.

A Tribal food system refers to the connectedness of people, culture, politics, law, and economics that allows for a particular Tribal community to provide food for all its members. In this sense, it is no different than a food system existing outside Indian Country. However, the unique role that centuries of traditions play around our foods is critical to how we think about and plan for today's tribal food systems and the Indian Country food system of tomorrow, and the unique legal and political status that Indian Country holds makes a Tribal food system unlike many others.[100]

Like any food system, to some degree all people in Indian Country are involved in a Tribal food system, but there are certainly major players who can contribute significantly to the robustness of the overall system. These include Native farmers and ranchers, Tribal leaders and Tribal governments, Tribal colleges and universities, Tribal health entities, food business owners, food distributors, lending and financial services institutions, nonprofits and of course, the members of the Tribal community themselves, regardless of their role in the community.

While 70% of all Indian people reside now in urban centers, the deep social, political, spiritual, cultural connections with the land base that is defined as Indian Country can not only provide the impetus for improving food systems within remote and reservation communities, but can become inextricably linked to improving the health and well-being of urban Indian citizens. Many Tribal members hold deep connections to their urban communities, while simultaneously nurturing equally important connections to their historic land base and their family members who continue to reside in those places. Connecting the two in ways that improve healthy food access is a policy and logistical challenge but one worth the undertaking.[102]

As Indian Country begins to take back its overall health and wellbeing, many steps will be taken on the journey. The journey is underway in many Native communities as small community gardens, farmers markets, and an increase in food production becomes more prevalent. However, the road will not be easy and time is of the essence since the health problems and food insecurity of our communities has reached crucial breaking points. Among the first steps that should be taken is an honest analysis of our greatest asset in this fight for our health: our lands and our ability to grow ourselves out of these problems.

FOOD & AGRICULTURE IN INDIAN COUNTRY BY THE NUMBERS

Approximately 2.1 million farms occupy 914 million acres of land in America.[103] As is borne out by the most recent Agriculture Census of 2012, the total number of American farms and farmers has been in decline for the last twenty years.[104] Across Indian Country, there are at least 58,475 Native American and Alaska Native producers operating 45,000 farms on 53 million acres of land.[105] Interestingly, Bureau of Indian Affairs data reflect that Indian Country is comprised of approximately 56 million acres of land, which would lead to the conclusion that almost all the Indian Country land base is involved in some form of food or agriculture production. While almost the entire land base is involved in some form of agriculture production, there are fewer than 100,000 Native farmers reporting into the Census of Agriculture. An extremely high number of Indian Country acres are in fact under lease to non-Native producers.

The majority of Native American food producers — 80%-— reside in only seven states: Arizona, Oklahoma, New Mexico, Texas, Montana, California, and South Dakota.[106] These producers are located in close

proximity to a large percentage of the Indian Country land base. (See, map below from the 2010 Census). *[Fig. 8]*

Interestingly, Apache County, AZ is the county with the largest presence of Native American food producers; South Dakota's largest farm within the entire state is owned by a Tribe; and the state of Oklahoma has the largest number of Native American food producers in the U.S. How is it that food production can be so disconnected with food access in these locations? This phenomenon is repeated throughout the entirety of Indian Country.

Overall, products sold from those farms generated $3.1 billion in market value[107], yet the majority of those farms — 56% — are classified as small farms, with annual earnings of $2500 or less.[108] Only 8% of Indian Country farms earn $50,000 or more each year.[109] And for many Tribes, a significant portion of their land base is leased to non-Native farmers and ranchers and has been for decades. This non-Native control of the land base is heavily regulated by the Bureau of Indian Affairs and requires patience, perseverance, and persistence on the part of Native producers just to gain access to their own lands for food production.[110] The historic and ongoing practice of leasing Native lands for commodity food production shipped to

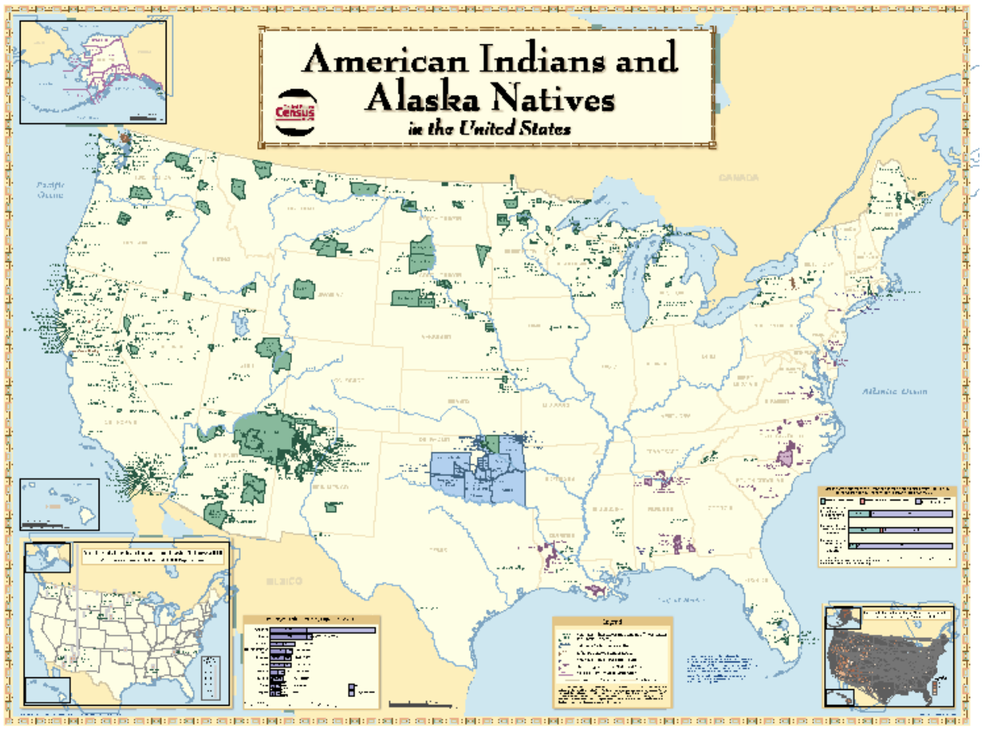


Fig. 8

off-reservation markets for consumption outside the communities living on those lands is at the heart of Native communities' lack of access to healthy foods and at the heart of ongoing economic decline of the very communities located on those fertile lands.

Despite this enviable and large land base in Indian Country to produce healthy and affordable food, this potential is not being realized. For example, in Cochiti Pueblo, New Mexico, Cochiti Youth Experience Director and economist A-Dae Romero (Cochiti/Kiowa) reports that local Cochiti food markets and local food producers capture only $50,000 annually, yet the community as a whole spends over $425,000 per month on food items—with at least a third of that coming from SNAP dollars. Nearly 100% of the community's food purchasing power leaves the Cochiti food system every month. In the course of a year, $5 million in food dollars flows out of the community, even though the community has a rich and historic tradition of food production.

FEDERAL FOOD PROGRAMS

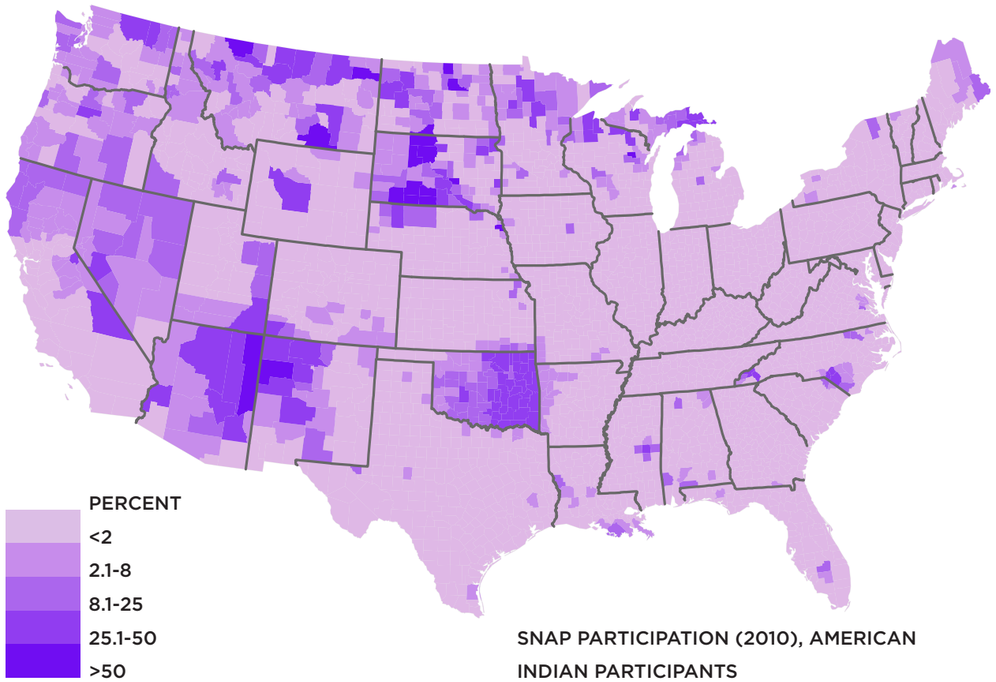
The lifeline for most tribal communities to feed themselves is their participation in federal food assistance programs. The federal food programs that provide the safety net for families and children include the:

- Supplemental Nutrition Assistance Program (SNAP);
- The Emergency Food Assistance Program (TEFAP);
- the Food Distribution Program on Indian Reservations (FDPIR);
- Food Help for Disaster Relief;
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);
- WIC Farmers Market Nutrition Program;
- Commodity Supplemental Food Program (CSFP);
- School Meals Program (which includes the National School Lunch Program, the School Breakfast Program, the Fresh Fruit and Vegetable Program, and others);
- Summer Food Service Program (SFSP);
- Senior Farmers Market Nutrition Program (SFMNP); and
- Commodity Supplemental Food Program (CSFP).

Two of the most significant federal programs serving Tribal people are the Supplemental Nutrition Assistance Program (SNAP) (because of the number of participants) and the Food Distribution Program on Indian Reservations (FDPIR) (because of its unique focus only on Indian people). It should be noted that SNAP and FDPIR cannot be accessed at the same time; meaning that the individual participant is ineligible to receive both program benefits.

SNAP

According to federal data, SNAP in 2008 served a monthly average of 540,000 low-income people identified as American Indian/Alaska Native only and another monthly average of 260,000 that identified as American Indian/Alaska Native and White. According to the National Congress of American Indians, 20% of all American Indian/Alaska Native households use SNAP.[111] During the debate leading to the ultimate passage of the 2014 Agricultural Act (2014 Farm Bill), heated debates occurred regarding continued funding for federal feeding programs like SNAP and FDPIR. SNAP was ultimately cut by $8 billion over the next decade, but $40 billion was proposed and passed by the House of Representatives in September 2013[112] in the arguments and activities leading to ultimate passage of the full Farm Bill. The likelihood of such debates and cuts to SNAP and FDPIR and other feeding programs occurring in the future is extremely high.



SNAP PARTICIPATION (2010), AMERICAN INDIAN PARTICIPANTS

Fig. 9

Even in the midst of food deserts, Tribal citizens still utilize the SNAP program. For example, more than half of Native people residing in Apache County, Arizona, participated in SNAP in 2010. Corson County, South Dakota, where the Standing Rock Sioux Reservation is located, also had a 50%+ SNAP participation rate among Native people in 2010. Between 25-50% of large swaths of Native populations in Oklahoma utilize SNAP. *[Fig. 9]*

FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR)

The only federal food assistance program available only to Native American and Alaska Native communities is FDPIR. The program serves 77,000-80,000 Tribal people on a monthly basis across 276 federally recognized Tribes.[113] Those monthly participation rates have been consistently on the rise since 2010 with virtually all program sites seeing a consistent 15% rise in program participation since 2010.[114] Instead of providing cash-like benefits, FDPIR provides participants with an actual physical package of food.

Unlike SNAP, FDPIR is almost exclusively administered at the local level by Indian Tribal Organizations (ITOs), with approximately 100 ITOs administering FDPIR, and only 5 State Agencies doing so.[115] Even though numerous Tribes participate in other feeding programs like WIC, Summer Food programs, School Lunch/School Breakfast programs, and others, the most pervasive feeding programs are SNAP and FDPIR.

The cultural significance of FDPIR cannot be ignored. FDPIR provides participants with a monthly food package. The history of commodity food (rations) in Indian Country as explained above is a history of injustice, and to forget that is to inevitably perpetuate that injustice.[116] The chart below indicates where FDPIR sites are located within Indian Country. *[Fig. 10]*

Administrative problems at the national and regional level within the federal government have plagued FDPIR for years and appear to be incapable of being remedied -- leaving Tribal governments with high levels of frustration and persistent injustices in the actual delivery of FDPIR foods.

At one time in late Summer 2014, over 30% of the food package was unavailable on warehouse shelves to be ordered by Tribal governments and all proteins available in the package except one were unavailable. Moreover, fresh fruits and vegetables often arrive to remote reservation delivery points spoiled and unable to be used.

FDPIR AND THE MISSED OPPORTUNITY OF ACCESSING HEALTHY, TRADITIONAL FOODS

The USDA Food and Nutrition Service (FNS) has had Congressional authority for over 10 years to purchase traditional foods for inclusion in the FDPIR food

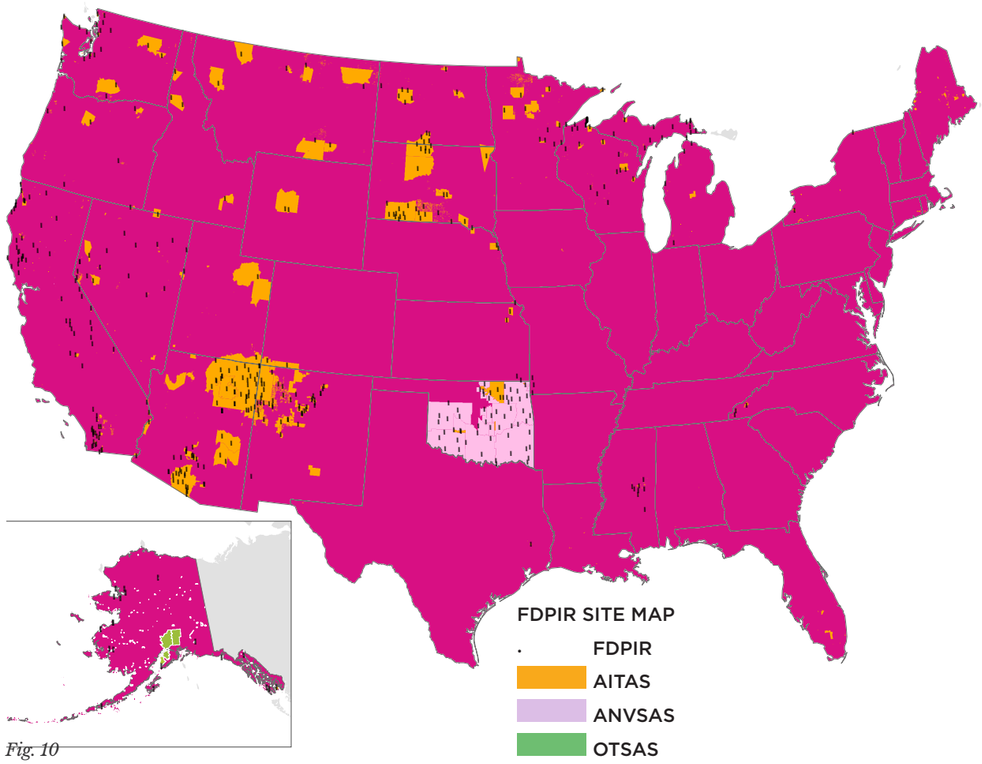


Fig. 10

package. There has been acknowledgement by the lead federal agency responsible for Native American healthcare that traditional foods are an important source of healthy and culturally appropriate nutrition for Native Americans. A 2007 U.S. Department of Health and Human Service's report, Obesity and American Indians/ Alaska Natives, stated:

Many traditional belief systems include the concepts of harmony and balance in respect to food, and these concepts can motivate individuals and communities to increase their use of traditional foods and adopt healthier lifestyles (Story et al, 2000). Examples of these types of foods include: wild rice (Minnesota), berries, teas, blue corn (Southwest), squash, roots, beans, salmon (Pacific Northwest) and other fish, fermented foods (e.g., heads and eggs of salmon) seal, beaver, bison (Plains) caribou, deer meat, wild game, whale. Most of these traditional foods are high in protein and low in fat and sugar.... One study reported that the extent and use of traditional foods and harvesting practices is often unrecognized or underestimated by non-Native health care providers.[117]

Moreover, a recent survey of FDPIR participants found that many participants would appreciate the incorporation of more traditional foods into their monthly food packages, especially bison and wild rice.[118] However, to date FNS has failed to consistently purchase traditional foods, even when those traditional foods met all food safety requirements and were readily available on the commercial marketplace. This failure to grasp the cultural significance of traditional foods, even in light of the congressional requirement that such foods be made available to tribal members, is stark proof that the ongoing administration of FDPIR is harmful to Native peoples, not only in the day-to-day functioning of the program, but in the inability to understand and implement clear congressional directives that would support the cultural health of the communities involved, in addition to improving the health outcomes of individual participants.

SIMPLY PUT, INDIAN COUNTRY IN MANY RESPECTS REQUIRES A MODIFIED POLICY AND SOLUTIONS-BASED APPROACH TO SOLVING PROBLEMS THAT MAY, ON THE SURFACE, APPEAR VERY SIMILAR TO THOSE PROBLEMS FACING OTHER POPULATIONS. BUT, DUE TO OUR UNIQUE POLITICAL, LEGAL, GEOGRAPHIC AND CULTURAL REALITIES, POLICIES AND SOLUTIONS REQUIRE A SECOND LOOK.

A MOVEMENT TOWARD THE RETURN OF TRADITIONAL FOODS

Tribal programs, nonprofit and grassroots Native groups across Indian Country are working daily to increase their communities' health and wellbeing and to increase their access to better food. There has been strong emphasis placed by countless Tribes to return to traditional means of food access and many of these programs are seeking to build food access resilience by improving the reliance on traditional and locally sourced foods.

There has been a growing emphasis among Tribes to focus more support on Tribal food production as a means to build resilient and diversified local economies while simultaneously improving health of local citizens. There has also been a growing interest in developing community gardens, sometimes in the service of providing traditional crops, though this is not always the case. The perplexing mystery remains: why is there such a disconnect between local, available food production on Tribal lands and the very people who would benefit from those foods, and where is all the food going that is currently being produced in Indian Country?

The combination of federal land leasing (referenced above) that takes agricultural control of local lands out of local Native hands, combined with the failure of feeding programs to calibrate their purchases to prefer foods produced by Native producers coming from Native lands are two fiercely ingrained federal policies that if changed could have dramatic impacts on local economies and healthy food access within a short time span.

CHALLENGES AND OPPORTUNITIES WITHIN NATIVE FOOD SYSTEMS TODAY

Many years ago, the Executive Director of the Intertribal Agriculture Council stated publicly that "we aren't sovereign if we can't feed ourselves".[119] The fact remains that in order to fully exercise Tribal self-determination and self-governance principles, Tribes must have support in removing the barriers that exist in this most important area of feeding ourselves.

When we were strong in our foods on this continent, we were stronger people – we were healthier. And for Indigenous peoples it all starts with the food. When Indian Country lost its ability to feed itself, through whatever means, we lost that part of ourselves that supports our ability to thrive. It is only by regaining our foods will we be able to restore our health, our resilience as peoples, and secure the stability and diversification within our own communities and local economies. But the challenges to secure that future require different approaches than those used in other communities and in predominately urban settings, if for no other reason than our unique legal status, the remote location of our lands upon which foods can be found, and the language, cultural traditions, and legal status of our communities.

Simply put, Indian Country in many respects requires a modified policy and solutions-based approach to solving problems that may, on the surface, appear very similar to those problems facing other populations. But, due to our unique political, legal, geographic and cultural realities, policies and solutions require a second look.

THE CHALLENGES FACED BY LOCAL MARKETS, CORNER STORES, MOBILE MARKETS, AND COMMUNITY GARDENS

An array of strategies appear across Indian Country, but most tend toward the lower end of the "retail spectrum" and with very few exceptions, do not usually incorporate a full-service grocery store setting.[120] Mobile food markets have been tried with varying degrees of success, most often due to the sheer transportation challenges of moving food across vast distances. Extremely remote stores must also face the challenge of exorbitant transportation costs of securing perishable food shipments, which is alone a formidable challenge.

The NB3 Foundation is already seeing, as are others funding projects in this area, a high number of projects focused on building community gardens to address the access to healthy foods in a remote or rural

community (or urban for that matter). Community gardens can provide a tremendous public service to get people more excited about food, about growing food, more knowledgeable about food, and in the case of Native communities, reenergizing the unique role traditional foods have in the community. However, there are a number of challenges that face this strategy in Native communities that must be taken into consideration.[121]

Many Tribal communities have instituted some version of farmers markets, community supported (or "tribally-supported") agriculture (CSA or TSA) or local food distribution initiatives. First Nations Development Institute, the largest national Native-led intermediary funder in Native food systems work, reported that among the projects it funded in 30 different tribal communities from 2012-2014 under its Native Agriculture and Food Systems Initiative (NAFSI), 13 were able to launch new farmers markets including two mobile farmers markets. Through these farmers markets, NAFSI grantees have sold nearly 10,000 pounds of fresh fruits and vegetables.[122]

The long-term success of these initiatives is still to be determined. It is evident from the success stories cited above, farmers markets can create important access points for healthy foods for tribal communities.

However, challenges still remain. In some communities, even those efforts at local food production systems that seemed among the most promising can easily die if the formula for success doesn't factor in the significantly longer distances between distribution points, the challenges of communities' purchasing power if in a high unemployment area, or the lack of available technical assistance, expertise, or commitment by the community.

What is often not discussed is that each of these models depends on purchasing relationships. If a farmers market, CSA/TSA, or related "market" based option is launched within a community with a high percentage of citizens unable to pay for their food, then the ability of a community to provide a livable income to the food producer can be challenging. Such programs as "double-up food bucks" simply will not work in a community that is predominately FDPIR client-based, as "double-up food bucks" is predicated on a SNAP benefit model and FDPIR is prohibited by law from using this as an incentive mechanism for healthier food purchasing. Some CSA/TSA, farmers markets and related models work in Indian Country but quite often their success is directly related to a Tribal government subsidy of some sort.[123]

TO UNLOCK THE POTENTIAL THAT INDIAN COUNTRY'S PEOPLE, OUR WORKFORCE, AND OUR LAND BASE HAVE IN FOOD PRODUCTION COUPLED WITH FOOD ACCESS, SIGNIFICANT INFRASTRUCTURE INVESTMENTS MUST BE UNDERTAKEN.

FINANCING HEALTHY FOOD ACCESS IN INDIAN COUNTRY

Food deserts in Indian Country are also credit deserts. Centuries of federal policy affecting Indian Country has led to generations of unbanked communities, low financial literacy rates, high unemployment rates, and general lack of experience in long-term private credit arrangements. In addition, lending institutions have generally been hesitant to lend into communities that face significant bureaucratic and regulatory engagement by federal agencies in the lending relationship along with fractionated ownership interests in the land base itself.

The underpinning for healthy food financing -- an individual or entity willing and able to freely enter into financing relationships -- is not easily achieved in Indian Country. While efforts by private and public lending institutions continue, and financial literacy and access to credit programs improve and extend deeper into Native communities, Indian Country simply requires an alternative way to enhance the willingness of financing institutions to engage effectively with communities and individuals.

That is not to say lending never occurs -- it does -- but it is a process that requires significant patience, a high tolerance for bureaucracy, and a deep understanding of the legal and political realities of Indian Country coupled with a commitment to get it done. By focusing the "credit access" conversation, at least partially, to better link credit access to increasing food access, and the creation of a unique policy initiative designed exclusively for Indian Country, the goals of healthy food financing within Native communities could be achieved.

But the efforts designed for communities that do not face Indian Country's political, legal, land tenure and related realities that literally do not exist for any other U.S. population group simply won't work. A fresh look and unique design are required.

FOOD DESERTS IN INDIAN COUNTRY ARE ALSO CREDIT DESERTS.

To unlock the potential that Indian Country's people, our workforce, and our land base have in food production coupled with food access, significant infrastructure investments must be undertaken. But the investments won't necessarily be only a corner grocery -- the investments might instead be in the distribution, aggregation, infrastructure, technical assistance and community-level food system deployment uniquely designed to meet the needs of rural and remote reservation communities.

NATIVE COMMUNITY DEVELOPMENT FINANCIAL INSTITUTIONS (CDFIS)

The unique role that Native Community Development Financial Institutions (CDFIs) can increasingly play in the area of food and health outcomes improvement through targeted financial commitments has yet to be fully realized. At present there are over 70 Native CDFIs located within communities in Indian Country.[124] They reach deeply into communities considered "high risk" credit areas and produce amazing results. However, they must receive additional attention and support in order for their current successes to be replicated and scaled up in the area of credit access for healthy food initiatives. Partnering in strategic and targeted infrastructure investments with other like-minded financial institutions and increasing access and deployment of training and technical assistance regarding the business development needs of various players in the food system are important and already identified needs.

In its publication, "Food Financing Efforts 2014: Native CDFI Support for Native Farmers and Ranchers" the First Nations Oweesta Corporation specifically noted that while over 40% of all Native CDFIs provide financial services to Native farmers and ranchers, over 70% desire additional technical assistance development lending products or training specifically for this group of borrowers and over 56% of Native CDFIs report not having enough capital to serve their borrowers' needs.[125]

In addition to the role of Native CDFIs in financing for healthy food production, special attention should also be paid to understanding the unique challenges faced by retail grocery locations operating on or near tribal lands or within urban Indian communities. While many remote or urban communities have extremely limited access to retail food locations, there are success stories. Knowing the winning combination of resources that leads to long-term sustainability of retail outlets is critical to replicating those successes elsewhere. For example, if a regional grocery chain can successfully provide reasonably priced healthy food options within remote communities, do they do so out of commitment to the community regardless of their financial success or do they do so because they have successfully met the supply chain, distribution, logistics, and purchasing challenges in order to maintain presence in the community. More needs to be understood.

HEALTHY FOOD ACCESS IN INDIAN COUNTRY

Innovations, Investment and Stakeholders

CURRENT INNOVATIONS IN HEALTHY FOOD ACCESS IN INDIAN COUNTRY: SIGNIFICANT FUNDERS

There are numerous examples of healthy food access innovations in Indian Country that are as varied as the people they serve. Among those innovations are projects supported by a variety of federal and philanthropic entities as well as by Tribes and Native nonprofits. Estimates of total funding to support Indian Country food access work are difficult to obtain as this would have to be aggregated over approximately 100 funding authorities in 17 agencies in the USDA alone. However, significant funders of this type of work over a period of time include: USDA; the Centers for Disease Control (CDC); the Administration for Native Americans (U.S. Department of Health and Human Services); the Indian Health Service (Health and Human Services); W.K. Kellogg Foundation; First Nations Development Institute; the Shakopee Mdewakanton Sioux Community; The Praxis Project; Robert Wood Johnson Foundation; NB3 Foundation; and the Walmart Foundation.

COMMUNITY-DRIVEN SOLUTIONS, GRASSROOTS ADVOCACY & NATIVE ORGANIZATIONS

The number of innovative, community-driven and grassroots advocacy efforts underway in Indian Country to strengthen local Native food systems are organically and explosively occurring.[126] These innovations are happening in almost every community and many are not even reported outside the community itself, as people decide to take matters into their own hands and return themselves to healthier foods. Some of these programs are readily duplicable elsewhere, while others are truly unique to the place and people.

Some are led by small community based organizations, some by Tribal governments. Some are fostered and encouraged at Tribal colleges and universities and others have partners outside Indian Country. These innovations need support to continue as most are functioning on small amounts of start-up capital and the sheer will and determination of the people involved.[127] The listing below is but a very small glimpse into what is happening locally, and the most important things to be done now are focusing on creating lasting generational change that will turn the corner for all of Indian Country.

NETWORK BUILDING, ADVOCACY AND POLICY CHANGE

NATIVE AMERICAN FOOD SOVEREIGNTY ALLIANCE

New Mexico

The Taos County Economic Development Corporation (New Mexico) partnered with First Nations Development Institute to develop the Native American Food Sovereignty Alliance (NAFSA). The overall goal of NAFSA is to develop a movement that gives voice to issues of Native sovereignty, food-system control and policy development, and serves as a strong network for collaboration among various organizations engaged in Native food-system control. NAFSA is dedicated to restoring the Indigenous food systems that support Indigenous self-determination, wellness, cultures, values, communities, economies, languages, families, and rebuilding relationships with the land, water, plants and animals that sustain us.[128]

NAFSA brings people, communities (rural, remote and urban), organizations and Tribal governments together to share, promote and support best practices and policies that enhance dynamic Native food systems that promote holistic wellness, sustainable economic development, education, reestablished trade routes, stewardship of land and water resources, peer-to-peer mentoring, and multigenerational empowerment.

NAVAJO NATION JUNK FOOD TAX AND ZERO TAX ON FRUITS AND VEGETABLES

Arizona

These are two very recent (spring 2015) tribal policies enacted by the elected officials of the Navajo Nation. Simply put, these policies use the inherent taxation rights and authorities of the Tribe to place a tax on all junk foods (as defined by the Navajo Nation) and simultaneously impose no tax on fruits and vegetables sold within the jurisdictional boundaries of the Navajo Nation. Navajo became the first governmental entity to make this bold move in 2015 and watching the impact and outcome of this new policy over time will be important to all Tribal governments as a means to address healthy food access within their jurisdictional boundaries.[129]

As this new policy has not been in place for even a year, the impacts of this policy shift will take some time to quantify and evaluate.

MVSKOKE FOOD SOVEREIGNTY INITIATIVE

Okmulgee, Oklahoma

The capital of the sovereign tribal Muscogee (Creek) Nation (MCN), an area in which over 50% of the residents live in poverty and 65% are overweight or obese, sought to challenge childhood obesity by targeting the lack of healthy food options in the community via a traditional cultural food revitalization movement. Mvskoke secured two policy wins in this area as a result of their Communities Creating Healthy Environments (CCHE) campaign: (1)

established the Tribal Food and Fitness Policy Council with the Inter-Tribal Council of Five Civilized Tribes — which represents over 500,000 American Indian people in the United States — to carry out health promotion activities nationally, and (2) passed a MCN tribal resolution which was designed to allow MCN tribal programs and entities such as Head Start and Elderly Nutrition to purchase local, fresh versus highly processed, cheap foods.[130]

MCN was the first Tribe that passed a tribal government resolution establishing a 'food and fitness policy council" and for over a decade MFSI was successful in receiving federal and foundation funding for its activities. However, in the last several years, its primary funding sources from USDA and RWJF both expired and the organization went on a brief hiatus until the Muscogee Creek Nation stepped in to provide support and stabilization. They have recently hired new staff and are re-energizing their work.

INDIGENOUS ENVIRONMENTAL NETWORK

Bemidji, Minnesota

The organization addressed the childhood obesity problem affecting American Indian tribal groups in their target area by seeking to improve residents' access to healthier and more affordable food choices in schools and the community. To this end, IEN achieved five policy wins. Two of the policy wins involved the Bemidji school district, which agreed to implement the Federal Great Trays program standards which requires schools to improve their menus with fresh, nutritious fruits, vegetables, and whole grains; many of which must be locally grown and organic. The remaining three policy wins were community-oriented and included establishing a community garden, a community kitchen, and establishing a Food Sovereignty Council that united the different tribal groups into a collective decision-making entity surrounding healthy food access.[131]

Establishment of Tribal food policy councils has been one of the central consistent actions among Tribes that tends to embed and encourage a broader array of follow-on actions that improve food and nutrition. In the early days of the "Let's Move in Indian Country" effort, the encouragement of food policy councils at the Tribal level was acknowledged as a central action important to promote and support. On a different note, as new Food Safety Modernization Act (FSMA) produce regulations become final and start to impact Tribal communities, revisiting the success of community kitchens will be of vital importance to determine if, in implementing these new federal policies, a decline in community kitchens or community gardens occurs.

ROCKY BOY

Montana

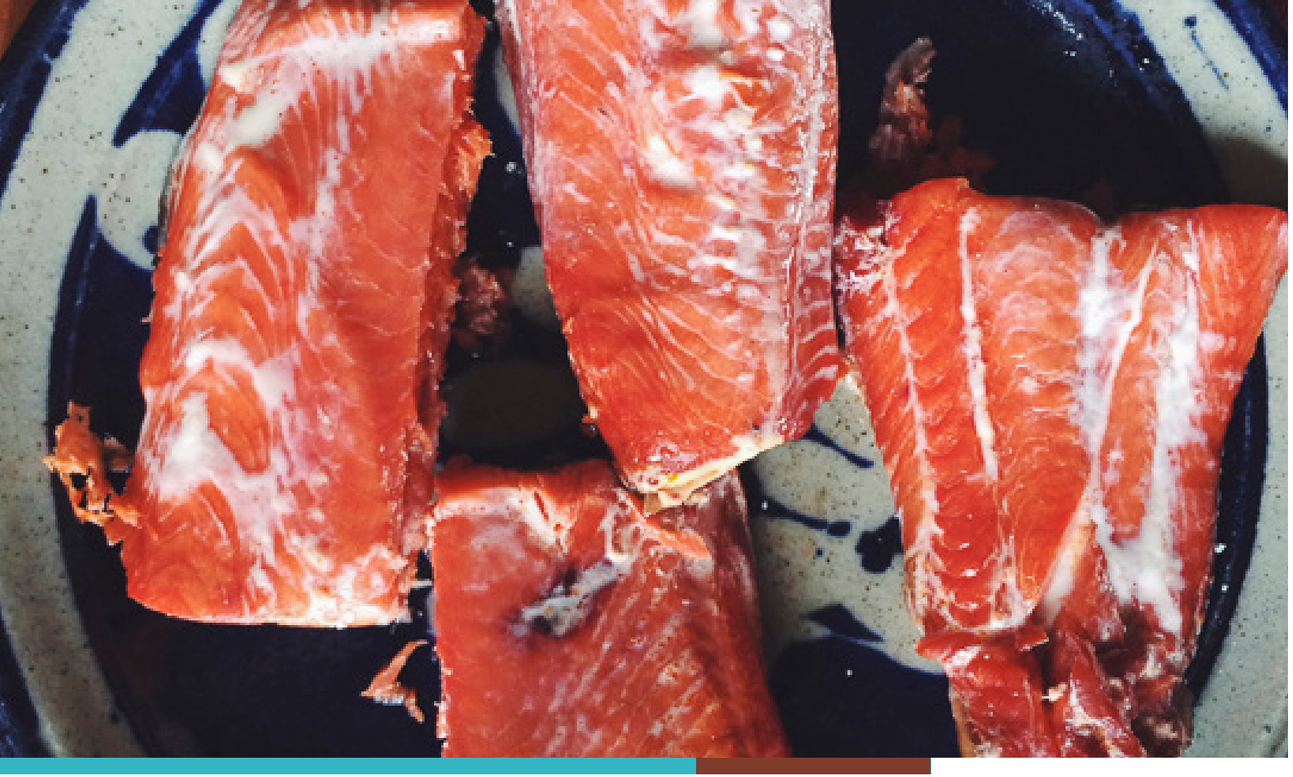
The Chippewa Cree Tribe won a fight to require the local farmers market to place food labels on their goods to ensure that residents could make informed nutrition-related decisions about their food purchases.

As the number of farmers markets in Indian Country continues to rise, an important next step should be encouraging the Rocky Boy requirement that all foods at markets place more information in the hands of consumers (food ingredient labels, source of foods, identity of Native food producers, etc.). Tracking the impact of that policy over time is import.[132]

ATHABASCAN OF YUKON

Alaska

A community organization serving 10 Alaskan Native villages sought to maintain food security for children by protecting the local, natural resources for traditional Alaskan Native subsistence lifestyle practices such as hunting and fishing. Athabascan accomplished three policy wins during their CCHE campaign, winning an important battle to keep



non-Native hunters out of sacred Alaskan Native lands to reduce devastation to the local wildlife and obtaining agreements with the federal Bureau of Land Management to decriminalize traditional Alaskan Native hunting and fishing practices.[133]

The policy issues that affect Alaska are uniquely challenging and require a policy response that will look quite different than the approaches utilized with Tribes in the lower 48 states. Subsistence food sources are vital to the health and wellbeing of Alaska Native peoples and ensuring their continued access to those sources is paramount. In addition, augmenting their food access with new approaches to local food production is essential to these communities as their traditional food sources continue to be adversely impacted by climate change.

COMMUNITY GARDENS, ENGAGING YOUTH AND ACCESS TO TRADITIONAL AND HEALTHY FOODS

FOOD IS OUR MEDICINE

Irving, NY (Seneca Nation)

Food is Our Medicine strives to improve Seneca Nation health outcomes by increasing access to culturally significant food and food usage. This joint project between the Seneca Nation and the Seneca Diabetes Foundation began in 2013. Since that time, the organization has overseen the building of multiple community gardens and dozens of raised beds where volunteers have planted over four hundred Native plants.[134]

Because this is such a new joint project, impact and evaluation will accumulate over time.

TOLANI LAKE - CULTIVATING HEALTHY NAVAJO LIFEWAYS IN THE LITTLE COLORADO RIVER VALLEY

Arizona

Tolani Lake Enterprises (TLE), Inc. is strengthening its Youth Initiatives Program by expanding and integrating the adult Edible Gardens workshops series and unifying it with the Sports and Activities Program (SAP). TLE, Inc. serves the Tolani Lake, Leupp, and Bird Springs Navajo communities which sit on the largest food desert in the United States. By growing fresh produce in greenhouses, farm plots, and in gardens located at the TLE Demonstration Site, youth are learning how to develop and maintain gardens at home. In addition, TLE is working to build the strength of the TLE-SAP program by diversifying its activities in an effort to prevent further increases in obesity and type 2 diabetes rates in the local communities.[135]

THE CHEYENNE RIVER YOUTH PROJECT

Cheyenne River Sioux Tribe, South Dakota

CRYP is a youth and family services organization, integral to the Cheyenne River Reservation's support system. It has incorporated the traditional Lakota values into the development of its 2-acre, naturally grown, pesticide-free Winyan Toka Win ("Leading Lady" in the Lakota language) garden. The garden produce is served in daily snacks and meals at the main youth center and the Cokata Wiconi teen center. CRYP has also hosted a small weekly farmers market to sell fresh produce and canned goods from its 2-acre Winyan Toka Win garden.[136]

Incorporating Native youth into any local strategy is essential to success of the project, but also to the health and wellbeing of the youth within the communities. Ensuring that a plan for future youth engagement is in place when the grants run out is important to long-term success of these integrated endeavors.

CSAS AND TRIBAL/NATIVE-OWNED ENTERPRISES

CHOCTAW FRESH PRODUCE

Mississippi Band of Choctaw Indians

Philadelphia, Mississippi

Launched in 2012, Choctaw Fresh Produce is 100% Tribally-owned and offers a variety of fruits, vegetables and herbs to the local community. Choctaw Fresh crops are pesticide- and chemical-free and can be found in select area grocery stores and farmers markets around Choctaw, Mississippi. Choctaw Fresh Produce also offers a CSA membership for their clients, a wholesale option, a Farm to School program, and they hope to expand soon into local casino and other area restaurants.[137]

Choctaw Fresh has strong support from the tribal government and this has provided stability and support for rapid expansion and growth.

ONEIDA COMMUNITY INTEGRATED FOOD SYSTEMS

Oneida, Wisconsin

Since 1994, Oneida Community Integrated Food Systems has helped Oneida families access healthy traditional food products. Through its integrated, holistic take on food systems, OCIFS has not only improved access to nutritious food, but has also stimulated the local economy and revitalized the Tribal community, bringing people closer together through food. OCIFS encourages long-term solutions to farm and nutrition problems on the Oneida reservation through a variety of projects, including farmers markets, food quality and health education, and, an 83-acre certified organic farm, Tsyunhehkwa, where they grow a variety of crops. The farm also allows OCIFS to sell value-added food products through its cannery and retail.[138]

Oneida's work in local food systems is legendary among other Tribes and it cannot be understated that significant tribal government commitment, staffing and support have been central to its success across its various initiatives.

TRIBAL COLLEGES

DINÉ POLICY INSTITUTE

Dine College, Tsaile, Arizona

Diné Policy Institute (DPI) is established under Diné College as a research institute to "mesh" western research practices with traditional Navajo values and Natural, Traditional, Customary, and Common laws (as found in the CN-69-02 of the Navajo Nation Code). Drawing from the research, DPI provides technical assistance and advisement to Navajo Nation policymakers.[139]

In 2014, it published Diné Food Sovereignty: A Report on the Navajo Nation Food System and the Case to Rebuild a Self-Sufficient Food System for the Diné People.

FOOD PRODUCTION EXTENSION PROJECT

Rosebud Sioux, Sinte Gleska University
Mission, South Dakota

The goal of the Food Production Extension Project,[140] based at Sinte Gleska University (SGU) in South Dakota, is to create a sustainable food system in the Rosebud Sioux Tribal community. Through a combination of education and technical assistance, SGU's program hopes to promote better health outcomes among Tribal youth and increase overall community food security. Since 2010,[141] SGU and the Rosebud Extension Service have been working with Tribal youth, Tribal producers, and SGU students, holding workshops on cultivation techniques, buffalo ranching, food safety, and more.[142]

Sinte Gleska is just one example of the role of Tribal Colleges and Universities in furthering the vision and creating capacity while also serving as learning labs. Tribal Colleges and Universities are significantly underfunded. For those that were provided "land grant" status by Congress in 1994, they do have access to relatively small amounts of formula and endowment funds provided by Congress. However numerous funding authorities are specifically unavailable to these colleges. Lack of equitable access to funding opportunities is a significant federal policy barrier.

FOOD SOVEREIGNTY ASSESSMENTS & COMMUNITY-BASED PARTICIPATORY RESEARCH

COMMUNITY OUTREACH AND PATIENT EMPOWERMENT (COPE) PROJECT

Navajo Nation, Arizona

In partnership with Navajo Nation leadership, local community health representatives, New Mexico Farm to Table and others, this project uses community-based participatory methods to map the Navajo food system. COPE will lead a collectively-designed assessment to inform and create a community-based strategy to increase access to healthy food for families in Navajo Nation. The actions undertaken at Navajo to map the Navajo food system and perform an assessment that will inform strategy is an important activity that all Tribes should incorporate into their work in these areas. The Food Sovereignty Assessment tool developed and recently re-released by First Nations Development Institute is a readily available tool.[143] What has been missing throughout Indian Country is the small amount of local support and leadership needed to bring those assessments to life.[144]

This is but a short list of the many, varied food access and healthy food initiatives emerging in Indian Country, many of which are centrally focused on sustainability, food access, traditional foods, and local food systems. Indian Country communities have shown strong interest and growing engagement in these types of efforts, but the capacity for ongoing success will depend on the ability of each project to find resources (capital, labor, political, etc.) either within their own communities, at an intertribal level, through federal or foundation sources, and ultimately through planned self-sufficiency to meet daily challenges in project deployment and achieve long-lasting stability.

NATIVE-LED FUNDING, TECHNICAL ASSISTANCE, TRAINING AND EDUCATION

The role of Native-led nonprofit intermediary funders and policy and educational institutions has been critical to supporting efforts to increase access to healthy food, improve health outcomes and to strengthen local Native food systems. These institutions are supporting front line work in Native communities and are able to build relationships with tribes and grassroots groups to deliver critically needed resources, technical assistance and training that many non-Native institutions are either ill-equipped and/or not willing to do for a variety of reasons.

FIRST NATIONS DEVELOPMENT INSTITUTE

The mission of First Nations Development Institute is to strengthen American Indian economies to support healthy Native communities. As a result, First Nations has awarded more than $25 million grants in total to Indian Country over the last 35 years to support Native food systems, economic and asset development. They are the largest Native-led grantmaker in the country. Between 2010 and 2014, First Nations Development has invested more than $4 million in funding toward reclaiming Native food systems through grantmaking, training and technical assistance, convenings, advocacy and public education. Since 2012, it has awarded more than 47 grants to 30 tribes and Native nonprofits to help them understand and strengthen their food systems and to eliminate food insecurity and hunger.[145]

THE NOTAH BEGAY III FOUNDATION

The mission of NB3 Foundation, a Native-led intermediary, is to reduce childhood obesity and type 2 diabetes among Native children. To this end, NB3 is providing sub-grantees with grants and technical assistance resources to support community driven solutions to increase access to healthy and affordable food and physical activity in communities. Since 2009, NB3 has awarded more than $1.6 million to more than 50 tribes and Native nonprofits to help increase access to healthy and affordable food, nutrition education, physical activity and to build the capacity of Native communities to develop community-based solutions to reverse trends of childhood obesity and type 2 diabetes.[146]

THE INTERTRIBAL AGRICULTURE COUNCIL

Intertribal Agriculture Council was launched in 1987 chartered originally by Congress to respond the urgent need for improving access to federal programs within Indian Country's food sector and to improve the use of natural resource base in Indian Country build community food resources, that would the health and economic stability of tribes using food and agriculture as a driving force. [147] Intertribal Agriculture Council's 15 regional technical assistance specialists funded by USDA as a component of the Keepseagle litigation settlement[148] provide direct farmer-to-farmer assistance to food producers in accessing programs at USDA, assisting in food systems development, and aiding producers and communities in understanding their business and legal challenges to result in more profitable production and how best to access USDA programs to implement change.[149]

THE SEVENTH GENERATION FUND

The Seventh Generation Fund (SGF), a Native-led intermediary funder, has had a long-standing history in providing seed money, organizational support and technical training to Native grassroots, community-based projects striving for holistic community health and renewal. SGF supports traditional agricultural methods, advocacy, community organizing and sustainable strategies for development that preserve or restore healthy and traditional life-ways for future generations.[150]

THE INDIGENOUS FOOD AND AGRICULTURE INITIATIVE

Indigenous Food and Agriculture Initiative provides ongoing technical assistance in the area of law and policy to tribal governments, tribal food businesses, tribal producers, and other nonprofit organizations. They also provide legal analyses of ongoing policy challenges and draft legislation, model food and agriculture codes, and legal guidance documents to aid in addressing the necessary issues surrounding food system policies.[151]

THE POTLATCH FUND

The Potlatch Fund, Native-led intermediary funder in the Northwest, has been providing small and ongoing support for grassroots projects such as the Nisqually Huckleberry Camp, a 10-day food and medicine harvesting camp for youth and families that builds better understanding of sustainable resources on traditional homelands and the Klamath Tribal Health food security program that promotes healthy lifestyles and sustainability by growing foods for Tribal members in need.[152]

THE INDIAN LAND TENURE FOUNDATION

Indian Land Tenure Foundation is providing resources to landowners to better understand and plan for land tenure challenges which is the basis for secure and stable food production on those lands.[153]

TRIBALLY-LED FOOD ACCESS & NUTRITION PHILANTHROPIC INITIATIVES

The Shakopee Mdewakanton Sioux Community of Minnesota undertook an unprecedented step in early 2015 by launching its "Seeds of Native Health" Campaign. The tribe has committed $5 million over the next two years to improve the nutrition of Native Americans through grant-making, sharing of best practices, capacity-building, sponsored research, and educational initiatives. To date, Shakopee has tapped First Nations Development Institute and the NB3 Foundation to administer $2.5 million in grantmaking and technical assistance to tribes and Native nonprofits to increase access to healthy foods and good nutrition. The University of Minnesota has also been named as a strategic campaign partner. In addition to grantmaking, Seeds of Native Health is planning to hold regional and national conferences to promote best practices and engage other funders -- foundations, corporate grantmakers and other tribes -- in efforts to increase investment to help address unmet needs in Indian Country.[154]

FEDERAL INITIATIVES

Let's Move in Indian Country (LMIC) seeks to improve the health of American Indian and Alaska Native children who are affected by some of the highest rates of childhood obesity in the country. Tribal governments, Urban Indian Centers, private businesses, youth leaders, and the nonprofit sector are each asked to play a key role by working together to raise the next generation of healthy Native children. LMIC seeks to acknowledge and advance the work that Tribal leadership and community members are already doing to improve the health of Native youth. A key program goal for LMIC is ensuring families have access to healthy, affordable foods.[155]

President Obama's recent (February 2015) announcement of the "Generation Indigenous" or "Gen-I" Initiative is focused on removing the barriers that stand between Native youth and their opportunity to succeed.[156] This initiative will take a comprehensive, culturally appropriate approach to help improve the lives of and opportunities for Native youth and affords opportunities for tribal, public and private partnership to improve the health and wellbeing of Native youth.

INDIAN COUNTRY HEALTHY FOOD ACCESS CASE STUDIES

Lessons Learned By Grassroots, Nonprofit and Federal Agencies

CASE STUDIES: LESSONS LEARNED AND CHALLENGES FACED BY GRASSROOTS, NONPROFIT AND TRIBAL FOOD ACCESS AND HEALTH INNOVATORS

Exciting and promising innovations and efforts across Indian Country while face a variety of challenges, and there are a number of lessons learned both by Native advocates and those investing in their work. Below are three brief case studies regarding the lessons learned in supporting strategies to increase access to healthy and affordable food and to improve health outcomes for Native children, families and communities:

- CCHE Challenges and Lessons Learned in Native Food Advocacy Work;
- First Nations Development Institute: The Role of Native-Led Intermediary Funders; and
- Centers for Disease Control's Traditional Foods & Approaches for Health Promotion and Type 2 Diabetes Prevention.

CASE STUDY: CCHE CHALLENGES AND LESSONS LEARNED IN NATIVE FOOD ADVOCACY WORK[157]

The Communities Creating Healthy Environments (CCHE) is a successful model public health initiative that focused on combating childhood obesity. CCHE chose a new path: instead of promoting healthy behaviors on an individual basis – an approach found to lead to minimal long-term population-level health improvements in communities of color – CCHE targeted the structural causes of childhood obesity, such as economic disadvantage, crime, food inequity, and lack of safe recreational spaces for children to play in historically disenfranchised communities. Community organizers and the Centers for Disease Control and Prevention had proposed the theory that improving a community's social conditions would allow community parents and children to make healthier choices that would not only reduce childhood obesity but also prevent other community health problems (e.g., chronic medical conditions) connected to childhood obesity.[158]

The Praxis Project led the CCHE program's national funding and capacity building initiative to support diverse, community-based organizations and tribal groups in the development and implementation of effective, culturally competent, policy initiatives to advance food and recreation justice. CCHE shared a number of insights from grantees and partners involved in the program. This included The Native Organizers Alliance (NOA), a project of the Alliance for a Just Society (CCHE Indian Country technical assistance partner). NOA provides training and support for Native organizers and organizations to build community organizing skills, share best practices, collaborate across communities, and elevate local work to the national level. The Alliance identified the following challenges and lessons learned for initiatives to improve community health in Indian Country based on its work providing support to CCHE-funded projects in Alaska (Council of Athabascan Tribal Governments, Fort Yukon, AK), Minnesota (Indigenous Environmental Network, Bemidji, MN), and Oklahoma (Mvskoke Food Sovereignty Initiative, Okmulgee, OK).

According to CCHE and its partners, there is a growing hunger among Native-led groups for training in organizing strategies, outstripping current capacities for culturally appropriate training tailored to the unique challenges of working in Indian Country. The magnitude of the unmet community needs in Indian Country is driving a new interest from leaders in nonprofit organizations, service providers and tribal governments in implementing community organizing strategies to advance policy reforms that expand access to health services and healthy foods for Native communities.

Since 2010, the Native Organizers Alliance has partnered annually with CCHE to conduct a Native Organizing Training for 25 Native organizers. Yet the level of interest has quickly outgrown a single annual training for 25 organizers: in 2014, over 200 people applied to participate. There is demand both for more national trainings/convenings and for local, on-the-ground trainings in states. For example, participants from the 2014 training cohort have asked for assistance in planning local training sessions in Alaska and Montana in 2015; and the American Indian Center of Chicago, which wants to develop a local organizing project to respond to the food desert problem that has particular impacts on Native children and elders there, has requested the Alliance's support to develop local trainings.

In reviewing the outcomes of CCHE grantees, program leadership identified that local partners need ongoing support to implement victories, consolidate gains, and plan next steps. For enacted policy changes to result in real improvements in people's lives, there is often ongoing work needed to implement and monitor the new policy, and also an opportunity to advance next steps that build on it. Without resources – including training, technical support, and financial resources – this important implementation/consolidation stage of the policy change process is often shortchanged.

"After winning changes in tribal policy on healthy food guidelines for the schools as well as the use of local produce, we lost our key organizer after the funding ended." Reflecting on the limited ability to follow-through on implementation, Stephanie

Berryhill, Program Development staff at Mvskoke Food Sovereignty Initiative, said, "After losing the staff member who led the work of both community engagement and working with the tribal government, we had very little ability to follow through on implementation given the other crucial areas we are working on."[159]

While the Mvskoke Food Sovereignty Initiative was highly effective in setting the stage for the tribal government to pass legislation supporting healthy food access and local sustainable food projects, it is now facing challenges in the implementation of these policies. Both there and elsewhere, there is a clear need for engagement beyond a single training or a limited-time commitment. Newly trained Native organizers and their organizations need regular, ongoing contact and mentorship, boots-on-the-ground support from experienced organizers, tailored local trainings, and help identifying and facilitating funding for ongoing work.

Successful support for policy change initiatives that benefit Native communities requires strategies and materials that are culturally appropriate for use in tribal communities and adaptable to both rural and urban contexts. For example, the Gwinzii Gwaraandaaii: Athabascan Initiative to Promote Healthy Villages and the Hunt-Fish-Share Campaign won significant policy reforms through a strategic, culturally appropriate story collection project which focused the media and policymakers on the impact of criminalizing traditional hunting and fishing in Alaska. Now, the organizers who participated in the 2014 Native Organizing Training are using their new skill set to raise awareness of the connection between traditional foods and the impact on the health of tribal villages. Yet, the geographic distribution and isolation of small, rural villages presents logistical and relationship-building challenges for this work. Overcoming these challenges will require both financial resources to support travel and special strategies to build relationships and leadership teams across geographic barriers.

Because existing organizational infrastructure in Native communities resides primarily within tribal leadership groups and social service organizations, successful policy change projects in Indian Country require tailored strategies and techniques that local organizers can deploy effectively in these organizational contexts. In Indian Country, the greatest opportunities to leverage existing resources, infrastructure, and community leadership come from working in partnership with tribal leadership groups and social service groups.

"With technical support, tribal governments, service entities and local organizers can build significant community support for basic policy changes. Public education framed by Native traditions can be created to foster an understanding of the long history of healthier environments captured in our histories. To achieve an all-around healthier environment that includes community communication, commitment and continuing access to decision makers, we need a resourced organizing infrastructure of local activists that has a role far beyond funding cycles and tribal and local elections," shared Judith Le Blanc, national coordinator of the Native Organizers Alliance of the Alliance for a Just Society.[160]

Yet, implementing community organizing strategies within groups that are accustomed to a social service delivery model involves significant shifts in organizational approach, how staff interact with constituents, and comfort level with engagement in the policy change process. Native organizers who see the opportunities and the potential impact of deploying organizing strategies within their groups/organizations need support to create internal alignment and design appropriate tactics and activities for their organizational contexts in order to leverage existing capacities to advance policy change.

There needs to be an avenue to connect Native organizers and local projects across geographies, both to sustain local efforts and to leverage national relationships for broader impact. Creating a nexus for Native organizers to come together, learn from each other, build community and coordinate projects serves two distinct purposes. First, it fulfills participants' desire to be connected with other Native organizers and communities across the country working to address similar challenges. This learning community sustains participants' commitment through the inevitable challenges that any local change initiative entails. Second, the establishment of a connected, coordinated network of Native organizers allows that network to engage strategically with potential allies at the national level, to have a seat at the table to elevate the needs of Native communities in national campaigns, and to advance complementary national policies that create further opportunities for progress and impact at the local level.

CASE STUDY: THE ROLE OF NATIVE-LED INTERMEDIARY FUNDERS

As evidenced in this report, Native Americans have a complex history in this country, necessitating an understanding of tribes' complicated relationship with federal government agencies, competing priorities for community services, and tribal sovereignty and jurisdictional issues. Native-led intermediary funders are best positioned to understand the dynamic forces at play in tribal communities and can bring to the table a knowledge of the "big picture" of Indian Country concerns. As a result, the Native funders are uniquely qualified to help mitigate any challenges with Native grantees, provide needed technical assistance and work with major donors as a bridge to strategically invest resources where they can achieve the biggest impact. The importance of their role has been increasingly recognized by major foundations, such as the W.K. Kellogg Foundation, Robert Wood Johnson Foundation, Walmart Foundation and others who are interested in making investments in Indian Country but need assistance in navigating the political complexities, unique and varied nature of tribal governments, cultures, socio-economic conditions and various capacities of tribes and nonprofits to engage in this important work.

For example, First Nations Development Institute (First Nations) has become the largest private grantmaker in Indian Country that supports programmatic efforts to reclaim control of Native food systems.[161] Through the support of the W.K. Kellogg Foundation, First Nations has invested more than $4 million in funding between 2010-2014 toward reclaiming Native food systems through grantmaking, training and technical assistance, convenings, advocacy and public education.[162] Moreover, First Nations has been a pioneering Native intermediary funder for the last 35 years --particularly in the food systems space -- in which it has awarded over $25 million to tribes and Native nonprofits. First Nations describes its approach to grantmaking in Indian Country as follows:

"First Nations sometimes invests in what mainstream funders may consider "high-risk" projects. It invests in start-up concepts and projects that are not necessarily heavily tested, but show innovation and potential for Native asset-control and development. By encouraging and rewarding innovation taking place in Native communities, First Nations believes that Native communities will continue to develop and test new models that fit the needs and circumstances of their communities.

Capitalization in the form of grantmaking, coupled with technical assistance and training (a provision of almost all First Nations grants), allows First Nations to make direct financial investments in Native communities and develop the capacity of tribes, nonprofits and community organizations to successfully run their projects. This grantmaking strategy of both financial and technical assistance allows First Nations to invest in projects that spring from the ground up, and which were directly conceptualized, developed and implemented by and for Native communities. Moreover, technical assistance develops organizational capabilities and capacity that will be in place long after the funding expires, leaving Native institutions stronger and more durable for future investment and community impact."[163]

Over the past three years, First Nations has awarded 47 grants to 30 tribes and organizations. "The programs and projects funded through the Native Agriculture and Food Systems Initiative (NAFSI) grant program are designed to address food insecurity in Indian Country by providing resources that will: increase access to traditional and fresh, healthy foods; increase community awareness and involvement with where food comes from; expand knowledge about the linkages between Native culture and family income; and finally, to support entrepreneurially-related food ventures."[164] While First Nations has documented the significant success of Native grantees within the NAFSI program, it has also experienced the reality of significant unmet needs in Indian Country to address food insecurity, hunger and related health disparities.

In its report, Grantmaking in Indian Country: Trends from the Native Agriculture and Food Systems Initiative, First Nations reported that after years of sporadic investment in NAFSI from funding entities, in 2011 it received a consistent stream of funding from the W.K. Kellogg Foundation, AARP Foundation, the Walmart Foundation, the Christensen Fund and USDA Rural Community Development Initiative and Office of Advocacy and Outreach. As a result, from 2011 to 2014 First Nations was able to award grants totaling more than $1.7 million directly to Native communities engaged in work related to reclaiming control of local food systems.[165]

From 2011 to 2014, First Nations reported that it received a total of 614 proposals from Native communities working to reclaim local food-system control. In total, First Nations received $24,095,124 in NAFSI grant requests from 2011 to 2014. As noted in the table below, each year First Nations was unable to meet the full funding demands. In 2011, First Nations met just over 5% of total requested funding, just over 7% in 2012, 8.21% in 2013 and 8.5% in 2014. *[Fig. 11]*

GRANT REQUESTS BY YEAR (REQUESTS AND UNMET NEED)					
	2011	2012	2013	2014	TOTAL
TOTAL NUMBER OF GRANT REQUESTS	75	226	134	179	614
TOTAL DOLLAR AMOUNT REQUESTED	$5,937,633	$7,704,973	$4,568,235	$5,884,283	$24,095,124
FIRST NATIONS FUNDING	$300,000	$555,000	$375,000	$500,000	$1,730,000
TOTAL AMOUNT OF UNMET NEED IN INDIAN COUNTRY	$5,635,633	$7,149,973	$4,193,235	$5,384,283	$22,365,124
PERCENTAGE OF NEED MET IN DOLLARS	5.05%	7.2%	8.21%	8.5%	7.18%

Fig. 11

On average from 2011-2014, First Nations has only been able to meet about 7.18% of total funding requests from tribal communities for food-systems funding.[166] "This sheer unmet need points to the fact that we are only meeting a fraction of the overall need for food, diet and health funding needed in Indian Country. Though First Nations is proud of the impact made over the last three years, there is still much work to be done."[167]

Native-led intermediary funders, like First Nations along with others such as the NB3 Foundation, Seventh Generation Fund, the Potlatch Fund and others, play a critical role in addressing the serious issues related to increasing access to healthy and affordable food, addressing Native health disparities and revitalizing traditional cultural lifeways and tribal economies. These Native grantmakers provide not only grants, but technical assistance, opportunities for capacity building and network-building for tribes and Native nonprofits. They also serve as a bridge for investment and advocacy between Indian Country and mainstream philanthropy that have traditionally shied away, with the exception of an important few funders, from direct engagement with tribes and Native communities.

However, not only are these Native grantmakers facing large unmet needs in their grantmaking efforts to empower Native-led solutions to food access and health issues, they are often times undercapitalized themselves as they work to invest critical and strategic resources in Indian Country as well as to keep their operations running strong and at a capacity to keep up with the needs of those they serve in Indian Country.

The majority of these Native intermediaries are not endowed. They rely on annual and sometimes multi-year but restricted investments from foundations, corporations, tribes and individual donors to support both their grantmaking and general operating needs. As a result, they often are put in a position where their funding is largely restricted to their grantmaking

efforts leaving a small margin to support important organizational infrastructure and operating needs which can strain and limit the capacity of these organizations, especially in times of economic uncertainty.

Investment in Native intermediaries needs to be increased, both in terms of resources to support increased grantmaking, capacity building and technical assistance in Indian Country, but to also ensure that their ability to be financially viable and sustainable. This is critical if these important conduits for Indian Country investment can keep pace with the evolving and multi-generational needs, challenges and opportunities that tribes and Native organizations face in working to address the challenges inherent in strengthening Native food systems and work to improve health outcomes.

Native intermediaries can serve as indispensable partners to foundations, public health and other food access/sustainable food systems stakeholders who are interested in deeper engagement in Indian Country and work to address disparities, achieve health equity and to create a healthier and sustainable environment. Without increased partnership and investment in these important Native institutions, in addition to tribes and Native nonprofits, the pace of change will continue to be slow and sporadic in Indian Country.

CASE STUDY: CENTERS FOR DISEASE CONTROL'S TRADITIONAL FOODS & APPROACHES FOR HEALTH PROMOTION AND TYPE 2 DIABETES PREVENTION

The Centers for Disease Control (CDC) has done considerable work in tracking the links between poverty and the health effects of limited access to healthy food, most notably in the "Native Diabetes Wellness Program," a multi-year project focusing on the intersection of nutrition, obesity, physical activity, heart disease, stroke, traditional foods and other factors that positively impact the health and wellbeing of Native communities. The Program was part of the CDC's Division of Diabetes Translation and was created from federal funding provided in 1997, with additional funding from the Indian Health Service's Special Diabetes Program and other partners.

CDC's support provided ongoing grant resources for development and release of a number of tools to combat these diseases. Two important publications focusing on the importance of traditional foods and food sovereignty in achieving health improvement goals were released through the efforts of this program: *Part I: Traditional Foods in Native America*[168] and *Part II: Good Food is Power.*[169] In addition, other public service and nutritional education activities were released, among these: public service announcements ("Our Cultures Are Our Health"); a Chickasaw TV video series; the EAGLE BOOKS series focusing on healthy living; and the Traditional Foods project, to name a few.[170]

The CDC "Traditional Foods Project" supported and followed 17 Native communities that sought to build the connections between healthy living, healthy food access, and local policy changes. The goals of the project were to "support traditionally-oriented, sustainable, valuable ecological approaches to diabetes prevention, focusing on community efforts to reclaim traditional foods and physical activity in their communities."[171] Additional goals were to: encourage local policy changes to increase availability and access to local, traditional foods and forms of exercise; revive, create and preserve stories of healthy traditional ways; and engage community members in health promotion activities.

Traditional Foods partners with CDC were: Nooksack Indian Tribe; Red Lake Band of Chippewa Indians;

Fig. 12

Sault Ste. Marie Tribe of Chippewa Indians; Standing Rock Sioux Tribe; Salish Kootenai College; Confederated Tribes of Siletz Indians; United Indian Health Services; Indian Health Care Resource Center of Tulsa; Ramah Navajo School Board; Cherokee Nation; Prairie Band Potawatomi Nation; Santee Sioux Nation; Eastern Band of Cherokee Indians; Catawba Cultural Preservation Project; Tohono O'odham Community Action; Aleutian Pribilof Islands Association; and the Southeast Alaska Regional Health Care Consortium. Each project site approached its goals in its own unique ways, incorporating traditional foods, nutritional messages, sustainable and ecological stewardship to the lands and food resources, and other culturally appropriate means to show improvement in Tribal members' health.

These projects are now coming to an end at the CDC due to decisions within the federal government to discontinue the funding of the project. We might never know what the full impact of a broader investment in these approaches might have been under continued funding by CDC alone or in combination with other funding partners. What we do know is that the entire effort was uniquely successful and the work should continue. As stated by Aubrey Skye, the Standing Rock Sioux's Native Gardens project coordinator: "The message is that even in the 21st century with the problems we face today, traditional ways have health benefits for now and for future generations," explained Skye. "We already have everything we need," he said, referring to the connection between the land and health. *[Fig. 12]*

In addition to the unique efforts in the Traditional Foods Project outlined above, the CDC has also identified and written extensively, as has the USDA, on other policy tools for action that can assist in creating what they call "healthy food environments." The nonprofit sector and others involved in sustainable food production, improvement of food access, and related concerns have likewise incorporated these policy levers as means to the overarching goal of improved healthy food access to rural and urban communities alike. These tools include: zoning (controlling locations for farmers markets, limiting competing commercial land activities, protecting spaces for food production, and controlling the entry of non-healthy food businesses); land use planning (deliberately influencing distribution and transportation, limiting food waste, locating retail and housing close to food production); farmland protection (controlling the loss of lands for production use); food store creation (encouragement of farmers markets, community gardens, community or tribal supported agriculture, creation of small retail food outlets, mobile markets, and subsidizing grocery retail location); community gardens (personal backyard and broader community-led gardening location development and organization), farmers markets/ CSAs and local food distribution, transportation and institution-based food access; and community food, food sovereignty, and health impact assessments within communities.[172] The most important of these tools is the *Food Sovereignty Assessment Tool, 2nd Edition* updated by the First Nations Development Institute as a re-release of their first edition released over 10 years ago.

WE STAND ON THE SOLUTION

Recommendations to Empower Indian Country Food Systems and Health

WE STAND ON THE SOLUTION: HEALTHY FOOD PRODUCTION IN INDIAN COUNTRY

The following section provides a high level overview of recommended considerations for advocacy priorities to increase access to healthy food and improve health outcomes. All of the recommendations pertain to various levels and opportunities for policy and system change related to:

- Market-Based Solutions;
- Native Food Production;
- Tribal and Grassroots Policy Change;
- Federal Feeding Programs: FDPIR "Commodities Program" and SNAP;
- Food Systems and Connections to Diet, Childhood Obesity Prevention and Improved Health Outcomes; and
- Funders and Technical Assistance Providers.

The underlying theme of these recommendations is simple and straight forward. We need to support Tribal self-determination and empower Indian Country to not only feed ourselves but to improve the health and wellbeing of current and future generations. This will take a variety of strategies to address the myriad of complex bureaucratic barriers, poverty, the lack of access to capital and technical assistance and the underdevelopment that exists in many Tribal communities that prevents the necessary data, infrastructure and resources to support strong and vibrant Indian Country food systems that can in turn help to eliminate health disparities.

As will be noted below, there is not one "silver bullet" or even one or a handful of stakeholders that can make this happen on their own. It will take concerted, collaborative and integrated efforts between Tribes, Native food producers, grassroots advocates, Native nonprofits, businesses, educational institutions, Foundations and Federal agencies working together to achieve the change that Indian Country needs.

MARKET-DRIVEN AND BUREAUCRATIC FLEXIBILITY AND REFORM TO ACHIEVE SOLUTIONS IN FOOD, FOOD ECONOMIES AND HEALTH

Market-driven solutions are an excellent way to improve both the health of Tribal food systems and the health of the people within them. According to the Intertribal Agriculture Council, the $1.1 billion in annual Tribal food sales in livestock alone can be turned into $9 billion by changing distribution and ownership patterns for those foods. At present, most tribal food products (livestock and fruits/vegetables/grains, etc.) go into an undifferentiated, raw product food supply chain. All value of those foods are captured outside the Tribal boundaries and not returned back to the Tribe.[173]

Additional control of the supply chain in the hands of Native producers and Native food companies means more of the value of the products is retained in the community. And the potential for Tribal producers to shift to foods that is higher value and healthier in their raw state is a potential as yet totally unrealized.

The bureaucracy that Native farmers and ranchers face is unique; they must uniquely bear the burden of BIA land use and agricultural leasing regulations that thwart agricultural resource management and local tribal control over the natural resources base. Most tribes have not had the resources to date to undertake a comprehensive agricultural resource management strategic planning and technical assessment process as mandated under the American Indian Agricultural Resource Management Act (AIARMA) passed in 1993.[174] The HEARTH Act of 2012[175] likewise provides significant federal policy levers that, if utilized, would allow tribes to exercise greater control over agricultural leasing on their lands.

Committing resources to ensure planning, land assessment and local leasing regulation processes will allow tribes to control their own destiny for sustainable and healthier food production on those lands within their jurisdiction. Without such efforts, the complex and draining bureaucracy that currently controls Indian land use will remain in place and thereby stall future healthy food production as a means to improved health outcomes. The bureaucracies that surround land leasing also translate into related licensing, regulatory issues, and related business-deployment concerns. Unlocking the bureaucracy for the purpose of healthy food production will likewise unlock the

bureaucracy for building healthy food processing, distribution, aggregation, and supply chains; unlocking for one purpose will unlock for all. Special attention must be paid to pushing through these highly technical federal bureaucratic shifts in approach and only those with in-depth knowledge of food systems development and the bureaucracy itself will achieve these goals.

In addition, increasing the amount of healthy foods grown locally and available locally to tribal people, particularly those who receive benefits from feeding programs, will add value to be retained in the local community when individuals use their feeding program benefits locally. Assisting Native food producers today to switch to foods that are healthier in their raw state will in turn increase income to those producers as well. While many producers are willing to do so, the reluctance to do so is normally bound up in the costs of making the transition.[176]

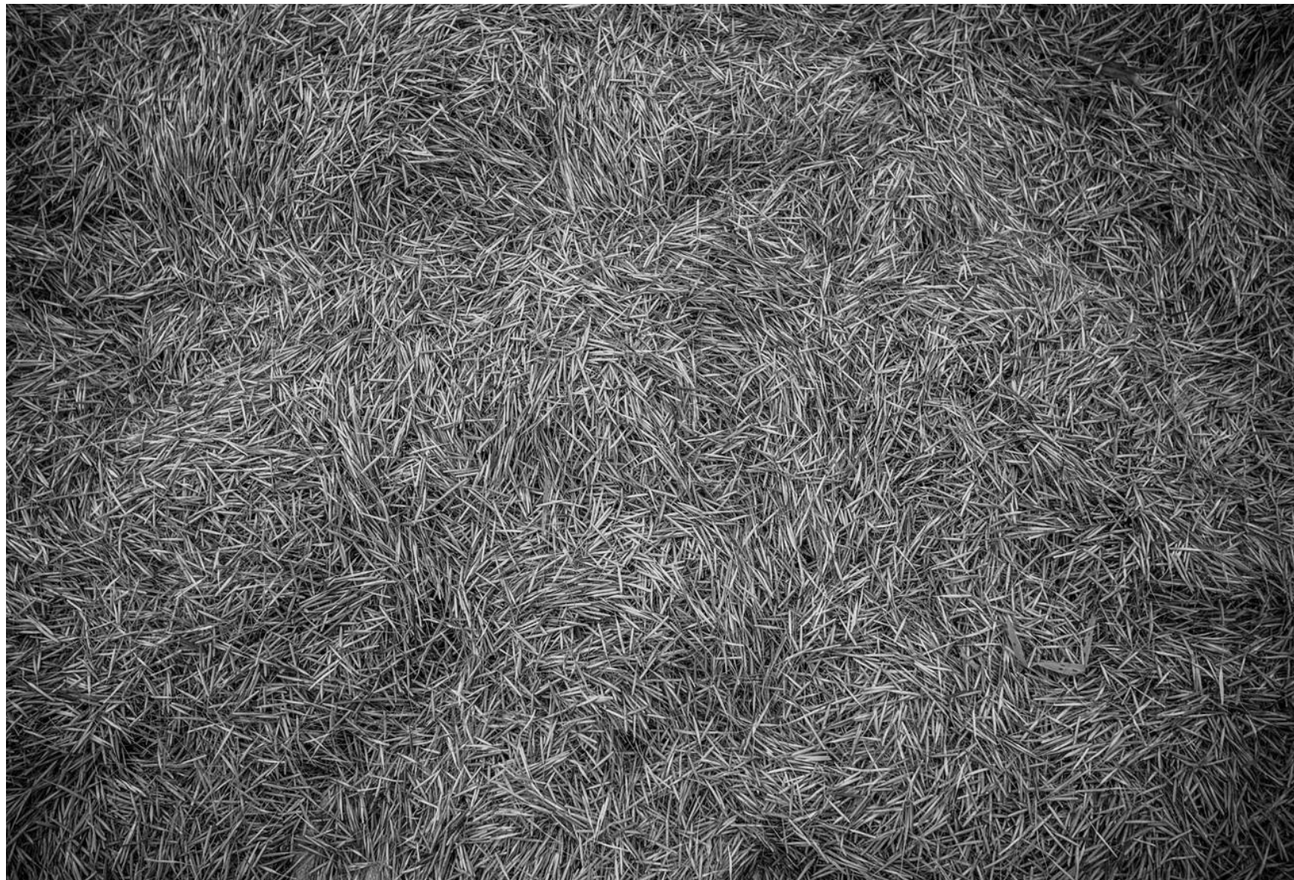
A COLLABORATIVE EFFORT TO CHANGE POLICIES AT THE FEDERAL, FOUNDATION, AND TRIBAL LEVELS: A NEW FRAMEWORK AND NEW PARTNERSHIPS

TRIBAL POLICIES

What Indian Country needs, which the federal government -- our trustee -- cannot provide, is support for innovation and the building and maintenance of an interconnected framework for healthy food growth in Indian Country. Federal funding is intermittent, over-committed, and generally ineffective when dealing with the unique challenges of Indian Country. Federal funding programs tend to err on the side of a "one size fits all" approach, and even though they are required by federal law to be in a trust relationship with Tribes, the general unwillingness to craft different policy solutions means that Indian Country can no longer wait on the federal government for assistance. Our health won't allow us to do so, and our traditions and cultures around food require us to move now, regardless of the ability or capacity of the federal government to assist.

The fact remains that in order to fully exercise Tribal self-determination, Tribes must not only have support in removing the barriers that exist to feeding ourselves, but Tribes, grassroots advocates, nonprofits and other stakeholders should forge pathways to create opportunities through advocacy to increase access to healthy food that can improve the health of Native peoples. Supporting Tribal governments to assume leadership at the local, Tribal level in these areas is critical to long-term stability. Tribal governments and grassroots/community advocates should consider the following recommendations regarding advocacy priorities in Tribal communities:

- Lobby extensively, either alone or in concert with foundations and nonprofit organizations, for the direct tribal management and control over all feeding programs to ensure tribal governments obtain the right and responsibility for purchasing foods for their people;
- Adopt, as financially capable, short-term subsidy programs to shift to local healthier food production on tribal lands;
- Adopt model food and agriculture codes at the tribal government level that protect local food systems, traditional foods, and create more favorable lending environments around healthy food financing;
- Taxes on junk food or unhealthy food (following the recently passed Navajo model) – modified for other tribes as appropriate;
- Prohibition on unhealthy food purchasing for Tribal-level health centers, child and adult care centers, community centers;
- Support for the direct management of all Tribal feeding programs by Tribal governments (as opposed to the current state-control or federal-control status);
- Incentive programs (tax credits and/or local-level financial incentives including preferred purchasing and/or selling) for:
- Healthy foods, farmers markets, tribal-supported agriculture organizations and other local community-driven market models; and
- Small-scale healthy food stores that are appropriate to the constrained infrastructures existing in tribal communities;
- Support of traditional foods outlets linking urban and rural/reservation locations;
- Support for sustainable, organic, traditional food production systems on tribal lands, including:
- Sustainable leasing policies and other land use policies that prefer culturally appropriate food systems;
- Land access policies that support traditional hunting and gathering sites and exclude non-traditional uses for those areas;
- Protection of water sources to secure availability of water and soil/land health for future healthy food enterprises;
- Creation of business models appropriate to Indian Country's healthy food sector stability (tribal food cooperatives, tribal food businesses) and others;
- Support farm-to-school programs, community gardens and farmers markets;
- Support healthy food marketing and labeling;
- Adopt purchasing preference programs in all public institutional settings over which tribal governments exert purchasing power (hospitals, clinics, day care, elder care programs, schools,



casinos, etc.);

- Provide land for use by community members and producers for healthy food production, harvesting, aggregation, and distribution;
- Implement food sovereignty assessments and lead community-based strategic planning efforts at the tribal level to create, within each tribe, a short and long-term vision for healthy food access;
- Work with local, regional and national tribal and grassroots leadership and public health partners to ensure integration of food access strategies with efforts and best practices to address health disparities; and
- Establish scholarship and education programs focusing specifically on food to ensure that next generation food producers, businesses, providers, and leaders are supported now and into the future.

NOW IS THE MOST PROMISING TIME TO ACCOMPLISH THE INTERRELATED GOALS OF HEALTHY FOOD FINANCING AND IMPROVED FOOD ACCESS IN INDIAN COUNTRY, RECALIBRATED TO LOCAL FOOD PRODUCTION.

FEDERAL POLICIES VIS-À-VIS TRIBES

Now is the most promising time to accomplish the interrelated goals of healthy food financing and improved food access in Indian Country, recalibrated to local food production. The federal government is in the process of implementing two key provisions of the 2014 Agriculture Act (Farm Bill). Both provisions, if approached strategically, with a national shift in policy in mind for Indian Country, could result -- particularly when augmented by new philanthropic efforts against a coordinated framework -- in seismic shifts in food access.

First is the requirement that USDA FNS conduct a study of the feasibility of placing management of all feeding programs within FNS' jurisdiction under direct tribal government jurisdiction. Second is the implementation of a provision allowing greater use of traditional foods within federal feeding programs and as donated food product in all public institutional settings in Indian Country.

These provisions, when coupled with the USDA's current broader focus on building capacity and infrastructure that supports local/regional food systems, mean that the promise for Indian Country has never been greater. By shifting focus and collapsing all federal feeding programs serving Indian Country (rural and urban) into one overarching Indian Country healthy food access program, coordinated with building of local/regional infrastructure to support local food producers and food systems infrastructure, the most significant and lasting change in this area since the U.S. first made contact with Indigenous peoples of this continent could occur.

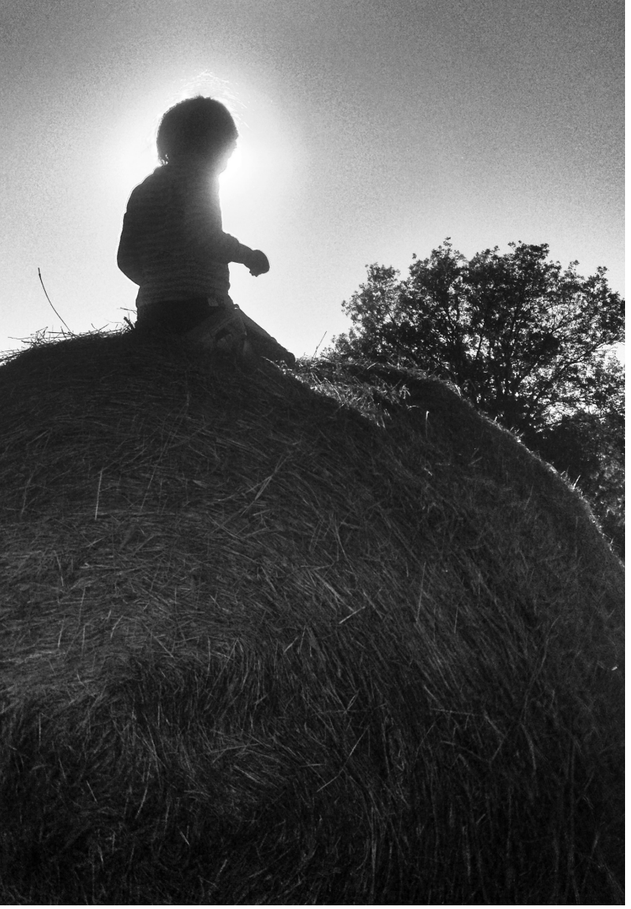
If direct tribal control were implemented, tribal governments could utilize their procurement authorities to prefer food produced by local, tribal and non-tribal producers, as well as local traditional foods, thus causing a shift in food production systems at the local level to a healthier model. If such a shift were also combined at the federal level with creating a preference for tribal food product purchasing in programs serving Indian people, a double-up on impact could occur. In order to achieve these broad goals, the following should be examined:

- Create a tribal preference for local and regional food infrastructure development to allow the building of local and regional packing, grading, storage, distribution, and retail infrastructure development in Indian Country tailored to the unique needs of these remote environments;
- Create "non-profit," "self-help" grocery stores as demonstration models for use in Indian Country allowing sufficient time to determine the usefulness of this model as opposed to a free-market private sector model;
- Amending programs such as "double-up food bucks" and related healthy food incentive programs to ensure flexibility in program implementation in Indian Country would bring additional federal resources to the battle; and
- Recalibrate federal feeding programs in ways that ensure that food aid and food production subsidies directly affecting Indian Country do not further undermine the local use of lands and resources to solve local food access problems.[177]

FOUNDATION POLICIES VIS-À-VIS TRIBES AND NATIVE-LED COMMUNITY ORGANIZATIONS

Foundations can play a key role in leading this effort. The ability to make swift change in federal programs is at best ambitious. Foundations and the nonprofit community can serve as a catalyst for change in Indian Country by providing critical funding for the following:

- Convene a tribal/public/private umbrella to solidify an "all appropriate options" framework and approach to policy change for Indian Country healthy food access;
- Provide financial support to Native-led community organizations to use community engagement strategies to advance policy changes that improve access to healthy foods;
- Provide financial support for key demonstration projects such as the nonprofit, self-help grocery model or the local food incubator to provide food producers in Indian Country the added security they need to switch production systems to healthier, locally-destined foods;
- Provide financial support for the launch and



maintenance of a comprehensive interconnected network or web of community gardens, farmers markets, food hubs, CSA/TSAs in Indian Country, and small local greenhouses to augment local production systems;

- Ensure a standard and stabilized approach to technical assistance for food producers, food entrepreneurs, food retailers, and food distributors/aggregators is supported; and
- Create partnerships with Tribes with charitable giving programs at state, regional and national levels such as with the Shakopee Mdewakanton Sioux Community, San Manuel Band of Mission Indians and numerous others that support food access, healthy nutrition and advocacy projects, to leverage and target joint funding, thought leadership, networks and policy change efforts to achieve maximum impact.

FOUNDATION POLICIES VIS-À-VIS NATIVE-LED INTERMEDIARY FUNDERS, TRAINING/TA PROVIDERS, TRIBAL COLLEGES, NATIVE AGRICULTURE AND FOOD SYSTEMS RESEARCHERS AND POLICY GROUPS

Foundations can provide valuable investment in Native organizations and institutions that are ideally positioned to partner directly with Tribes, Native food producers, communities and advocates through direct access to capital, technical assistance and capacity building strategies.

- Increase investment in national, regional and local Native-led intermediary funders and training/TA providers to support:
  - Increased grantmaking, technical assistance, education, culturally appropriate training and capacity building for tribes and Native nonprofits pursuing food access and food systems strategies;
  - General operating support for these intermediaries to sustain and expand their capacity to partner directly with Native communities, to conduct research and advocacy as well as support their efforts to work in partnership with mainstream philanthropy and policymakers to maximize impact of investment;
- Increase financial resources available to the Native CDFI network of institutions to improve their ability to invest in healthy food financing or local projects;
- Increase investment in tribal colleges and organizations engaged in research, policy analysis and technical assistance to tribes and nonprofits working to strengthen Native food systems; and
- Invite the above entities to participate in policy and strategic resource development and investment discussions on the issues of food access and its intersections with health. These organizations can serve as important resources and thought leaders who can not only mobilize internal and specialized expertise but also have direct access to tribal and grassroots leadership and experts in the field who are directly engaged in work to increase food access and address health disparities. Native voices must be at the table moving forward.

STEPS TOWARD INCREASED AND STRATEGIC PARTNERSHIP WITH INDIAN COUNTRY

Recommendations for Funders, Stakeholders and Policymakers

STEPS TOWARD PARTNERSHIP WITH INDIAN COUNTRY

To repeat the words of National Congress of American Indians President Brian Cladoosby:

"Together, we can build a strong partnership between all of our nations…one that will secure a brighter future for all our people."

These words hold true not only for the potential and transformative change that tribes and Native communities can foster together but also through the building of partnerships with key non-Native allies, stakeholders, policymakers, public health institutions, the private sector and mainstream philanthropy. The first steps in that partnership building are education and understanding not only of the troubling and often dark history of the U.S. engagement with Tribes but also the failure of federal policies to address the root causes and injustices that persist today. There must also be recognition of the fact that Native peoples have not always had a seat at the table not only in regard to federal policies that impact tribes but in policy and work within public health and philanthropy to address health disparities.

Nevertheless, it is clear a new era is beginning in the specific work to reverse the epidemic of childhood obesity and health disparities that disproportionately affect low income and communities of color that include Native Americans. In recent years, philanthropic leaders such as the Robert Wood Johnson Foundation, W.K. Kellogg Foundation, the Northwest Area Foundation and others are just a few of a number of philanthropic and public health leaders starting to invest in approaches that seek to address historic inequities and disparities by investing in work to dismantle racial, health and structural inequities and to support community-led work and policy change to transform current conditions. The American Heart Association and its Voices for Healthy Kids Initiative is a part of this growing movement.

However, even in conversations and work aimed at the goal of working toward racial and health equity, Native Americans have not always been included in these discussions and strategies. Today's conversations in philanthropy and public health regarding racial and health equity are almost always framed with regard to Blacks, Latinos and Whites without mention of Native Americans and other racial and ethnic minorities.

"IN ORDER TO FULLY EXERCISE TRIBAL SELF-DETERMINATION AND SELF-GOVERNANCE PRINCIPLES, TRIBES MUST HAVE SUPPORT IN REMOVING THE BARRIERS THAT EXIST IN THIS MOST IMPORTANT AREA OF FEEDING OURSELVES." - *JANIE HIPP, INDIGENOUS FOOD AND AGRICULTURE INITIATIVE*

According to Michael Roberts (Tlingit), President of First Nations:

"I would say that American Indians are mostly invisible to philanthropy…[For] most Foundation program officers, most of what they know is what they were taught in school. Generally Indians are examined in one of two ways, that they are either 1) relics of the past – lived in tipis, hunted buffalo, and were either savages or at one with nature (the mythical Indian), or 2) the study of them is like a tourist visiting a culture."

Negative stereotypes in the media, the lack of knowledge regarding tribes and their unique political and legal status and the fact that very few Native people serve in leadership roles in mainstream philanthropy and large-scale public health institutions are among the reasons for this disconnect. The lack of data on Native Americans and the realities they currently face is also a key driver for their lack of inclusion in food systems and health-related philanthropy and public health policy work.

"In many areas of this country, Native Americans are quite literally an invisible community and I think in those cases it's likely a symptom of 'out of sight out of mind,'" recently shared Jasmine Hall Ratliff, Program Officer at The Robert Wood Johnson Foundation. "Even when a foundation wants to address disparities in communities of color, when you look at data Native Americans are completely left out. Data is so often displayed for Black, White, Latino and sometimes (though not always) Asian; it is incredibly rare you see Native Americans included. So unless you pause to ask, "who's missing?" and make the concerted effort to ensure all people of color are included, it can be easy to have an implicit bias against Native Americans ."

A number of funders and policymakers should be commended for taking an important step in making a commitment to not only ensure the increasing inclusion of Native Americans and Tribes but in also making a commitment to invest the time and resources needed to build authentic relationships and partnerships within Indian Country. However, in doing so, funders and policymakers not as familiar with Indian Country will need to be open to understanding and embracing the deep and varied levels of underdevelopment, disparities and complex legal and political realities that Tribes and Native American people live within.

Frameworks for advocacy, policy change and strategic grantmaking that serve other populations may not work for Indian Country. Funders and advocates of non-Native food access advocacy and health disparities work will need to be open to sitting down to partner with Native leadership and stakeholders to devise a

framework that can truly work in Indian Country. It will be a process but it is very much achievable and long overdue. Some policy levers and mechanisms to achieve change may be similar to approaches implemented elsewhere in the country with other populations. Others may be vastly different yet will be designed to achieve common outcomes to improve access to healthy and affordable food and address childhood obesity and Native health disparities.

There are multiple levels and opportunities for engagement and impact with Indian Country to support food access advocacy, health, programmatic and food systems infrastructure work at the grassroots, tribal, nonprofit, regional, national and federal levels. These arenas for engagement and investment are vast and sometimes complex but are ripe for engagement and investment that could lead to big policy wins for Native Americans and their day-to-day efforts to increase access to healthy food and improve the health of their children, families and Tribal Nations. To this end, a commitment by funders, policymakers, Native nonprofits, Tribes and communities will be required to engage in dialogue with stakeholders, to partner in working groups with leading Native and non-Native stakeholders to devise actions plans. Work must also take place to find ways increase investment to support food systems/food access strategies, programs and advocacy work in Indian Country.

CONSIDERATIONS FOR PARTNERSHIPS AND FUNDING IN INDIAN COUNTRY

There is recognition that in the past, philanthropy and public health institutions haven't always had successful engagements with Indian Country projects and partnerships they have invested in. This needs to be explored further. Many of the reasons are real and need to be addressed from both sides.

It is evident generally that funders often feel a great deal of risk is involved when making grants in Indian Country. A frequent response by funders with regard to their engagements in Indian Country have been, "We have made grants to tribes and Native communities previously and they have not gone well." Typically examples have been shared a lack of capacity for financial management, reporting or challenges related to Native grantees achieving stated deliverables and difficulties encountered in evaluating the "success" of projects.

According to Rick Williams, former President of the American Indian College Fund, "The above reasons for not giving are real. However, the question that is not asked, is 'How do you deal with these issues to consistently create successful projects?' The underlying premise is of course that the "Indians failed" when in reality it is the Foundations that failed to understand and learn different ways to create success."

This statement warrants deeper discussion. Every funder and organization's experience is different. Nevertheless, it should be noted that this is definitely a two-way process between Native grantees/tribes and funders. Both sides need to work to come to the middle -- a point of collaboration and compromise -- and invest in work together to achieve success.

Moving forward, one strategy that will be important will be to ensure the diversity within partnership building and grantmaking in Indian Country. "Diversification is a way for foundations to mitigate risk," according to Mike Roberts. "What makes risks more pronounced in Foundations' portfolios is that fact that there is not diversification of Foundations' investment in Indian Country. Losses on the one grant in their portfolio looms huge. The way to counter this is to practice the same sort of diversification strategy Foundations use with their investment in Universities,

in Community Foundations, and in organizations led and governed by non-Natives – diversify – make sure that there are many of these investments so that the singular investment in this sector does not sink the entire portfolio."

FINAL CONSIDERATIONS

There is much work to do to build the multi-level approach and level of partnerships needed to address the deep, complex and immense challenges of improving access to healthy and affordable food that in turn can address health disparities among Native Americans. It will require a great deal of work and commitment from Indian Country, Native institutions (both on tribal lands and in urban settings), Tribes, grassroots advocates, Native producers, philanthropy and policymakers. There are a number of entities both within and outside of Indian Country who are ready and willing to make that commitment.

Patience, openness to mutual learning, compromise, an appreciation for differences of approach, a variety of expertise and the commitment to forge strategic partnerships over time will be needed. What is truly exciting is that despite the immense challenges facing Indian Country that are documented in this report, there are tremendous opportunities to achieve impact and profound and positive change. Numerous "bright spots" and opportunities for impact and partnership exist. Investment and partnership with Indian Country and urban Indian communities on food systems and health disparities have the potential to have broad implications within public health and philanthropy that could inform work with other low income, rural, urban and/or communities of color.

Finally, it is the belief of the authors and many within Indian Country, that there are unique opportunities for Tribes and Native stakeholders to add tremendous and strategic value to current advocacy and programmatic strategies outside of Indian Country related to food access, childhood obesity prevention, health disparities work and racial equity. The unique political and legal status of tribes, different models of innovation and strong relationships that tribes increasingly have within Congress, The White House and other federal and state entities also afford numerous possibilities for strategic partnership around shared and overarching goals and policy priorities to increase healthy food access and reduce childhood obesity and other health disparities.

ENDNOTES

1. The University of Arkansas' School Law, Indigenous Food and Agriculture Initiative's immense body of research and expertise played a significant role in the development of this report and the formulation of its findings.

2. First Nations Development Institutes work, research in food systems and the following publications were instrumental in informing the development of this report and its recommendations: Highlighting Outcomes under the Native Agriculture and Food Systems Initiative 2012-2014, First Nations Development Institute (2015), http://www.firstnations.org/system/files/2015-Highlighting-Outcomes-Under-NAFSI.pdf, and First Nations Development Institute. (2014). Food-Systems Grantmaking in Indian Country: Trends from the Native Agriculture and Food Systems Initiative, Longmont, Colorado: First Nations Development Institute.

3. The working draft document, " Food & Agriculture in Indian Country," (December 2014) developed by the Indigenous Food Agriculture Initiative, University of Arkansas School of Law, and commissioned by the NB3 Foundation helped to inform the development of this briefing report as did the commitment by AHA/ Voices for Healthy Kids to furthering the knowledge its own knowledge and that of the larger field.

4. The Praxis Project and Native Organizers Alliance of the Alliance for a Just Society were significant contributors to this reports findings and recommendations based on their work with the Communities Creating Healthy Environments Program.

5. Ibid.

6. The W.K. Kellogg is a significant funder of much of the food systems, grantmaking and research cited in this report that was administered by various contributing organizations to this report including First Nations, NB3 Foundation and the Indigenous Food and Agriculture Initiative.

7. The Robert Wood Johnson is a significant contributor to research and grantmaking efforts by the NB3 Foundation as well as its joint partnership with AHA and Voices for Healthy Kids.

8. The following report by the Diné Policy Institute helped to also significantly inform this briefing report and policy recommendations: DINÉ FOOD SOVEREIGNTY: A Report on the Navajo Nation Food System and the Case to Rebuild a Self-Sufficient Food System for the Diné People, Dine Policy Institute (2014), Dine College, http://www.dinecollege.edu/institutes/DPI/Docs/dpi-food-sovereignty-report.pdf.

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97. First Nations Development Institute has published a free "Food Sovereignty Assessment Tool (FSAT)." However, tribes sometimes struggle to have adequate resources to fully implement these assessments. http://www.indigenousfoodsystems.org/sites/default/files/tools/FNDIFSATFinal.pdf

98. The NB3 Foundation explored these challenges with regard to data collection pertaining specifically to childhood obesity and devised a series of recommendations from Indian health experts on steps needed to improve health data collection and analysis. See " Convening 4: Obstacles, Challenges and Opportunities to Improve Data Collection, Sharing and Management. "Crystal Echo Hawk, Olivia Roanhorse and Marian Quinlan, "Turning the Tide for American Indian Children: Combatting Childhood Obesity and Type 2 Diabetes in New Mexico." The NB3 Foundation, Santa Ana Pueblo, New Mexico. (November 2012): pp.67-69

99. Jennifer Lee Schultz & Stephanie Carroll Rainie, "Good Data Leads to Good Sovereignty," Indian Country Today, (June 2014) http://indiancountrytodaymedianetwork.com/2014/06/03/good-data-leads-good-sovereignty

100. Ibid

101. In discussing food systems, it's easy to get caught up in the food production aspect, which invariably looks through a more rural or reservation lens. However, the majority of the US American Indian population lives in urban centers, not rural or reservation areas. Focusing on the needs of the urban American Indian communities is as important as focusing on the needs of rural, reservation and remote American Indian communities, but the land base of Indian Country does not exist within urban, metropolitan boundaries. Utilizing the Indian Country land base in a way that allows local rural, reservation and remote citizenry to survive and thrive while connecting their urban relatives to that land base in a way that supports urban Indian communities is a separate exercise, but one that should be pursued.

102. http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf. Important data reflected in the last two Census periods can help guide the venue for urban investments in healthy food access. The report cited reflects that the ten places with the highest percentage of American Indians and Alaska Natives are: Anchorage, AK; Tulsa, OK; Norman, OK; Oklahoma City, OK; Billings, MT; Albuquerque, NM; Green Bay, WI; Tacoma, WA; Tempe, AZ; Tucson, AZ; Sioux Falls, SD; Spokane, WA; Eugene, OR; Topeka, KS; Sacramento, CA; and Santa Rosa, CA. In addition, the city with the largest American Indian population is New York City, followed by Los Angeles, followed by Phoenix, Oklahoma City, Anchorage, Tulsa, Albuquerque, Chicago, Houston, San Antonio, Tucson, Philadelphia, and San Diego. Targeted efforts into these urban centers, and specific linkages to Tribal land bases could bear important positive results in the health, wellbeing and general food access in urban centers and the rural/reservation homelands.

103. USDA—National Agricultural Statistics Service, Census of Agriculture: Publications 2012, Highlights, available at: http://www.agcensus.usda.gov/Publications/2012/Online_Resources/Highlights/Farm_Demographics/#how_many.

104. Id.

105. USDA—NASS, 2012 Census of Agriculture, Vol. 1, at 581, available at: http://www.agcensus.usda.gov/Publications/2012/Full_Report/Volume_1,_Chapter_1_US/usv1.pdf.

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107. Ibid.

108. Harris & Radice.

109. Ibid.

110. It does happen, but ongoing fractionation problems within reservation boundaries creates additional challenges to food production.

111. "How Will Farm Bill & Food Stamp Cuts Impact Indian Country, February 5, 2014, found at http://indiancountrytodaymedianetwork.com/2014/02/05/how-will-farm-bill-food-stamp-cuts-impact-indian-country-153422.

112. "House Approves $40 Billion Cut to Food Stamps Over 10 Years", September 20, 2013, found at: http://indiancountrytodaymedianetwork.com/2013/09/20/house-approves-40-billion-cut-food-stamps-over-10-years-151360.

113. USDA-FNS, Food Distribution Program on Indian Reservations Fact Sheet (July 2014), available at http://www.fns.usda.gov/sites/default/files/pfs-fdpir.pdf.

114. Interview with Roxanna Newsom, Chickasaw Nation FDPIR Coordinator and Past-President of the National Association of FDPIR program managers (April 2015).

115. NAFDPIR/UDSA-FNS Data (2014).

116. However, the stark realities of the lack of available food vendors and a means to access food vendors makes SNAP as an alternative simply not viable, and in fact a dangerous and false choice. In some Tribal communities, the fact that the programs are administered by Tribal governments, may actually help with ensuring food makes its way to participants who have no other means to travel to the food. And in some locations, Tribal governments have used their resources to provide grocery store-like settings where participants can pick their foods from available package items in an environment that encourages and supports their own personal dignity, while also allowing participants to access nutrition education opportunities.

117. Halpern, P. "Obesity and American Indians/Alaska Natives," U.S. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation (2007) xi.

118. NAFDPIR Traditional Foods Survey (2014), on file with author.

119. Ross Racine, Executive Director, Intertribal Agriculture Council who has served as an agricultural advisor to Congress for over two decades and an important figure involved with the National Congress of American Indians advancing policy across all Indian Country.

120. Most market settings also are hinged on a mix of "giving" food to citizens and selling food to citizens, with a mixture of "sales" coming through actual EBT transactions and some through regular commercial non-benefit sales. Hinging a "store" concept to communities that are remote and suffer from high unemployment and in some cases an insufficient infrastructure is creating failure from the beginning. "Stores" depend on willing sellers and buyers, and without that a store will fail as a business venture.

121. Challenges in maintaining community gardens are seldom addressed or discussed, but should be examined from time to time. These can include: ensuring ongoing engagement with the community; increasing engagement of the next generation; determining the extent or role of tribal government support with community gardens; identifying and securing long-term land access for gardens; identifying labor needs on an ongoing basis; and many more day-to-day challenges of keeping community gardens strong and viable. When initial grant funding for a garden disappears, either within or outside Indian Country, often the garden disappears. These types of challenges aren't new - - Victory Gardens of decades ago or more recent 1960s and 1970s community efforts at food production are for the most part written of in the past tense. Gardens of today could see the same fate unless efforts are made to more firmly embed them into the community. In addition, little is discussed in the literature concerning challenges in maintaining long-term commitments to community gardens in rural or remote settings.

122. Highlighting Outcomes under the Native Agriculture and Food Systems Initiative 2012-2014, First Nations Development Institute (2015), http://www.firstnations.org/system/files/2015-Highlighting-Outcomes-Under-NAFSI.pdf.

123. Finally, as many tribal communities exist within communities that are driven by livestock production and ranching enterprises and not necessarily fruit and vegetable enterprises, the launch and sustainable success of farmers markets, CSAs or local food distribution systems must be preceded by the creation of fruit and vegetable production systems that can harvest into such markets or systems.

124. www.nativecdfi.net. Native CDFIs have been increasing in number and their ability to be in "high risk" credit deserts is critical to building infrastructure for healthy food. They can alone, or in combination with larger financial institutions, bring much-needed resources to bear. However, they also have needs to increase in number and location throughout Indian Country and increase their own access to greater pools of financing resources. Native CDFIs need further support and attention, particularly if they are to play an increasingly more critical role in healthy food financing in the years to come. They will need more partners in this important work.

125. http://www.youblisher.com/p/990031-Food-Financing-Efforts-2014/

126. A number of innovative projects and strategies are highlighted by the First Nations Development Institute's Highlighting Outcomes Under the Native Agriculture and Food Systems Initiative, 2012-2014, Longmont, Colorado: First Nations Development Institute.

127. See "Native Voices Rising" for an analysis on the challenges that grassroots advocacy groups face and recommendations to funders for best practices for support of these efforts.

128. For information on the Native American Food Sovereignty Alliance: http://www.nativefoodsystems.org/about/news/fsa

129. For more information on the Navajo Nation Junk Food Tax & Zero Tax on Fruits and Vegetables, see the Office of the Navajo Tax Commission: http://www.navajotax.org/ . Also see: http://www.latimes.com/nation/la-na-ff-navajo-tax-20150330-story.html

130. For information on the Mvskoke Food Sovereignty Initiative: http://www.mvskokefood.org

131. For more information the Indigenous

Environmental Network: http://www.ienearth.org

132. For more information on Rocky Boy: www.ccheonline.org

133. For more information on Athabascan: www.ccheonline.org

134. For more information on Food is Our Medicine: https://sni.org/search?search=food+is+our+medicine

135. For more information on Tolani Lake Enterprises: http://tolanilake.org

136. For more information on Cheyenne River Youth Project: http://www.lakotayouth.org

137. For more information on Choctaw Fresh Produce: http://www.choctawfreshproduce.com

138. For more information on Oneida Community Integrated Food Systems: http://www.oneidanation.org/ocifs/

139. For more information on the Diné Policy Institute: http://www.dinecollege.edu/institutes/DPI/policy.php

140. http://portal.nifa.usda.gov/web/crisprojectpages/1003761-food-production-extension-project.html

141. http://portal.nifa.usda.gov/web/crisprojectpages/0223427-sgu-land-institute-extension-project.html

142. For more information on the Sinte Gleska University Food Production Extension Project: see http://www.sintegleska.edu and http://portal.nifa.usda.gov/web/crisprojectpages/1003761-food-production-extension-project.html

143. First Nations offers this free tool to tribes and Native nonprofits. http://www.indigenousfoodsystems.org/sites/default/files/tools/FNDIFSATFinal.pdf

144. For more information on COPE, Navajo Nation: https://www.facebook.com/COPEProject/timeline

145. For more information on First Nations Development Institute: http://www.firstnations.org

146. For more information on the NB3 Foundation: www.nb3foundation.org

147. The technical assistance funded through Intertribal Agriculture Council streamline existing programs, assist producers with applications for federal loans and program funding, and create a working bridge between Indian Country producers and USDA. They work one-on-one with farmers and ranchers, food businesses and those beginning in farming and food production and interface with tribal governments and other nonprofit organizations. In each of the years since their launch, the technical assistance program specialists have held over 350 individual and group meetings to help build individual producer success. The economic impact for Indian Country attributable to this network of specialists has been very significant; nearing $10 million in loans and over $3 million in conservation contracts over less than 2 years time. Those impacts range from working with an tribal community conservation districts to ramp up community food access through obtaining hoop house funding through USDA; launching and scaling up individual farmers and ranchers operations through building better business plans that lead to improved credit access; accessing loans to build their operations, and; deploying a "mobile farmers market" that retraces traditional trade routes in Indian Country while exposing Native traditional food products to markets throughout the country.

148. The Keepseagle v. Vilsack settlement allowed those farmers who could prove discrimination a monetary compensation of $50,000 (Track A) or $250,000 (Track B – which required higher levels of proof). In addition, farmers received tax relief, debt relief, and programmatic relief. Programmatic relief included the seating of a Council for Native American Farming and Ranching, meant to provide ongoing advise to the Secretary and USDA; the launch of a "Technical Assistance" program that was provided through the Intertribal Agriculture Council. The Intertribal Agriculture Council provides the technical assistance program through 15 regional technical assistance specialists trained to serve as the bridge between the Department and Native producers. The programmatic relief responsibilities of the USDA will expire at the end of 2015, unless voluntarily extended by the USDA. There are at present approximately $380 million in leftover funds ("cy pres") that are still the subject of motions and arguments before the Court to determine proper disposition. A trust has been proposed by the parties as a proper next step for disposition of the remaining funds not claimed by individual claimants, however the creation of the trust is by no means accomplished and could not be realized if it becomes the center of protracted litigation

149. For more information on the Intertribal Agriculture Council: http://www.indianaglink.com

150. For more information on the Seventh Generation Fund: http://www.7genfund.org

151. In addition, the Initiative began a Summer Leadership Summit for Native Youth involved in food and agriculture (2014) and this annual gathering will provide technical assistance and training for young and beginning farmers and ranchers and food entrepreneurs. For more information on the Indigenous Food and Agriculture Initiative: http://law.uark.edu/ifai/

152. For more information on The Potlatch Fund: http://www.potlatchfund.org

153. For more information on the Indian Land Tenure Foundation: https://www.iltf.org

154. For more information on the Shakopee Mdewakanton Sioux Community's "Seeds of Native Health" Campaign: http://seedsofnativehealth.org

155. For more information on Let's Move Indian Country: http://lmic.ihs.gov

156. For more information on Generation Indigenous: http://genindigenous.com

157. Makani Themba, Ditra Edwards and Judith LaBlanc, Internal draft working paper on lessons learned from CCHE grantees Indian Country, The Praxis Project and Native Organizers Alliance of the Alliance for a Just Society, (May 2015).

158. Frieden et al., 2010.

159. Ibid.

160. Ibid.

161. First Nations Development Institute. (2015). Highlighting Outcomes Under the Native Agriculture and Food Systems Initiative, 2012-2014, p. 2 Longmont, Colorado: First Nations Development Institute.

162. Ibid.

163. First Nations Development Institute. (2014). Food-Systems Grantmaking in Indian Country: Trends from the Native Agriculture and Food Systems Initiative, p.

2, Longmont, Colorado: First Nations Development Institute.

164. First Nations Development Institute. (2015). Highlighting Outcomes Under the Native Agriculture and Food Systems Initiative, 2012-2014, p. 2 Longmont, Colorado: First Nations Development Institute.

165. First Nations Development Institute. (2014). Food-Systems Grantmaking in Indian Country: Trends from the Native Agriculture and Food Systems Initiative., p. 2, Longmont, Colorado: First Nations Development Institute.

166. First Nations Development Institute. (2014). Food-Systems Grantmaking in Indian Country: Trends from the Native Agriculture and Food Systems Initiative, p. 3, Longmont, Colorado: First Nations Development Institute.

167. First Nations Development Institute. (2015). Highlighting Outcomes Under the Native Agriculture and Food Systems Initiative, 2012-2014, p. 4 Longmont, Colorado: First Nations Development Institute.

168. http://www.cdc.gov/diabetes/projects/ndwp/pdf/part-i---traditional-foods-in-native-america-april-21.pdf.

169. http://www.cdc.gov/diabetes/projects/ndwp/pdf/part-ii---good-food-is-power-april-21.pdf.

170. http://www.cdc.gov/diabetes/projects/ndwp/resources.htm

171. http://www.cdc.gov/diabetes/projects/ndwp/traditional-foods.htm#%20Project%20Goals

172. http://foodsecurity.org/CFAguide-whatscookin.pdf. This document provides a strong overview of the means to measure food security, food deserts, and indices/demographics of communities when evaluating and planning for improved food availability. Health impact assessments (HIA) are tools by which policies can be assessed for their potential impact on health outcomes. HHS has identified the HIA tool as an important step in the planning process and strongly suggested using HIA tools in the health impact decision-making process. http://www.cdc.gov/healthyplaces/hia.htm. The differing types of health-related assessments are explained here: http://www.cdc.gov/healthyplaces/types_health_assessments.htm. Food sovereignty assessments were first encouraged by the First Nations Development Institute in a publication they released over 10 years ago; that publication was recently updated for use and is the preferred means of community assessment in Indian Country. http://www.firstnations.org/knowledge-center/foods-health/FSAT-2nd-Ed.

173. When Tribal-raised raw products leave the reservation in their raw state, they are leaving at the lowest price point possible. By adding value to those products, and controlling the marketing and distribution of those products more closely, a change in income derived from these products can be achieved.

174. Pub. L. 103-177, 107 Stat.2011; 25 U.S.C. 3701 et seq. Passed in 1993, the AIARMA mandates that if tribes undertake a process of community planning and technical analysis of the agricultural productivity of the natural resource base, the plans adopted through this process will control the sustainable long-term use of the lands for agricultural purposes. The tribe can then control those lands for healthy food production purposes. However, the BIA has never received appropriations to deploy this important assessment and planning tool.

175. The HEARTH Act of 2012 is also known as the Helping Expedite and Advance Responsible Tribal Home Ownership Act of 2012; Pub. L. 112-151, 126 Stat. 1150, 25 U.S.C. 415. The HEARTH Act, while focusing primarily on homeownership also contained important provisions allowing for more stable agricultural leasing to occur in Indian Country upon the enactment of land leasing regulations by tribal governments.

176. Ideally, once the transition occurs, these experienced farmers could bifurcate their markets to ensure their local citizens are fed first, before sending value added food products to other local communities outside their jurisdiction at higher price returns to the individual operation. This would ultimately lead to raising all boats - - locally available healthier foods and production of foods that would yield greater return to the individual farm businesses.

177. Considerable discussion is underway to refine and redraft international food aid programs rooted in federal policy. Recalibration of these food aid and food subsidy programs to ensure that local use of local resources to improve food production for local food access at the international level should gain momentum vis-à-vis Indian Country policy. If food aid and food subsidy policies have an unintended negative consequence on foreign citizens, can the same not be the case as those policies are applied domestically within Indian Country? More research and policy refinement is needed in this important area.

NATIVE STRONG

THE SOCIAL DETERMINANTS OF HEALTH OF TYPE 2 DIABETES AND OBESITY

A RESEARCH FRAMEWORK

A RESEARCH FRAMEWORK FOR THE NOTAH BEGAY III FOUNDATION'S NATIVE STRONG: HEALTHY KIDS, HEALTHY FUTURES PROGRAM

NATIVE STRONG

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For more information, or to order additional copies of this report, please call 505-867-0775 or email grants@NB3 Foundation.org.

ABOUT THE NOTAH BEGAY III FOUNDATION

Notah Begay III (NB3) Foundation, a 501(c)(3) nonprofit organization, is the only national Native American nonprofit organization solely dedicated to reversing Native American childhood obesity and type-2 diabetes. NB3 Foundation is setting a national standard for investing in evidence-based, community-driven and culturally relevant programs that prevent childhood obesity and type 2 diabetes, ensuring healthy futures for Native American children and their communities.

ABOUT NATIVE STRONG: HEALTHY KIDS, HEALTHY FUTURES

Native Strong is a national program of the NB3 Foundation. It is framed to help reverse childhood obesity and diabetes trends through four core functions – collaboration, strategic grantmaking, knowledge building and capacity building. Critical to and integrated across each of these core functions is research and evaluation, policy, advocacy and communication. Native Strong has supported 41 communities in our Promising Program and Capacity Building grant programs[1] across the country. Grantees (Native controlled nonprofits or Tribal programs) are utilizing various strategies to improve the health of their community and children such as, conducting community health assessments and hosting community convenings to drive action, conducting nutrition education, and physical activity programing to strengthening existing programs and finally, identifying policy, system and environmental strategies to sustain their work.

EXECUTIVE SUMMARY

Native American communities have and continue to build strong and thriving communities and governments, however many continue to struggle with challenges like high unemployment rates, low graduation rates, lack of access to healthy food and little access to quality health care, to name a few. Unfortunately, Native American people are all too aware of these systemic challenges in their community, but often have little voice or input within the research and public health community when it comes to the discussion of the social determinants of health in addressing childhood obesity within Native American communities.

Multiple years of research have made clear that Native American children are among the most likely to be obese and overweight and are at high risk for developing type 2 diabetes. What is less clear are the complex causes behind this growing epidemic and the culturally appropriate and effective ways to address the causes and improve the health for Native American children. In other words, beyond eating more vegetables or getting in more exercise, what are the deeper causes making our children and communities obese and sick?

This research project aims to better understand these issues by examining the social determinants of health of childhood obesity and type 2 diabetes among Native American people from a Native/Indigenous perspective. Using this perspective, this paper considers the unique indigenous factors (i.e. historical trauma, self determination, cultural activities, etc.) in better understanding the role and impact of the social determinants of health among Native people. The goal of this research project is to: 1) provide a research framework to guide the NB3 Foundation's approach to addressing childhood obesity in Native communities, 2) begin to analyze the current infrastructure for collecting available public data and 3) investigate the gaps and issues with data collection, access and dissemination.

Social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces, economics, social policies, and politics. – World Health Organization, 2014.

REALITIES OF TYPE 2 DIABETES AND OBESITY AMONG NATIVE CHILDREN AND YOUTH

- American Indians and Alaskan Natives ages 10-20 had the highest risk of developing type 2 diabetes when compared with other racial/ethnic groups (Centers for Disease Control and Prevention, 2014).
- A 2002 study using Indian Health Service data demonstrated that the number of Native American youth diagnosed with diabetes increased by 71% and prevalence increased by 46% between 1990 and 1998; prevalence in the general population increased by only 14% (Acton, Rios Burrows, Moore, Querec, Geiss, & and Engelgau, 2002).
- The Urban Indian Health Commission found in 2007 that urban American Indian youth were two to three times as likely as their peers in the general population to either be obese or at risk of becoming obese (Urban Indian Health Commission , 2007).

SOCIAL DETERMINANTS OF HEALTH

- Social determinants of health (SDOH) are "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics" (World Health Organization, 2014)
- Determinants related to type 2 diabetes and obesity include:
  - *Poverty and family socioeconomic status*
  - *Educational attainment and access to education*
  - *Childhood obesity*
  - *A family history of type 2 diabetes*
  - *Lack of access to medical care*
  - *Lack of exercise and safe spaces to exercise*
  - *The ability to purchase high quality and poor diet*
  - *Increased stress and unstable living conditions*
  - *Participation in cultural activities and heritage*
  - *Historical trauma*
  - *Racism and Social Exclusion*
  - *Self- Determination/Autonomy*

HEALTH FROM AN INDIGENOUS PERSPECTIVE

- Health from an indigenous perspective incorporates ideas of life balance, living in harmony with others and the land, as well as one's connection to food in creating or providing it (King, Smith, & Gracey, 2009). It also considers one's relationship within a community as well as an individual's physical, mental, emotional and spiritual health (King, Smith, & Gracey, 2009). This perspective connects well with the social determinants of health model.
- Indigenous determinants to be considered for this research project include:
  - *Self-determination/autonomy*
  - *Access and utilization of traditional lands*
  - *The impact of historical trauma*
  - *Experience of race-based social exclusion*

THE CHALLENGE OF DATA FOR NATIVE AMERICANS

- The lack of available data specifically on Native American populations--due to the relatively small size of the American Indian and Alaska Native populations in the US, these groups are rarely included in a large enough proportion within a sample to produce valid and useful statistics for their population. This limits the number of studies Native Americans are included in and creates a significant challenge for finding data on this population.
- The universal applicability of qualitative research-- Many of the studies reviewed and cited in this framework use qualitative research methods. While qualitative research provides a greater understanding of the unique social and cultural dynamics of a particular community and adds additional evidence to the body of research, the methodological limitations associated with qualitative research make any findings not universally applicable.

This paper is providing the NB3 Foundation an approach and research framework to better understand the impact and role of the SDOH in addressing childhood obesity among Native American children. The full report is outlined into three key sections. The first section provides background information on the SDOH model and indigenous determinants of health and a rationale for utilizing this model to analyze the root causes of type 2 diabetes and obesity among Native American children and youth. The second section provides a detailed description of the study design, including research questions, the process for selecting specific social determinant indicators and associated data. The last section provides the expected limitations and planned outcomes of this research.

This document provides a baseline of information on the SDOH and serves as a model for the NB3 Foundation's research moving forward. Using this paper as a framework, NB3 Foundation intends to compile the data on selected SDOH indicators and publish several briefing and issue papers. These papers will be available on the NB3 Foundation website and in other forms with the goal of educating the community, foundations, Tribal Leaders, advocates and policy makers. These papers will include:

- Five (5) state (NM, AZ, OK, MN, WI) fact sheets, 1-1.5 pages, on the tribes within each state, state level data and appropriate social determinant indicators.
- Six (6) fact sheets, 1-2 pages, on specific SDOH indicators and how they apply in Indian Country, including examples of statewide, tribal and national data.
- Summary report of our findings

As far as we know this is one of few research projects being conducted with a Native/ Indigenous lens. As a result, it is our hope that this research will provide an initial framework and highlight data indicators for communities to consider in addressing childhood obesity and improving the health of their children. Underlying root causes can help communities develop a clearer picture of the driving causes behind childhood obesity and type 2 diabetes and help communities be strategic in addressing them. In addition, this research has the opportunity to highlight the challenges in collecting Native American-specific data and to advocate for improved sources of data to better understand the realities of health and life for Native Americans.

“AS FAR AS WE KNOW THIS IS ONE OF FEW RESEARCH PROJECTS BEING CONDUCTED WITH A NATIVE/INDIGENOUS LENS.“

Rationale and Background Information

WHAT ARE SOCIAL DETERMINANTS OF HEALTH AND WHY WILL WE USE THIS MODEL?

As this research project focuses on examining the social determinants of health related to Type 2 diabetes and obesity among Native American children and youth, it is important to first understand what social determinants of health are. By definition, social determinants of health are "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics" (World Health Organization, 2014). This model views health from a broader perspective than individual health choices as the primary determinants of health and allows for forces such as poverty, education, and access to healthcare to have influence on the health outcomes of the individual and community.
For example, social determinants of health focus less on a person's exercise habits and more on the challenges to exercise in a community because built environment provides no safe spaces for physical activity (Singh, Siahpush, & and Kogan, 2010). And social determinants of health look less at individual eating choices and more at how living in food-deserts makes fruits and vegetables difficult to obtain (Townsend, Peerson, & and Murphy, 2001). Health from the social determinants perspective may involve complex factors such as whether individuals live near their families, workplace stress and unemployment, how far someone lives from a doctor's office, and the quality of the air they breathe (Devitt, Tsey, & and Hall, 2001; Robert Wood Johnson Foundation, 2010). All of these external circumstances impact the health of the individual and community, and yet may not be considered in a traditional individual health determinants model.

The ability to consider the context and conditions in which a person's health is formed and impacted gives the social determinants of health model explanatory power and efficacy in creating system wide change that a traditional "health risk" or "health behavior paradigm" does not (Jack, Jack, & Hayes, 2012). Social determinants of health allow us to identify non-traditional strategies for addressing health disparities instead of relying solely on changing individual health behaviors within preexisting social and economic conditions. Glasgow et al. notes that, "We need to embrace and study the complexity of the world, rather than attempting to ignore or reduce it by studying only isolated and often under representative situations," if we are to see theoretical policies translate into to real life intervention success (Glasgow, Lichtenstein, & Marcus, 2003; Jack, Jack, & Hayes, 2012). Social determinants give us a language and model to "embrace" the complexity of the world and study their impact on health at a community wide scale.

The social determinants of health model also fits naturally with how many indigenous and Native cultures view health. Health from an indigenous perspective often incorporates ideas of life balance, living in harmony with others and the land, as well as one's connection to food in creating or providing it (King, Smith, & Gracey, 2009). Nettleton et al. describes an indigenous perspective of health as, "not individual, but one that encompasses the health of the whole community and the health of the ecosystem in which [indigenous peoples] live" (Nettleton, Napolitano, & Stephens, 2007). From this perspective, Native Americans consider one's relationship within a community as well as an individual's physical, mental, emotional and spiritual health when evaluating well-being (King, Smith, & Gracey, 2009). In short, an indigenous perspective of health, much like the social determinants of health model, is "substantially social-cultural" (Nettleton, Napolitano, & Stephens, 2007) and defines health by its relationship to one's community, culture, and the environment.

RESEARCHERS HAVE NOTED THAT MANY OF THE STUDIES DONE ON INDIGENOUS HEALTH HAVE BEEN FROM NON-INDIGENOUS PERSPECTIVES (WILSON & ROSENBERG, 2002) THAT FAIL TO ACCOUNT FOR THIS SOCIALLY-ORIENTED UNDERSTANDING OF HEALTH. UTILIZING INDIGENOUS SOCIAL DETERMINANTS OF HEALTH TO ANALYZE THE ROOT CAUSES OF HEALTH DISPARITIES AMONG NATIVE AMERICAN CHILDREN AND YOUTH IS ONE WAY TO BRIDGE THIS GAP.

Finally, it should be noted that while we utilize the word "determinant", social determinants of health should not be seen as deterministic or give the impression of predictability (Gonzales, 2014). These models are not linear and the relationship between a determinant and a related health outcome is not causal in nature (Gonzales, 2014). Rather social determinants of health can be seen as influences on the development of a person or people group's health. They create the context in which health is developed and dealt with. Moreover, each community, whether indigenous/tribal or not, is unique, and the social determinants of health within that community will manifest themselves in ways unique to that community. While we can find common determinants and their associated indicators, social determinants will be shaped by the history, culture, landscape, and resources of a community. Therefore, consideration of these factors within each community is vital.

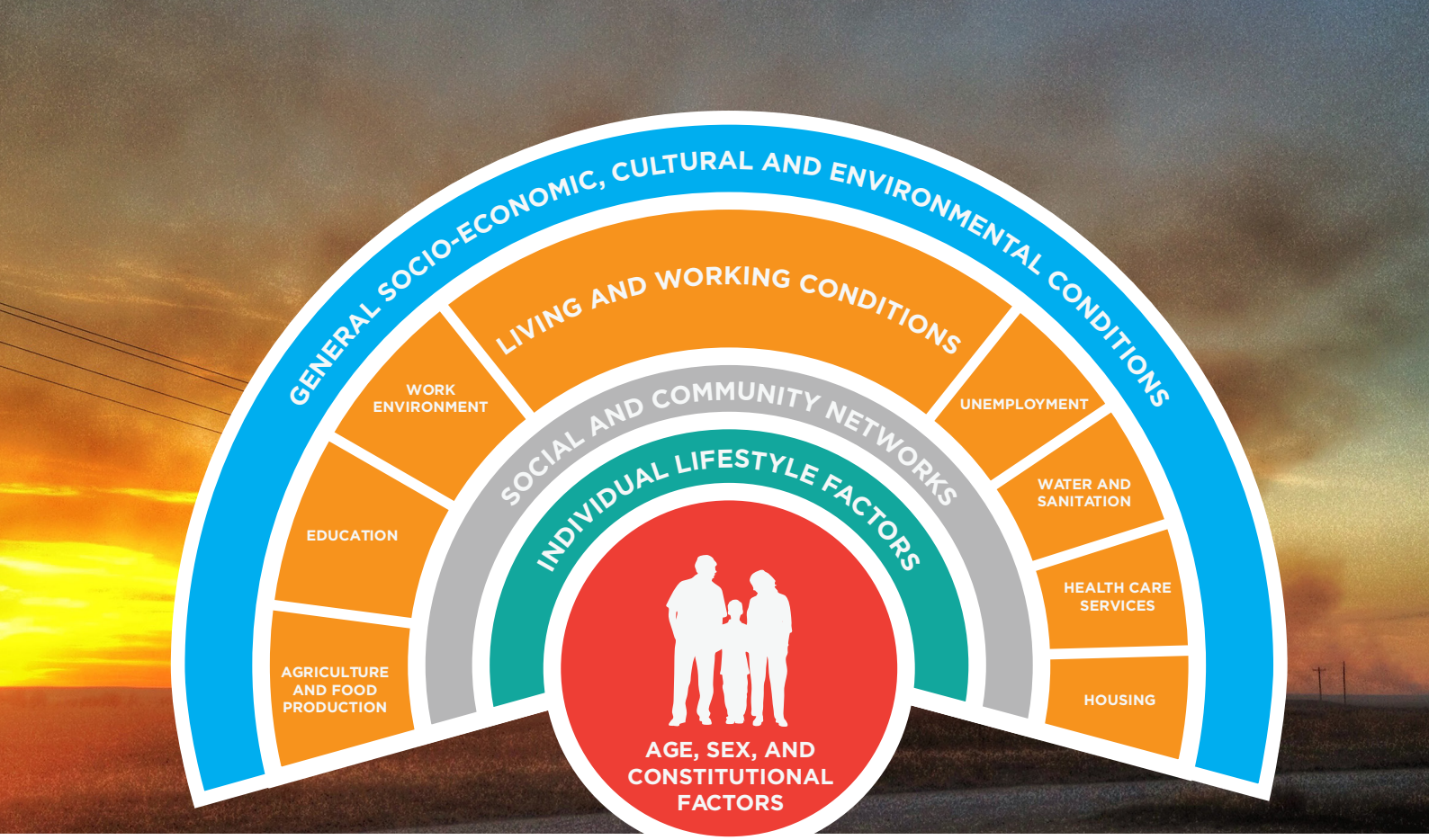


Figure 1 Dahlgren and Whitehead's "Rainbow" model of the Social Determinants of Health from their 1991 report. Reprinted from "Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews" by C. Bambra et al., 2010, Journal of Epidemiological and Community Health, 64. p. 285. Copyright 2010 by BMJ Publishing Group. Reprinted with permission

KEY CONCEPTS IN THE SOCIAL DETERMINANTS OF HEALTH MODEL

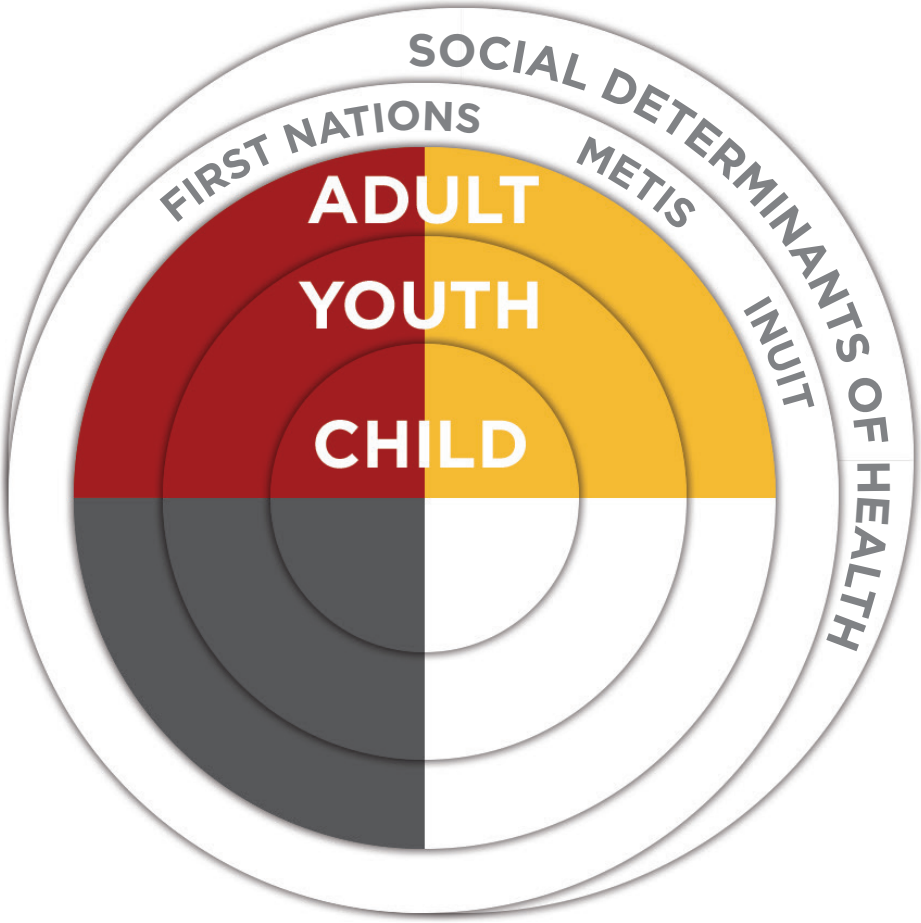
The concept "determinants of health" began in the 1970s out of a growing understanding that there were specific factors, both biological and social, that influenced health. This term refers more to structural rather than individual or behavioral determinants (Stahl, Wismar, Ollila, Lahtinen, & Leppo, 2006). Health researchers found that policies addressing these determinants had the potential for greater efficacy in making system-wide changes compared to policies promoting individual behavioral changes alone. The successor to this original research is the social determinants of health model, which prioritizes factors in health that represent inequalities created by social structures such as poverty (Stahl et al., 2006).

Dahlgren and Whitehead first conceptualized the social determinants of health model in a 1991 paper. In it, they present a "rainbow" type model (Figure 1.) that places biological givens such as sex, age and hereditary factors at the center and overlays them with successive layers of influence: lifestyle factors, community, living and working conditions, and socioeconomic, cultural, and environmental conditions (Dahlgren & Whitehead, 1991).
The authors use this model to demonstrate how an individual is impacted not only by personal health determinants and lifestyle choices but also by the conditions in which they live, work, play, grow and change. The model was further refined in 2003 to encompass a core set of social determinants that research had overwhelmingly shown as influential on population health—the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport (Wilkinson & Marmot, 2003).

Researchers within the public health field have gone on to develop models with greater complexity and a better understanding of the social determinants that impact the health and lives of specific groups of people. For this paper, we have focused on research

surrounding the social determinants of health of Native and indigenous peoples. Researchers working within Native health place particular emphasis on models that incorporate an indigenous understanding of health and the unique conditions and challenges faced by these populations. One particular example, the "Integrated Life Course and Social Determinants Model of Aboriginal Health" model (Figure 2.), incorporates "four dimensions of health across the life course including, physical, spiritual, emotional and mental [health]" and "reflects Aboriginal contexts and social determinants that not only have a direct impact on health but also interact with one another to create vulnerabilities and capacities for health" (Reading & Wein, 2009). This model allows for analysis of social determinants of health through the context of Native and indigenous cultures in addition to social structures and history. This context is imperative for our research.

Additionally, Reading and Wein classify social determinants of health into three categories—proximal, intermediate and distal—based on Marmot's 2007 analysis of the underlying "causes of causes" of health (Marmot, 2007). In this analysis, Marmot suggests that determinants most immediate in one's life may have been influenced by determinants further removed from them, either through distance or time. Proximal determinants are conditions that directly impact one's spiritual, emotional, physical and mental health. These include health behaviors, physical environment, education, food security, and socioeconomic status. Intermediate determinants are described as the originators of proximal determinants. They are the secondary layer of determinants, not directly impacting an individual but influencing the environment and conditions in which this person lives. These determinants include access to healthcare and exposure to traditional culture. Finally, distal determinants are the political, economic and social contexts that surround both intermediate and proximal determinants. In the case of indigenous and Native peoples, distal determinants incorporate the historical legacies of colonialism, racism and social exclusion as well as the early repression and reemergence of tribal self-determinism (Reading & Wein, 2009).



INTEGRATED LIFE COURSE AND SOCIAL DETERMINANTS MODEL OF ABORIGINAL HEALTH

- MENTAL HEALTH
- PHYSICAL HEALTH
- EMOTIONAL HEALTH
- SPIRITUAL HEALTH

Figure 2 The integrated life course and social determinants of health model for aboriginal people groups in Canada. Reprinted from "Health Inequalities and Social Determinants of Aboriginal Peoples' Health" by C. L. Reading and F. Wien, 2009, National Collaborating Centre for Aboriginal Health, p. 26. Copyright 2007 by Charlotte Loppie Reading. Reprinted with permission

In their model, Reading and Wein also incorporate the concept of life course, or the study of long-term effects of physical and social exposures through every stage of development - from gestation to adulthood - on the one's overall health and disease risks (Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power, 2003; Reading J. , 2009). The life course concept "...explicitly recognizes the importance of time and timing in understanding causal links between exposures and outcomes within an individual life course, across generations and in population-level disease trends" (Solar & Irwin, 2010). It "directs attention to how SDOH operate at every level of development...both to immediately influence health and to provide the basis for health or illness later in life" (Solar & Irwin, 2010). The incorporation of the life course concept is essential for making the case that interventions addressing the social determinants of health in childhood will have long-term positive impacts on the lives of Native children since our research will focus on the social determinants of health as they impact Native American children and youth. Additionally, it allows for the social determinant model to be adjusted from an adult centric model to a child/youth centric model as it assumes that exposure to certain determinants and health risks at a particular period in life, usually in early life, has a lasting effect that remains relatively constant throughout an individual's life (Reading J. , 2009).

INDIGENOUS SOCIAL DETERMINANTS OF HEALTH

In the last several years, researchers have pursued a new avenue of inquiry looking at specific "indigenous" social determinants of health. Increasing evidence suggests that the social determinants of health model cannot fully explain the inequalities experienced by indigenous peoples, and determinants more related to their unique life experiences must be taken into account (Brown, McPherson, Peterson, Newman, & Cranmer, 2012). Moreover, policies and practices to improve the social conditions and contexts that determine indigenous health will be most effective if the identities, connections and experiences that are fundamental to being indigenous are considered (Brown et al., 2012; Wilson, 2003).

THE INCORPORATION OF THE LIFE COURSE CONCEPT IS ESSENTIAL FOR MAKING THE CASE THAT INTERVENTIONS ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH IN CHILDHOOD WILL HAVE LONG-TERM POSITIVE IMPACTS ON THE LIVES OF NATIVE CHILDREN SINCE OUR RESEARCH WILL FOCUS ON THE SOCIAL DETERMINANTS OF HEALTH AS THEY IMPACT NATIVE AMERICAN CHILDREN AND YOUTH.

If social determinants of health are those conditions in which people are born, live, work, age and change, then "indigenous" social determinants of health are those life and work conditions unique to indigenous people and communities that impact and contribute to their health. Indigenous determinants could account for, among other things, the impacts of the traditional practices,

beliefs, customs, history, language and culture held by Native Americans (King, Smith, & Gracey, 2009). Although there is no consensus on the definition of "indigenous", it is generally accepted to incorporate the concepts of "ancestral occupation of land, separation from colonizing peoples, language, culture, self-identification, group recognition, and self-determination" (Nettleton, Napolitano, & Stephens, 2007). Specific indigenous determinants have therefore focused on those conditions that arise out of the indigenous experience, such as speaking one's traditional language, participating in traditional and cultural activities including the provision of food, use of traditional healing practices, identifying with or participating in traditional spirituality, and spending time on indigenous land (King, Smith, & Gracey, 2009). Unlike many other types of social determinants of health, some indigenous determinants of health, such as language transmission and preservation, access to traditional lands, and participating in traditional spirituality, can be seen as strengths of indigenous communities rather than weaknesses.

Below we explore several indigenous determinants in greater depth to gain a better understanding of their impact within indigenous populations such as Native American children and youth:

Self-Determination/ Autonomy—Public health and psychology researchers have shown that greater personal self-determination, or the control a person is able to exert over their circumstances and decisions, is strongly correlated with better health outcomes (Murphy, 2014; Richmond & Ross, 2009).

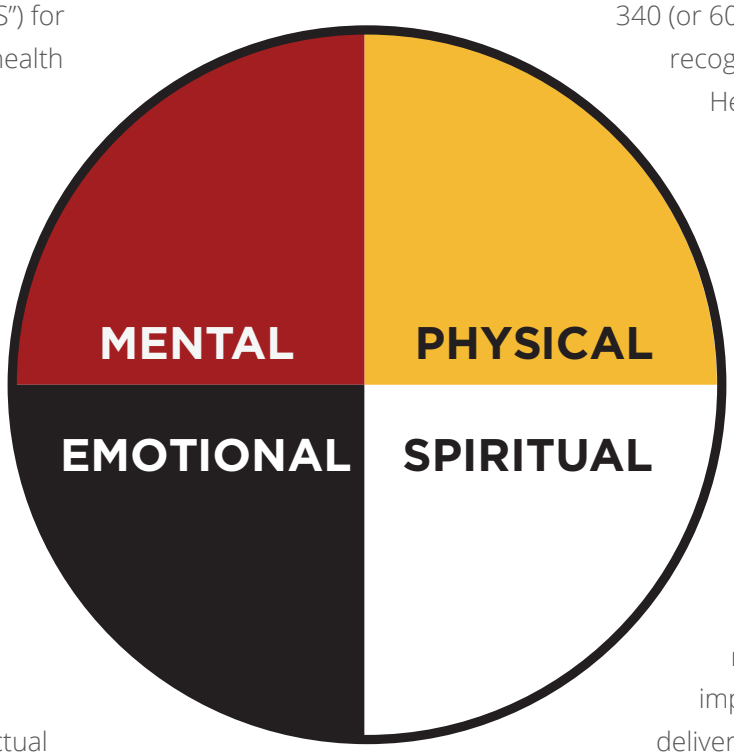
Indeed, social psychologists researching self-determination (also described as autonomy in the literature) have found that nothing is more important than self-determination/autonomy in an individual's healthy development and psychological wellbeing (Marmot, 2007; Murphy, 2014).

Self-determination can also apply to a community. A group of people can suffer a loss of autonomy when they experience oppression, assimilation, colonization, or any other form of domination or control. Due to outside pressure, they can no longer live self-endorsed lives according to their own values and preferences. (Murphy, 2014). Rather, they must live according to dominant group's values and preferences. However, when communities are able to rise up from under such oppression to regain self-determination, they reclaim the freedoms to govern themselves, choose their membership, and make decisions that reflect their values, identity, language, and cultural norms, without external influence (Murphy, 2014).

STUDIES IN OTHER COUNTRIES HAVE FOUND THE SAME POSITIVE ASSOCIATIONS BETWEEN SELF-DETERMINATION AND HEALTH. SPECIFICALLY, NATIVE YOUTH SUICIDE RATES WERE SIGNIFICANTLY LOWER OR NEAR ZERO IN TRIBAL COMMUNITIES THAT HAD SUCCESSFULLY PURSUED FACTORS OF CULTURAL CONTINUITY LIKE, AMONG OTHER THINGS, SELF-GOVERNANCE AND CONTROL OVER CERTAIN SOCIAL SERVICES LIKE HEALTHCARE (CHANDER & LALONDE, 2008).

The desire for these freedoms drove the Native American sovereignty and the self-determination movements in the US. Since the middle of the last century, Native American tribes have advocated for greater self-governance and the ability to exercise decision making over issues that affect their own people. While change was slow in coming, a landmark

bill in 1975 set the federal government and the tribes on a path towards greater tribal self-determination. Called Public Law 93-638 ("PL 93-638"), the Indian Self-Determination and Education Assistance Act fundamentally changed the political relationship between the federal government and the American Indian and Alaska Natives tribes. Importantly, it shifted responsibility for specific services from the federal government to the individual tribes, increasing a tribe's control over its own destiny (Cornell & Kalt, 2010). It created the ability for tribes to contract with the federal departments, like the Bureau of Indian Affairs ("BIA") and the Indian Health Service ("IHS") for federal funds to provide health and social services to their people and make decisions about how those funds would be spent. These services would have otherwise been managed directly by federal agencies, limiting tribal control and oversight. It also transitioned the "federal government and its agents from its heretofore ubiquitous and dominating role as actual service provider and reservation-governing decision maker to program advisor and advocate for tribal self-governance and greater tribal control over public programs" (Cornell & Kalt, 2010). PL 93-638 in a very real sense restored some of the tribes' freedoms for decision making and governance that they had lost when they were subjugated by the federal government in the decades and century before.



This change has wrought significant results. While PL 93-638 impacted multiple social service areas, in health, it has created greater autonomy and satisfaction under multiple measures of healthcare delivery (Cornell & Kalt, 2010). A survey by the National Indian Health Board found that tribes contracting under PL 93-638 found improved patient satisfaction and decreased waiting times, both positive measures for healthcare delivery (Cornell, Jorgensen, Rainie, Starks, & Grogan, 2012). Moreover, the high number of "638" contracting tribes compared to the number of tribes receiving direct services from IHS provides strong evidence that tribes desire to have greater control and self-determination with respect to their health: "As of December 2013, the IHS and Tribes have negotiated 83 self-governance compacts that are funded through 108 funding agreements with 340 (or 60%) of the 566 federally recognized Tribes" (Indian Health Service, 2014). While the Indian healthcare system continues to be systematically underfunded and insufficient to meet the full needs of Native Americans, the self-determination policies of PL 93-638 have made a measurable improvement on the delivery of care and satisfaction with the system.

Studies in other countries have found the same positive associations between self-determination and health. In one of the few quantitative studies looking specifically at the relationship between health and self-determination, Chandler and LaLonde found among the First Nations tribes in British Columbia, Canada a connection between factors of "cultural continuity", those actions that preserve a tribe's cultural past as well as enable them to have control over their future, and suicide rates among their youth (Chander & Lalonde, 2008).

Specifically, Native youth suicide rates were

significantly lower or near zero in tribal communities that had successfully pursued factors of cultural continuity like, among other things, self-governance and control over certain social services like healthcare (Chander & Lalonde, 2008). While they did not speculate as to the reasons why they found this association, Chandler and LaLonde did demonstrate that the positive association between factors of cultural continuity and reductions in youth suicide rates was statistically significant and persistent over time (Chander & Lalonde, 2008).

Access and Utilization of Traditional Lands—Multiple researchers have worked to elucidate the relationship between health and access to and utilization of traditional lands (Kingsley, Townsend, Phillips, & Aldous, 2009). They have found that the relationship between Native individuals and their traditional lands has a strong influence, even a potentially deterministic impact, on the health of an indigenous person and their greater community. This connection is first revealed through the indigenous concept of health. As mentioned previously, this concept of health is more holistic than its western counterpart, and it involves all aspects of a person and community—the physical, social, cultural, emotional and environmental components (Kingsley et al. 2009; Harris & Harper, 2000). Many indigenous peoples use the image of the "wheel" to describe their understanding of health (Figure 3.); in this wheel, the physical, mental, emotional and spiritual components of health are connected and in equilibrium with each other (Kingsley et al. 2009; Reading and Wein, 2009).

When one of these elements is out of balance, ill health results; maintaining balance within this medicine wheel is essential for good health (Wilson, 2003). In interviews with the Anishinabek, "First Peoples", of northern Ontario, Canada, it was made clear that the ability to maintain or rebalance your health lies with a person's or community's connection to "Mother Earth" or the land (Wilson, 2003). The Anishinabek believe that the land supports all four elements of life (physical, mental, emotional, and spiritual) on a daily basis through what she provides (Wilson, 2003).

Other studies have similar connections between traditional land and health. Australian indigenous people living on their traditional land, instead of in urban areas, have been shown to have lower rates of diabetes and cardiovascular disease, and lower overall mortality and morbidity rates (McDermott, O'Dea, Rowley, Kight, & Burgess, 1998) and research among the Inuit peoples of Canada have also shown that feeling good, or having a sense of wellbeing, is strongly dependent upon eating traditional food taken from their traditional lands (Borré, 1994). When this connection to the land is disrupted, the consequences can be seen in the health and wellbeing of indigenous communities. Without access to the land, the First Peoples were no long able to live how they and their ancestors previously had; they were without the "living classroom" the land provided to teach them the ways of their people (Brown et al., 2012). Indeed, a connection to the land, as seen by one Namgis First Nation elder, is so central to the way of life and health of an Indigenous people that it should be the starting point and not a separate conversation when looking at ways to improve the health of the First Peoples (Brown et al., 2012).

RICHMOND AND ROSS FOUND THAT A SHIFT IN CULTURE AND REDUCED ACCESS TO THE LAND AND ENVIRONMENTAL RESOURCES HAS, IN THE MINDS OF ONE INDIGENOUS COMMUNITY, RESULTED IN A LOSS OF BOTH INDIVIDUAL AND COMMUNITY HEALTH AS WELL AS A WAY OF LIFE: "WE LOST OUR TRADITIONAL WAY OF LIFE AND I THINK THAT'S WHY PEOPLE HAVE POOR HEALTH NOW, BECAUSE WE DON'T EAT OUR TRADITIONAL FOODS OR DO THINGS LIKE WE USE TO" (RICHMOND & ROSS, 2009).

In addition to impacting physical health, a connection to the land has spiritual, mental and emotional health implications. Wilson found that Anishinabek beliefs about being connected to the land were deeply rooted in a spiritual connection to the land, and that the people are connected spiritually to both the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Creator and Mother Earth through traditional healing practices and medicines that are provided by the land (Wilson, 2003). One man describes "harvesting medicine as medicine" for him, connecting him with Mother Earth and being rejuvenated both spiritually and physically through the act of picking plants and thanking Mother Earth for her provision (Wilson, 2003). Some indigenous peoples also believe that the land is alive and contains ancestors (Kingsley et al., 2009) and spirits (Wilson, 2003) which they can connect to through interaction with the land.

A connection to the land also impacts indigenous identity, which has important implications for mental and emotional health. A connection to Mother Earth is deeply imbedded in many indigenous people's understanding of themselves and their way of life: "Mother Earth is everything that you see. You look everywhere on earth and you see Mother Earth. The way you raise your children, the way people do things together, the way we live among our people. She is in everything we do" (Wilson, 2003). The land is not just influencing identity but is actually a part of identity (Wilson, 2003). Native land, in the eyes of indigenous people, is fundamental to and inseparable from their sense of being (Brown et al., 2012). It also provides a sense of belonging to a group, a people and a history (Kingsley et al., 2009; Brown et al., 2012), and can be a protective factor in preventing negative mental health outcomes (Walters & Simoni, 2002). Chandler and LaLonde found that communities that actively pursued acts of "cultural continuity," including reclaiming connections to traditional lands, positively impacted identity formation among their youth that correlated to the reduction in suicides among this population (Chander & Lalonde, 2008).

It should be noted that much of the research in this field to date is anecdotal and qualitative in nature, which presents limitations on the universal applicability of the aforementioned studies. However, like Kingsley et al. noted, each study adds additional, if not broadly applicable, evidence demonstrating the centrality of land to the health and wellbeing of indigenous people (Kingsley et al., 2009). Additional research, particularly research that incorporates cultural specific dimensions between health and place and recognizes the complexity of the indigenous understandings of health, identity, spirituality and place, is needed (Wilson, 2003). Furthermore, we noted that much of the research in this field is from Australia and Canada and few studies have looked at relationship between land and health among the Native Americans in the US; additional research among the Native American populations would broaden our understanding of the importance of land, place, and health specifically for these people groups.

RESEARCHERS HAVE NOTED THAT MANY OF THE STUDIES DONE ON INDIGENOUS HEALTH HAVE BEEN FROM NON-INDIGENOUS PERSPECTIVES (WILSON & ROSENBERG, 2002) THAT FAIL TO ACCOUNT FOR THIS SOCIALLY-ORIENTED UNDERSTANDING OF HEALTH. UTILIZING INDIGENOUS SOCIAL DETERMINANTS OF HEALTH TO ANALYZE THE ROOT CAUSES OF HEALTH DISPARITIES AMONG NATIVE AMERICAN CHILDREN AND YOUTH IS ONE WAY TO BRIDGE THIS GAP.

Historical Trauma—No discussion of indigenous determinants of health would be complete without a consideration of historical trauma. Historical trauma is "[the] cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from

massive group trauma" brought on by the long-term subjugation, colonialization and genocide perpetrated against indigenous people around the world and the Native American and Alaska Native peoples in the United States (Brave Heart, Chase, Elkins, & Altchul, 2011). For Native Americans, historical trauma manifested itself through the displacement from ancestral homelands, loss of spiritual ties to the land, population loss through mechanisms such as disease and warfare, and an eventual "cultural genocide" including the killing of millions of individuals, the forced relocation of entire tribes, and the compulsory assimilation of Native American children through mission schools.

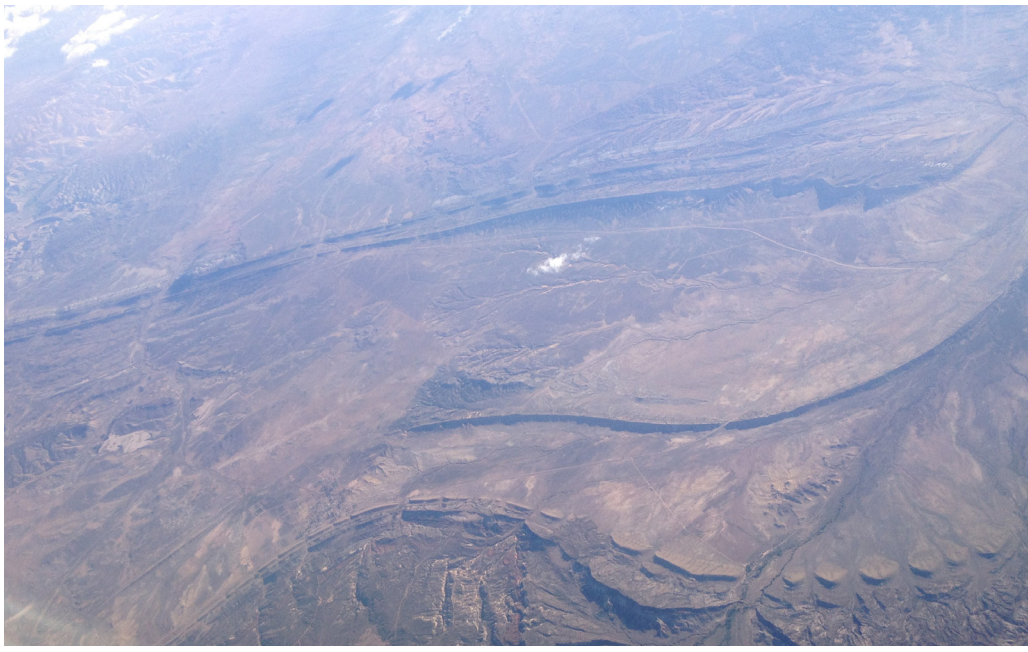
MULTIPLE PAPERS HAVE EXPLORED THE CONNECTION BETWEEN HISTORICAL TRAUMA AND THE CURRENT HEALTH DISPARITIES EXPERIENCE BY INDIGENOUS POPULATIONS, FINDING CORRELATIONS BETWEEN THE EXPERIENCE OF HISTORICAL TRAUMA AND THE PHYSICAL MANIFESTATIONS OF DISEASE (BRAVE HEART M. Y., 1999; STRUTHERS & LOWE, 2003; SOTERO, 2006).

Multiple papers have explored the connection between historical trauma and the current health disparities experience by indigenous populations, finding correlations between the experience of historical trauma and the physical manifestations of disease (Brave Heart M. Y., 1999; Struthers & Lowe, 2003; Sotero, 2006). And while the connections between historical trauma and physical health are still being discovered, Whitbeck et al. posit that the continuation of disease experienced by Native Americans is due in part to the continuation of historical trauma:

"Finally, we believe that these findings suggest that the "holocaust" is not over for many American Indian people. It continues to affect their perceptions on a daily basis and impinges on their psychological and physical health. There has been no 'safe place' to begin again. The threats to their way of life and culture have been ongoing, the losses progressive as each generation passes away. These losses are so salient because they are not truly 'historical' in the sense that they are not in past. Rather they are 'historical' in the sense that they began a long time ago. There has been a continual, persistent, and progressive process of loss that began with military defeat and continues through today with loss of culture…the losses are not over. They are continuing day by day" (Whitbeck, Adams, Hoyt, & Chen, 2004).

Brave Heart and Walters echo this belief, pointing to a cultural holocaust that persists to this day through cultural appropriation, racism, and oppression (Brave Heart & DeBruyn, 1998; Walters & Simoni, 2002).

The Whitbeck paper goes on to explore a new technique for modeling and measuring historical trauma, which may eventually enable researchers, if appropriate, to quantitatively include historical trauma within empirical social determinant models. While it is outside of the scope of our research to attempt to measure historical trauma, our analysis of the social determinants of health would not be complete without a discussion of historical trauma as it continues to have a significant impact on the health of Native Americans in the US.



Experience of race-based social exclusion—For many indigenous peoples, race is a crucial social determinant of health. A large body of research has been devoted to the interactive effects of race and socioeconomic indicators such as income and education level because socioeconomic status is often inextricably linked with race due to a long history of social trauma and institutional racism (Anderson & Bulatao, 2004). Research suggests, however, that even when socioeconomic status is removed from the equation, race alone remains a strong predictor of health for minority populations, including American Indians (Williams D. R., 1999; Devitt, Tsey, & and Hall, 2001); this may be due to race impacting the quality of care individuals receive (Liburd, Jack Jr, Williams, & Tucker, 2005).

THE STARK REALITIES CREATED BY RACISM AND HISTORICAL TRAUMA PLAY OUT IN THE HIGH RATES OF CHRONIC DISEASE, MENTAL HEALTH AND SOCIETAL ISSUES EXPERIENCED BY NATIVE AMERICAN ADULTS AND CHILDREN. AMERICAN INDIANS AND ALASKA NATIVES HAVE THE HIGHEST PREVALENCE OF TYPE 2 DIABETES IN THE WORLD, AND THE INCIDENCE IS INCREASING AMONG THE AI/AN POPULATION FASTER THAN ANY OTHER ETHNIC POPULATION (BRIGHAM AND WOMEN'S, 2010).

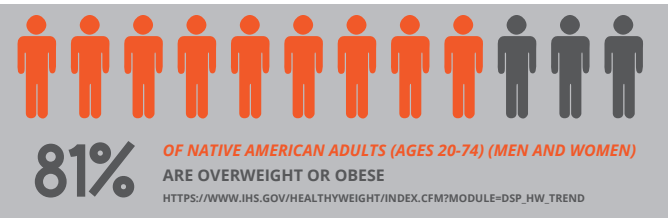
Racism also impacts health through the experience of historical trauma. Health scientists, psychologists, and anthropologists have conducted many studies on the long-term effects of historical trauma and institutionalized racism, finding that these processes act through a variety of mechanisms to impact Native American health. For example, the experience of historical trauma may increase a Native American's mistrust of non-native clinicians and counselors, which creates further barriers to adequate care (Belcourt-Dittloff & Stewart, 2000).

The stark realities created by racism and historical trauma play out in the high rates of chronic disease, mental health and societal issues experienced by Native American adults and children. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world, and the incidence is increasing among the AI/AN population faster than any other ethnic population (Brigham and Women's, 2010). Moreover, cardiovascular disease is the leading cause of death among Native Americans and this rate is significantly higher than the US general population (Brigham and Women's, 2010). With respect to mental and social health issues, American Indians suffer from high rates of suicide, homicide, domestic violence, child abuse, accidental death, and alcoholism (Brave Heart & DeBruyn, 1998). Native women and adolescents are particularly vulnerable populations; in 2006, the infant mortality rate for American Indians was 48.4% greater than the mortality rate for white infants and Native American women were two to four times more likely to experience rape than women of other races (Bohn, 2003). Similarly, Native American women were nearly twice as likely to die of diabetes (Walters & Simoni, 2002). These are only a few of the many health disparities that exist for Native Americans

when compared to other racial groups.
The experience of racism can be overt, as evidenced by discrimination, racism, and cultural appropriation (Belcourt-Dittloff & Stewart, 2000; Fine-Dare, 2002), but it can also be more subversive. One of the most important arenas in which we see the latter form of discrimination is the Native American health care system. Native Americans are both an "underserved and under-represented" population in terms of health care needs. The US Commission on Civil Rights has found that Native Americans lag 20-25 years behind the general population in health status, representing the most severe unmet health care needs of any group in the US, and despite their need for improved healthcare and services, the monetary value of Native American care is significantly less than the average health expenditures for all Americans (US Commission on Civil Rights, 2003). They found that IHS, despite funding increases, still operates with an estimated 59 percent of what it needs to provide adequate care (US Commission on Civil Rights, 2003). In addition to indirect racism leading to a lack of access to adequate healthcare, trauma and exclusion due to racism can lead to increased stress, contributing to psychological distress, depression, anxiety, physical health, and high blood pressure (Walters, 2002). The amount of control individuals have over their own lives and work environments, integration into family and social networks, and access to social support all impact the amount of stress individuals experience over their lifetimes. Feelings of "powerlessness"," lack of control," and "exclusion" all lead to increased individual stress (Burgess, Johnston, Bowman, & Whitehead, 2005; Devitt, Tsey, & and Hall, 2001). Research in biology and medicine suggests that chronic, low-level stress over an individual's lifetime leads to an overproduction of stress-mediating hormones, the cumulative effect of which is known as "allostatic load." This research suggests that long term, low level stress such as that caused by cultural change, historic trauma, and racism is likely to have long-term health effects, particularly in relation to chronic diseases such as cardiovascular disease, hypertension, and diabetes (Devitt, Tsey, & and Hall, 2001). Long term stress and racism may also be linked to an increase in behaviors which increase health risk, including smoking and substance abuse, limited use of screening programs such as mammography, and non-adherence to medical recommendations from clinicians (Brondolo, Gallo, & Myers, 2009).

SOCIAL DETERMINANTS ASSOCIATED WITH TYPE 2 DIABETES AND OBESITY

With this theoretical foundation for understanding social determinants of health, it is important to see how they play out in the lives of Native American children, youth, and families experiencing Type 2 diabetes and obesity. Diabetes affects 29 million Americans, including 15% of the American Indian adult population (Centers for Disease Control and Prevention, 2014). Current research suggests that type 2 diabetes accounts for approximately 90% to 95% of diabetes cases (Raphael, Anstice, Raine, McGannon, & Rizvi, 2003; Centers for Disease Control and Prevention, 2014).



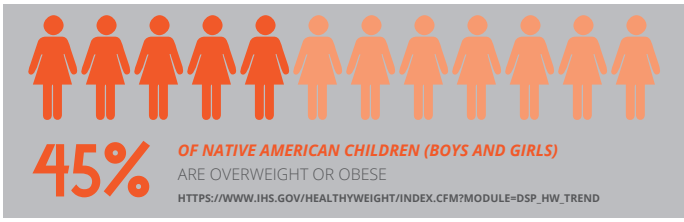
This chronic illness has become an increasing problem in recent years, particularly for Native American youth. American Indians and Alaskan Natives ages 10-20 had the highest risk of developing type 2 diabetes when compared with other ethnic groups (Centers for Disease Control and Prevention, 2014). A 2002 study using Indian Health Service data demonstrated that the number of Native American youth diagnosed with diabetes increased by 71% and prevalence increased by 46% between 1990 and 1998; prevalence in the general population increased by only 14% (Acton, Rios Burrows, Moore, Querec, Geiss, & and Engelgau, 2002).

BOTH DIABETES AND OBESITY ARE DISPROPORTIONATELY ASSOCIATED WITH LOW-INCOME STATUS, AN ISSUE WITH WHICH MANY NATIVE AMERICAN COMMUNITIES STRUGGLE (RAPHAEL, ANSTICE, RAINE, MCGANNON, & RIZVI, 2003; STORY, 1999).

Obesity, an associated chronic health problem, is also disproportionately affecting Native American youth and children. In the NHANES II study, American Indian children had significantly higher BMI's for nearly every age and sex group compared with reference populations; 39% of Native American children were overweight or obese compared with 15% for all other races combined (Story, 1999). Similarly, the Urban Indian Health Commission found in 2007 that urban American Indian youth were two to three times as likely as their peers in the general population to either be obese or at risk of becoming obese (Urban Indian Health Commission , 2007).

Given these findings, it is important to understand the social determinants and risk factors related to the development of diabetes and obesity in both adults and children, especially for Native Americans and indigenous peoples. Risk factors early in life include childhood obesity, a family history of type 2 diabetes, high and low birth weights, formula feeding, and gestational diabetes (Moore, 2010; Barker, Hales, Fall, Phipps, & and Clark, 1993). Both diabetes and obesity are disproportionately associated with low-income status, an issue with which many Native American communities struggle (Raphael, Anstice, Raine, McGannon, & Rizvi, 2003; Story, 1999). Income inequalities cause a "cluster" effect that produces excess risk through three main mechanisms: "deprivation of [material goods and access to services], excessive stress, and the adoption of health-threatening behaviors" (Benzeval, 1995; Raphael, Anstice, Raine, McGannon, & Rizvi, 2003). Other determinants related to type 2 diabetes and obesity include lack of access to medical care, safe spaces to exercise, and the ability to purchase high quality, nutritious foods. Many Native Americans live long distances from grocery stores

in "food deserts", leading to a lower quality of overall nutrition (Story, 1999). Forced cultural change and assimilation are associated determinants as well. These forced changes have led to groups abandoning traditional agricultural practices and food production and lower participation in traditional activities such as hunting and gathering (Story, 1999). Like other individuals with lower income status, they may also lack access to doctors, leading to difficulty not only with prevention but with receiving an early enough diagnosis for lifestyle interventions to have an impact (Raphael et al., 2003).



Although lack of exercise and poor diet play a role in the development of obesity and type 2 diabetes across all age groups, these factors are particularly likely to impact children. Several studies have shown higher than average sedentary behaviors among Native American youth compared to children of other races (Gray & Smith, 2003; Fontvieille, Dwyer, & Ravussin, 2002). Similarly, a 2009 New Mexico Middle School Youth Risk and Resiliency Survey found that 20% of the Native students indicated that they had no days with 60 minutes of physical activity and nearly 30% indicated they watch 3 or more hours of TV on an average school day (English, 2012). Encouragingly, however, other studies are showing promising improvements in the physical activity of Native children. When analyzing the responses of Native parents on measures of their children's health and wellbeing, researchers with the National Survey of Children's Health have found that approximately 50% of American Indian/Alaska Native 10- to 17-year-olds participated in sports teams or took sports lessons during the previous year and they participated in at least 20 minutes of moderate to vigorous physical activity 4.8 days per week, which is not statistically significantly different that children of other races (US Department of Health and Human Services, 2013).

The ability to engage in physical activity and maintain a healthy weight is partially dependent upon access a safe places to play and exercise. The US Department of Health and Human Services demonstrated in a 2005 report that a lack of built environment appropriate for safe physical activity increases risk of obesity and type 2 diabetes (US Department of Health and Human Services, 2005). Unfortunately, Native American children often find themselves with few options in their communities. Studies have found that Native American youth in low-income urban communities have fewer resources such as parks, YMCA clubs, and recreational centers, leading to increased levels of childhood obesity (Gordon-Larsen, Nelson, & Page, 2006). And 2007 US DHHS study found that many Native communities lack facilities, equipment and trained physical education staff to provide opportunities for safe physical activity (Halpern, 2007).

Finally, in addition to diet and exercise, increased stress negatively impacts children and adults. Chronic stress is linked to the development of type 2 diabetes and is common amongst individuals who struggle with unemployment, workplace related stress, food and housing insecurity, and the chronic stress of "exclusion" from minority status or feelings of lack of control over their own lives, all issues which may pertain to current Native American peoples (Raphael, Anstice, Raine, McGannon, & Rizvi, 2003; Devitt, Tsey, & and Hall, 2001; Story, 1999). Additionally, chronic stress can lead to behaviors such as substance abuse, smoking, poor meal planning, and low physical activity, all of which impact on the development of diabetes (Raphael et al., 2003)

Study Objectives and Research Questions

NATIVE STRONG OBJECTIVES

We have three objectives for the Native Strong Social Determinants of Health research project. The first is to examine the root causes of childhood obesity and type 2 diabetes among Native American's through the lens of social determinants of health in order to empower tribal and off-reservation communities to address the social and economic conditions underpinning these health disparities, and to provide non-native philanthropies and policy advocates with a better understanding of health from a Native/Indigenous perspective. Through this research, we will better illustrate the unique health challenges faced by Native children and their families.

The second objective is to analyze the current infrastructure for collecting data on early onset type 2 diabetes, childhood obesity and their associated SDOH determinants and indicators among Native American children and youth. The third objective investigates the issues and gaps in data collection and access/dissemination.

To meet these objectives, our efforts will focus on three research questions:

- Which social determinants of health are most explanatory of the health realities faced by Native American children and youth with Type 2 diabetes and obesity?
- What is the health status of Native American children and youth with Type 2 diabetes and obesity, as described through the lens of SDOH indicators?
- Which public data are available for this population at the tribal, state, and national levels? What are the limitations of data for this population? What are our recommendations for improving data collection for Native American populations and access to such data?

INDICATOR TABLES | 2015

NATIVE STRONG

PROXIMAL INDICATORS

- Participation in physical activity
- Childhood/youth overweight and obesity
- Consumption of healthy foods
- Tobacco/Alcohol/Drug use among teens
- Breastfeeding rates
- Access to safe areas to play, exercise
- Housing conditions
- Access to early education
- Reading/Math proficiency
- Graduation Rates
- Access to healthy foods Child hunger rates
- Poverty/Socioeconomic status
- Family Income
- Parental employment
- Percentage of Children qualifying for free or reduced lunch

INTERMEDIATE INDICATORS

- 638 or Direct Service tribe
- Exposure to domestic violence
- Unstable living conditions
- Access to cultural activities

DISTAL INDICATORS

- Historical trauma
- Racism and Social Exclusion
- Self-Determination/Life Control

STUDY DESIGN

Our study will be conducted through a literature review and, as appropriate and available, secondary data analysis of publicly held data sets pertinent to our investigation. It will utilize the social determinants of health model to examine the indicators related to the development of type 2 diabetes and obesity among Native American children and youth. This model, as discussed at length above, will be child and youth centric, as the NB3 Foundation programs are targeted to this population. Our model will include the concepts of life course, relevant health behaviors, and proximal, intermediate and distal indicators (Reading and Wean 2009). Categorizing the indicators in such a way will also allow us to incorporate a needed discussion of indigenous and non-quantitative indicators such as historical trauma and self-determination, both of which have been shown to have a significant impact on the health and wellbeing of indigenous and Native peoples.

We have already identified a set of indicators that are most strongly correlated with the development of diabetes and obesity among children and adults. We conducted this research through examining the literature on social determinants of health, using key word searches on Google Scholar and PubMed. These searches included "social determinants of health and diabetes", "social determinants of health and obesity", "social determinants of health and Native American", "social determinants of health and American Indian", "indigenous social determinants of health", "social determinants of health models." We prioritized those indicators identified in the literature as having a strong correlation to the development of obesity and type 2 diabetes among Native and non-native populations.

We also evaluated the indicators in light of the following questions:

- What are the NB3 Foundation's priorities with respect to data?
- What type of data should be considered: qualitative, quantitative or a composite?
- Is the indicator age, racially and culturally appropriate?

Knowing the program and NB3 Foundation's focus on children and youth, we gave priority to those indicators that have been studied in relation to children and youth or would be relevant in early childhood through young adulthood. The NB3 Foundation has also expressed a priority on access to healthy food and participation in physical activity;

PRELIMINARY LIST OF DATA SOURCES

CHILD/YOUTH HEALTH BEHAVIORS	National YRRS survey; State YRBS survey through tribal epidemiology centers; KidsCount
PHYSICAL ENVIRONMENT	Housing-National Native American Housing Survey (Dec 2014); Census
EDUCATION	Digest of Education Statistics, Census, KidsCount, state education departments
FOOD INSECURITY	Census; KidsCount; state health and human services departments, NM YRBS
POVERTY/SOCIOECONOMIC STATUS	Census
ACCESS TO HEALTHCARE	IHS; Tribal epidemiology centers
CHILD WELFARE	State departments of human services; US Administration for Children and Families

therefore, some of our indicators are related to these priorities. Our indicators will also be a composite of quantitative and qualitative analysis in order to incorporate distal indicators such as historical trauma and self-determination.

With these considerations, we chose a set of indicators that incorporate the proximal/intermediate/distal construct utilized by Reading and Wein as well as those indicators that would be relevant and have an impact on children and youth. We also included relevant health behavior indicators to provide personal health context for our findings. Tables 1-3 (page 29) contain our final selection of determinants for the study.

While we anticipate, based on an initial survey of available data, that we will provide data on one or more of the indicators under each determinant, it is possible that finding appropriate data for each indicator may be more difficult than anticipated. In that event, we will revise our indicator list to include a more readily available indicator and data source at that time. A further discussion of the limitations to our research is included below.

For each of these indicators, we will identify and utilize publically held data sets and academic literature to collect data, and endeavor to utilize data from multiple geographic levels—tribal, state, and national, focusing on the five states where the majority of Native Strong grant recipients reside (Arizona, New Mexico, Oklahoma, Minnesota, and Wisconsin) and the tribes within them.

Additionally, we will consider the following questions during our data selection in order to ensure that the data source is reliable, statistically valid for our population, and available for future updates.

- Is the data resource appropriate for addressing the study questions?
- Are the key variables needed to conduct the study available in the data source?
- Is the population we are interested in included in the data source? Are the data for the population we are interested in complete?
- Is the data source valid or has other quality assessments been applied to the data source?
- Is the data source respected and well utilized?
- Is the data source updated periodically to enable the NB3 Foundation to update its research in the future?

After an initial survey of data sources available that meet these criteria, we have compiled a preliminary

list of data sources (page 31) that we will utilize during our research. This list is by no means exhaustive and more may be added as we become aware of new data sets during the course of our data collection.

LIMITATIONS OF THIS STUDY

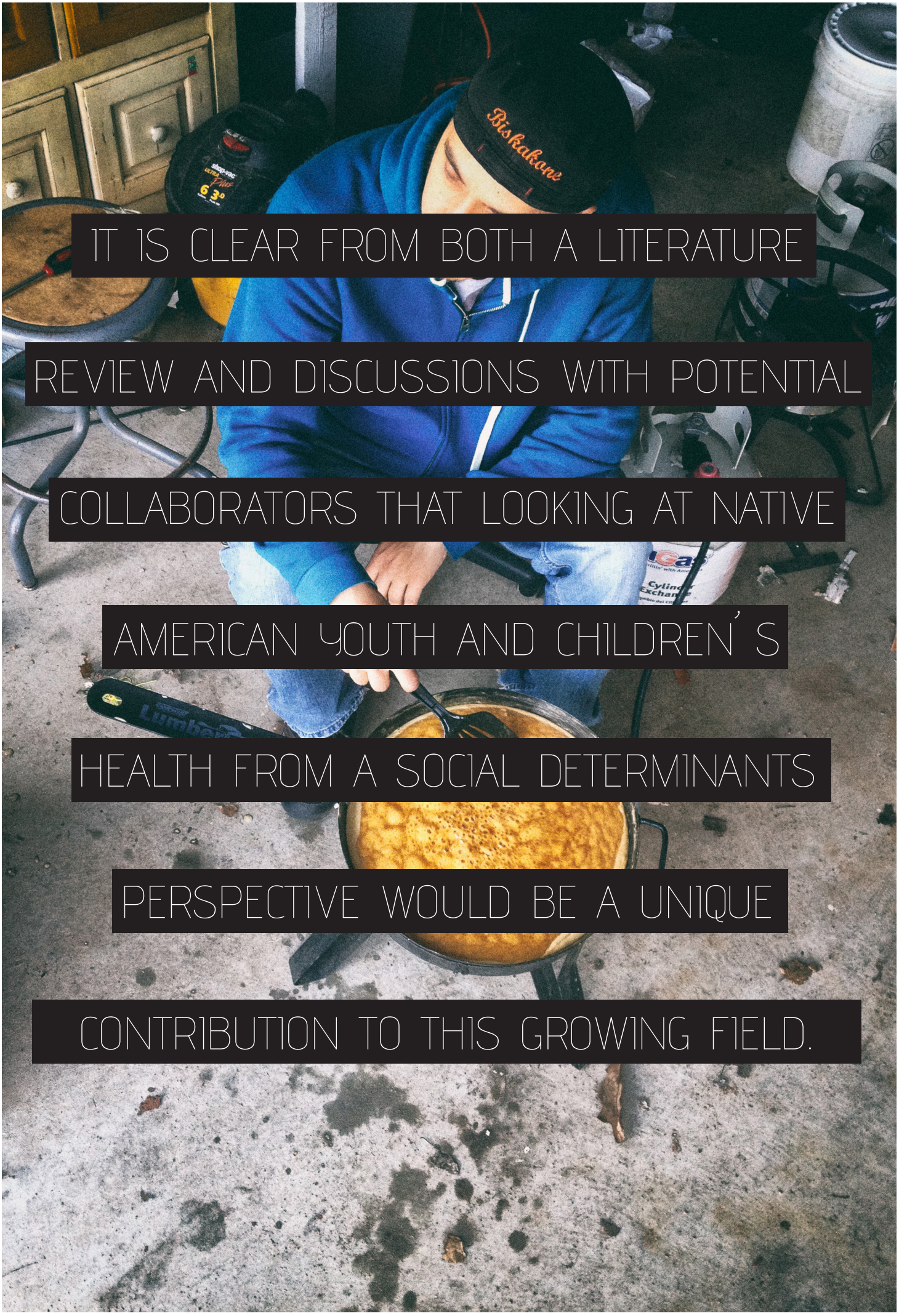
The most significant limitation we face in this research is the lack of available data specifically on Native American populations. Due to the relatively small size of the American Indian and Alaska Native populations in the US, these groups are rarely included in a large enough proportion within a sample to produce valid and useful statistics for their population. Indeed, the studies that include Native Americans in a significant enough proportion are few and far between; the decennial Census and American Community Survey (5-year estimates only) being the most well-known.
It will be a significant challenge to find data sets that include Native Americans within the study population, however, the list of data sources provided in the previous section all contain valid statistics for Native American/American Indian populations.
A related limitation concerns the inherent challenges associated with utilizing qualitative studies. Many of the studies reviewed and cited in this protocol use qualitative research methods. These methods are completely valid, appropriate and useful for doing research among tribal or indigenous communities; they contribute to the greater understanding of the unique social and cultural dynamics of a particular community and add additional evidence to that body of research. Moreover, they provide direction to understanding the issues and concepts in relationship to another population. However, study findings derived from qualitative methodologies may not be statistically valid for all populations and therefore cannot be universally applied; this arises from issues related to, among others, small sample size, the potential for the results to be influenced by researcher biases and idiosyncrasies, the findings being unique for the population studied, and the difficulty to maintain, assess, and demonstrate study rigor. This is the nature of many studies with the Native Americans and indigenous populations; we acknowledge these limitations and work with them.

Expected Outcomes of Study and Dissemination of Results and Publication

It is clear from both a literature review and discussions with potential collaborators that looking at Native American youth and children's health from a social determinants perspective would be a unique contribution to this growing field. Moreover, this research would provide foundations and policy advocates with a better understanding of health from a Native/Indigenous perspective and the unique health challenges faced by Native children and their families.

Using this paper as the framework for our research, we intend to compile the data on our social determinants of health indicators and publish several briefing and issue papers. These papers will be available on the NB3 Foundation website and in other forms with the goal of educating the community, foundations, Tribal Leaders, advocates and policy makers. These papers will include:

- Five (5) state (NM, AZ, OK, MN, WI) fact sheets, 1-1.5 pages, on the tribes within each state, state level data and appropriate social determinant indicators.
- Six (6) fact sheets, 1-2 pages, on specific SDOH indicators and how they apply in Indian Country, including examples of statewide, tribal and national data.
- Summary report of our findings


IT IS CLEAR FROM BOTH A LITERATURE
REVIEW AND DISCUSSIONS WITH POTENTIAL
COLLABORATORS THAT LOOKING AT NATIVE
AMERICAN YOUTH AND CHILDREN'S
HEALTH FROM A SOCIAL DETERMINANTS
PERSPECTIVE WOULD BE A UNIQUE
CONTRIBUTION TO THIS GROWING FIELD.

NATIVE STRONG
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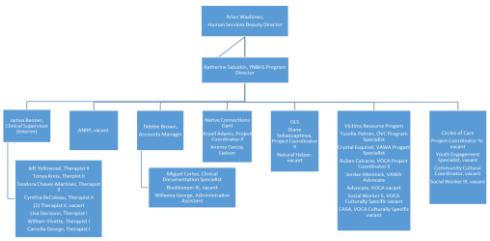
Yakama Nation Behavioral Health Services

YNBHS Organizational Chart



YNBHS Funding Sources

Elizabeth Nason, TAD

Arlen Washines,
Deputy Director

Katherine Saluskin, MSW, Program Director Line Item: 3515211.551111 (638 Master Contract)

Jim Renner, Interim Clinical Supervisor (Contract) Line Item: 3515211.551111(638 Master Contract)

Tonya Kreis, MED, Therapist II **Line Item: 3685210.512111(Medicaid Reimbursement)**
Jeff Yellow Owl, MSW, Therapist II **Line Item: 3685210.512111 (Medicaid Reimbursement)**
Teodora Martinez-Chavez, MBS, Therapist II **Line Item: 3515211.551111 (638Master Contract)**
Lisa Davisson, BA, Therapist I **Line Item: 3515211.551111(638 Master Contract)**
Cynthia DeCoteau, BA, Therapist II **Line Item: 3515211.551111(638Master Contract)**
Will Vrettis, BA, Therapist I **Line Item: 1391521.512111(DLS Youth Suicide Prevention)**
Camella George, BS Therapist I **Line Item: 1391521.512111(DLS Youth Suicide Prevention)**
Therapist II, (vacant) **Line Item: NA (OVCA Grant)**
Therapist II, (vacant) **Line Item: 1391.5211(DLS Youth Suicide Prevention)**

Debra Brown, Office Manager/Bookkeeper **Line Item: 3685210.512111 & 3515211.5511(638Master Contract)**
Willeena George, Administrative Assistant **Line Item: 3515211.551111(638 Master Contract)**
Miguel Cortez, Clinical Document Improvement Specialist **Line Item: 3685210.512111(Medicaid Reimbursement)**
Bookeeper III, (vacant) **Line Item: 3685210.512111 (Medicaid Reimbursement)**

Native Connections Grant
Aryell Adams, AA, Native Connections Coordinator **Line Item: 1375211.512111 (Native Connections Suicide Prevention)**
Jeremy Garcia, Native Connections Liaison **1375211.512111 (Native Connections Suicide Prevention)**
CLS Youth Suicide Prevention Grant
Diane Sekaquaptewa, Special Projects Coordinator **Line Item: 1391521.512111 (DLS Youth Suicide Prevention)**
Community Natural Helper (vacant) **Line Item: 1391521.512111 (DLS Youth Suicide Prevention)**
Victims Resource Program DOJ/OVC/VAWA/OVCA (2) Grants
Tuvella Palmer, BA, Coordinator **Line Item: 1397521.512111(DOJ/OVC)**
Crystal Esquivel, BA, Social Worker **Line Item: 1397521.512111 (VAWA/OVC)**
Jordan Minnick, Victims Advocate **Line Item: 1397521.512111 (VAWA)**
Ruben Calvario, AA, Project Coordinator II **Line Item: 1273.512111 (OVCA)**
Victims Advocate, (vacant) **Line Item: 1273.512111(OVCA)**
Social Worker II, (vacant) **Line Item: NA (OVCA)**
CASA, (vacant) **Line Item: NA (OVCA)**

Program Specialists, (vacant) **Line Item: NA (Circles of Care)**
Social Worker III, (vacant) **Line Item: NA (Circles of Care)**
Youth Engagement Specialist, (vacant) **Line Item: NA (Circles of Care)**
Community Cultural Coordinator, (vacant) **Line Item: NA (Circles of Care)**

YNBHS Program Description

- The Yakama Nation Behavioral Health Program will provide limited range of high quality professional Mental Health and confidential services. Our focus is to serve children, teens, adults, elders, veterans and families to reflect the unique social cultural and traditional experience of our clients in strengthening the family system. If you suffer from: 1) Depression/Stress; 2) Anxiety; 3) Trauma; 4) Anger; 5) Family Conflict; 6) Thoughts of Self Harm; 7) Work related Issues, YNBHS will provide a response in a timely manner to ensure quality service delivery.

Services Include

- 1) Individual, Family, Support Group Therapy, and Couples Counseling- YNBHS provides counseling and therapy to eligible individuals on a referral and voluntary basis.
- 2) Outreach and consultation to local school districts- Yakama Nation Tribal school, Mount Adams School District, Wapato School District, Toppenish School District and Granger School District clinical counseling , and support services for Native students- Therapists go into the schools to provide therapy to eligible students, whose mental health needs are more significant than a "Academic School Counselor" can provide. This is completed on a referral basis.
- 3) Crisis Management/ Outpatient Services- For individuals who are experiencing crisis and want immediate mental health care. If patient's mental health needs exceed the capacity of suicidal ideations or self-harm to self or others, a Designated Mental Health Professional from Comprehensive Mental Health is called or local law enforcement to detain individual for their safety.

Services Continued

- 4) Victim Resource Program- Yakama Nation Behavioral Health Services (YNBHS) partnered with other Tribal Agencies and non-Tribal organizations developed a Wellness Center that facilitates Crime Victims on the Yakama Reservation that is inclusive to victims of sexual assault, physical abuse, date rape, elder abuse, and other crime association to victims. It is our intentions to pursue a wellness center from a Social Work prospective. The Social work method provides a comprehensive approach to help to enhance the wellbeing of individual people achieve changes in their lives, for the better, in turn making a difference in our communities and wider society. VRP also provides victims of crime Advocacy and Case Management for victims of domestic violence, sexual assault, date rape, and human trafficking.
- 5) Community Support and Education Services- Wellness/ Historical Trauma Training, groups and counseling- Training provided to community by request. Our Special Projects Unit also does outreach and education to schools, community events, and local fairs.

Services Continued

- 6) Trauma Evaluation (TBD)- Including the Adverse Childhood Experience assessment to Intake process.
- 7) Bio/Social/Psycho Assessment Services- Provided by Therapist I at initial time of face-to-face with patient to determine patient's diagnosis.
- 8) Address suicide prevention/ intervention/ postvention services that is included to community outreach, training, and counseling services- Special Projects Unit provides Question, Persuade and Refer trainings to community, schools, and other Tribal departments on request.
- 9) Domestic Violence Perpetrator Program- Domestic Violence Perpetrator and MRT (Moral Reconation Therapy)- Assessments, Individual and Group therapy- Certified Therapist provides DV perpetrators an assessment, individual, group therapy by referral, usually by the Tribal Courts and/or individual needing specialized counseling.

Services Continued

- 10) LICWAC staffing consults'- Clinical Supervisor attends staffing's to provide expert clinical consulting on behalf of YNBHS.
- 11) Anger Management- Provided by Therapist who is certified to provide Anger Management services.
- 12) Healing Seasons- YNBHS has partnered with University of Washington Indigenous Wellness Research Institute to provide our Therapists with evidence-based practices (EBP's) therapy techniques, such as CPT (Cognitive Processing Therapy), Narrative Exposure Therapy (NET) and Motivational Interviewing (MI); to work with patients who experienced trauma/grief/loss on a voluntary basis.

Yakama Nation Behavioral Health Services (YNBHS) will partner with other Tribal Agencies and non-Tribal organizations to develop a Wellness Center that will facilitate Crime Victims on the Yakama Reservation. It is our intentions to pursue a wellness center from a Social Work prospective. Social work, help to enhance the wellbeing of individual people achieve changes in their lives, for the better, in turn making a difference in our communities and wider society.

Victims Resource Program Continued

The Yakama Nation Wellness Center will provide support for crime victims through a system of holistic care. Individually care plans created for each victim by a team of care providers, natural helpers will help victims navigate social support. Support includes crisis counseling, individual counseling, family counseling, Domestic Violence Advocacy, Drug and Alcohol outreach, Court Appointed Special Advocate outreach, Medicaid outreach, Anger Management counseling, Suicide Prevention Training, Historical Trauma/ Greif counseling, and sexual assault outreach. The Wellness Center will provide a safety net for victims that have recently became homeless, or in need of safe keeping by referring to homeless shelters, safe houses and or purchasing a motel room, depending on eminent harm or danger status of the victim. The Project Coordinator will provide Administrative and coordination of events.

OFFICE FOR VICTIMS OF CRIME

A Community Readiness Assessment (CRA) will also be conducted and Strategic Action Plan to assist with building the foundation of the Wellness Center. This assessment will also set the stage for future grants thru the Department of Justice Office of Victims Crime (DOJ/OVC).

- Office of Violence against Women (OVW)- This is a 3 year grant that focuses on the following: Develop a coordinated community response team that will enhance Domestic Violence Revised Yakama Codes (RYC) protocols for domestic violence response.
- 1. expand and improve services to support victims, YNBHS will hire a victim advocate to work with victims of domestic violence, dating violence, sexual assault, sex trafficking and stalking.
- 2. Work with the community to create education and prevention campaigns informing the Yakama Reservation about domestic violence, dating violence, sexual assault, sex trafficking, and stalking.
- 3. provide legal advice and representation of victims of domestic violence, dating violence, sex trafficking, sexual assault, or stalking who need assistance with legal issues that are caused by and/or suffered abuse.
- 4. Provide services to youth (ages 11-24) who are victims of domestic violence, dating violence, sexual assault, or stalking and the needs of children and youth who are exposed to these crimes, including support for the non-abusing parent or caretaker of the youth or child.

Office of Crime Victims Advocacy (OVCA) serves as a voice within state government for the needs of crime victims in Washington State. The purpose of this funding is to support individuals who have been hurt or harmed; impacted or affected by crime; suffered physical, financial, or emotional harm as a result of the commission of crime regardless if the event has been reported to law enforcement or when the event occurred.

Grants

DOJ/OVC: Serving Crime Victims- $450,000.00 for the 3 years.
DOJ/OVW: Office of Violence against Women- $446,445.00 for 3 years.
OVCA: Office of Crime Victims Advocacy- $547,854.00 for 2 1/5 years.
OVCA- Cultural Specific- $500,000.00 for 2 1/5 years.

The Project Director is Katherine Saluskin. The OVC Project Specialist is Tucelia Palmer (Yakama member). The OVW Project Specialist is Crystal Esquivel (Yakama member). OVCA Project Coordinator is Ruben Calvario (unenrolled). The Advocates is Jordan Meninick (Yakama member).

Native Connections Grant

The project goals are to reduce the impact of substance abuse, mental illness, and trauma on the Yakama Indian Reservation and within its boundaries, through a public health approach. We will use a holistic approach bringing together Reservation communities, local agencies, and Yakama Nation agencies to support and provide wrap-around-services for Yakama/AI/AN youth and young adults, up to ages 24. We purpose to serve at least 200 Yakama and other AI/AN youth (8-24 years of age) annually. This will be achieved by:

1) Increasing our understanding across the reservation about suicide risk and protective factors, why they exist, and why each risk as well as protective factors must be addressed;

Native Connections Continued

2) Conduct a community assets, needs and readiness assessment from all seven towns across the reservation to bringing community members together to 2a) share how youth suicide and substance use impact the quality of life for everyone across the Yakama Reservation, 2b) to obtain an inventory of the resources currently available that can be leveraged to improve the quality of life for community members 2c) to Identify our community's strengths and weaknesses;

3) Share assessment findings with the community to 3a) engage community members in discussions about needs, assets, and the community's response; 3b) increase key leaders and community members awareness and how they can contribute to the community's assets; 3c) use the information about community needs to assess our service delivery priorities; 3d) use the data for decision making to address community needs and how to use the available assets; and use the data to inform strategic planning, priority setting, program outcomes, and program improvements

Native Connections Continued

Native Connections award is $1,000,000.00 in the span of 5 years.

The Native Connections Project Director is Katherine Saluskin, who is enrolled Yakama. The Native Connections Project Coordinator II is Aryell Adams, who is a descendant of the Yakama Nation and enrolled member of the Cherokee Tribe and Liaison is Jeremy Garcia who is an enrolled member of the Yakama Nation.

Tribal Youth Suicide Prevention Grant (GLS)

There is a high rate of suicides among the Native American communities within the Yakama Reservation. Adolescents and young adults make up the majority of suicides that have taken place. There is also a high rate of alcohol and drug abuse within the Yakama Nation community.

YNBH will track attendance, administer and collect evaluations on all efforts to ensure that outcomes are being improved. Evaluations will be anonymous and will request for population identifiers such as ethnicity, gender identity, age and feedback on the impact of the activity itself. Surveys will also be conducted in local schools, Pow-wows, youth conferences, health fairs and other social events for community feedback on awareness efforts. To further support the impact, data collection and analysis will also be conducted within the juvenile justice system, foster care programs, behavioral and substance use programs to monitor trends throughout the time activities and efforts are being made within the community.

The purpose of the proposed project is to develop and implement tribal youth suicide policies and evidence-based prevention programs that enhances awareness, identification, referral and treatment strategies.

GLS Continued

Conduct Suicide Prevention trainings across the Yakama Reservation.

1) Each year provide consistent training opportunities to youth, community members, adults serving youth, and service providers

a) Six 1-hour QPR-Question, Persuade, and Refer trainings per year for community members and parents; (up to 30 per class)

b) Two ½ day SafeTalk for adults in youth serving positions: teachers, school staff, tribal social services, health care providers, and police (up to 30 per class)

c) One 2-day ASIST Applied Suicide Intervention Skills Training for adults directly serving youth: school Therapists, school nurses, foster parents, child welfare staff, juvenile justice staff (up to 30 per class)

d) One 2-day Assessing & Managing Suicide Risk AMSR trainings for Behavioral Health Therapists year 1, 3, and 5 (all Therapists)

GLS Continued

2) Train and maintain at least 4 trainers for QPR suicide awareness and prevention for community training opportunities.

The amount awarded for this grant is $8,644,636.00 for the span of 5 years.

The Project Director for this grant is Katherine Saluskin (enrolled Yakama). The Project Coordinator II is Diane Sekaquaptewa (enrolled Yakama). The Therapist I is William Vivette (enrolled other, Yakama descendent) and Camella George (enrolled Yakama). The Natural Helper is Shaniya Gunnier-Shipman (enrolled Yakama).

Circles of Care Grant

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services provided the Yakama Nation with a grant for Planning and Developing Infrastructure to Improve the Mental Health and Wellness of Children, Youth and Families in American Indian/Alaska Natives (AI/AN) Communities (Short Title: Circles of Care VII) grants. The purpose of this program is to provide tribal communities with tools and resources to plan and design a holistic, community-based, coordinated system of care approach to support mental health and wellness for children, youth, and families. These grants are intended to increase the capacity and effectiveness of mental health systems serving AI/AN communities. Circles of Care grantees will focus on the need to reduce the gap between the need for mental health services and the availability and coordination of mental health, substance use, and co-occurring disorders in AI/AN communities for children, youth, and young adults from birth through age 25 and their families.

Circles of Care Grant Continued

This grant will employ a Program Specialist, Social Worker III, Youth Engagement Specialist, and a Community Cultural Coordinator.

This grant is in the amount of $403,119.00 for 3 years.

Mental Health Promotion Project (MHPP) (Washington State DSHS/DBHR)

Mental health is a state of well-being in which individuals can realize their own abilities, can cope with the normal stresses of life, can work productively, and are able to make a contribution to his or her community.

Mental health promotion works at three levels:

- strengthening individuals,
- strengthening communities, and
- reducing structural barriers to mental health

Structural barriers to mental health can be reduced through actions to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, health services, and support to those who are vulnerable.

MHPP Continued

Promotion of mental health can be achieved by working to improve your community in a variety of ways. Here are just a few examples:

- early childhood interventions (e.g. home visiting for pregnant women, pre-school psychosocial interventions, combined nutritional and psychosocial interventions among disadvantaged populations);
- social support to old age populations (e.g. befriending initiatives, community and day centers for the aged);
- programs targeted at vulnerable groups such as minorities, migrants, and people affected by conflicts and disasters
- mental health promotion activities in schools (e.g. programs supporting normal transitions and changes in schools, increasing the atmosphere of child-friendly schools);
- mental health interventions at work (e.g. stress prevention programs);
- housing policies (e.g. housing improvement at a policy level);
- violence and substance abuse prevention programs (e.g. community policing initiatives);

MHPP Continued

In the past YNBHS hosted camps for families, hosted Conferences, and supported Triple D Basketball camps.

This grant is awarded yearly in the amount of $10,000.00 per year.

Healing Seasons

Purpose and overview

The purpose of this project evaluate the effectiveness of culturally adapted Narrative Exposure Therapy (NET) and culturally adapted Motivational Interviewing with Skills Training (MIST) in preventing HIV / STI sexual risk behavior by directly addressing posttraumatic stress disorder symptoms or substance misuse. The program consists of up to six (6) weekly 90-120 minute counseling sessions that are free to the participants as well as four (4) computer surveys for which the participants' are paid. After completing the first survey, participants are assigned by chance to either NET or MIST.

The counseling is offered in four clinical locations:

1. Yakama Nation Behavior Health (YNBH), Toppenish, WA
2. Comprehensive Healthcare (CompHC), Yakima and Sunnyside, WA
3. Indian Health Services, White Swan, WA – (both YNBH & CompHC counselors)

Healing Seasons Continued

Additionally, high school student participants can complete their counseling sessions on campus.

Recruitment

The project opened recruitment in July 2017. Please refer to the consort chart in the following pages for further recruitment information.

In order to participate in the project, a person must be

1. American Indian or Alaska men and women and descendants
2. At least 16 years old or older
3. Living on or near the Yakama reservation
4. At least subthreshold Posttraumatic Stress Disorder (PTSD)
5. Some substance use in the previous 12 months
6. Some lifetime sexual activity

Healing Seasons Continued

Interested callers may not participate if they meet any of the below criteria:

1. Self-harm or suicide attempt in the previous 30 days
2. Homicidal ideation in the previous 3 months
3. Psychiatric medications that have not be stable for at least 2 months**
4. And alcohol dependence diagnosis with severe withdrawal symptoms**
5. Unable to understand the process and provide consent.

** Interested callers are encouraged to call back once medication has stabilized or severe withdrawal symptoms have been resolved.

Any caller for whom this program is not a good fit is referred to alternative programs and services within the community.

Healing Seasons Continued

Healing Seasons is funded through the University of Washington Indigenous Wellness Research Institute. Project will provide:

- Alternative therapy approaches that is client driven and developed by Yakama Nation members
- Sustainable therapeutic skills that will outlast the life of the grant
- Hire an additional full time counselors at YNBH and Comprehensive Health
- Train additional counselors from YNBH & COMPHC in two different therapies to enhance their skill set
  - Counselors will be train in 1 therapy, then toward the end of the grant, train in the second therapy. This is to ensure solid skill development before taking on a new therapy.
- Continuing Education Credits will be available:
  - Attend the 2 day training, attend supervision meetings, see clients
- Trained counselors will be provided additional support
  - (e.g. therapy for themselves & weekly supervision by clinical psychologists)
- Provide six free therapy sessions at four sites: Toppenish, White Swan, Sunny side, Yakima
  - Funds for transportation costs for participants
  - Provide treatment engagement support to participants
- Hire up to two research assistants who live in the Yakama area
  - Must have at least a bachelor degree and 1-year experience or equivalent.
  - Yakama Preference Given
  - Job announcement will be posted early summer with possible start date in August
- YNBHS will be reimbursed $298.88 per session.

Conclusion

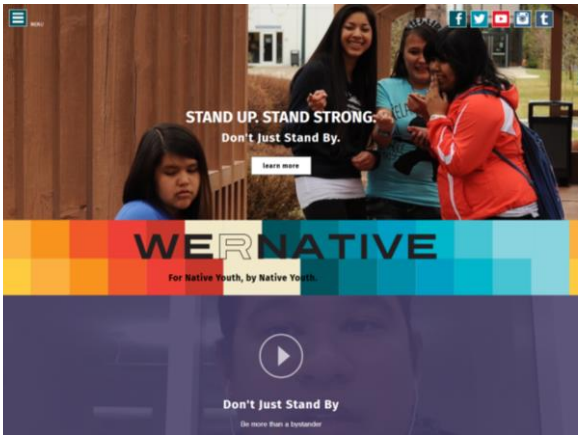
Yakama Nation Behavioral Health Services has expanded its services in the past 4 years.

Staff has increased from 7 employees to 30 with the funding of grants.

The Victims Resource Program was created to assist and serve victims of crime because Yakama Nation did not have a program that provided support or resources for victims of crime. YNBHS took a clinical Social Work approach to work comprehensively with victims to learn coping skills and address the trauma issues that may contribute to victimization.

YNBHS also recovered the Domestic Violence Perpetrator program. This program was originally under Justice Services and funded with Tribal funds. We made a proposal to ascertain the program and sustain it through 3rd Party billing. Also, we wanted to take a comprehensive mental health approach to the Perpetrators. The Therapist who provides DV Perp services is also certified in Anger Management.

YNBHS is planning on becoming a Trauma-Informed Care agency. TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment". This will be implemented through grant funding.

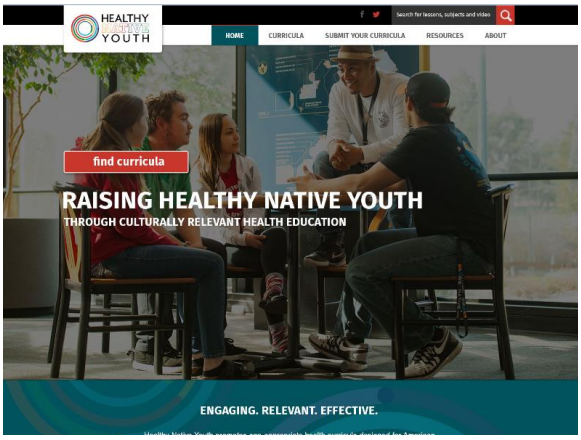


Never A Winning Hand PSA

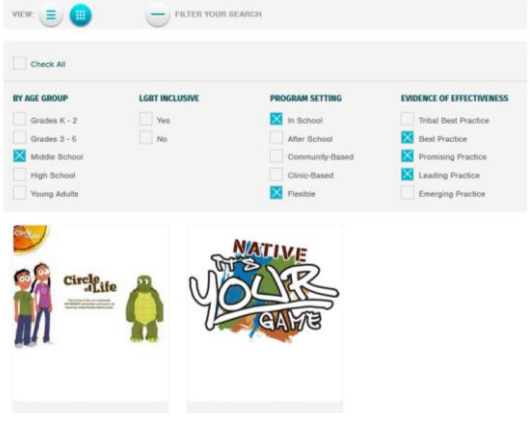
Long Version:
https://vimeo.com/233006812

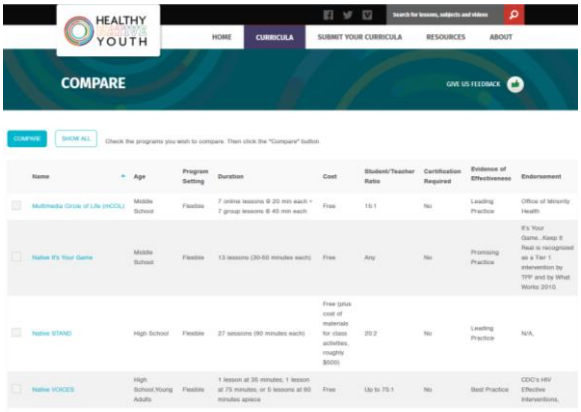
Short Version (One Minute):
https://vimeo.com/233006446

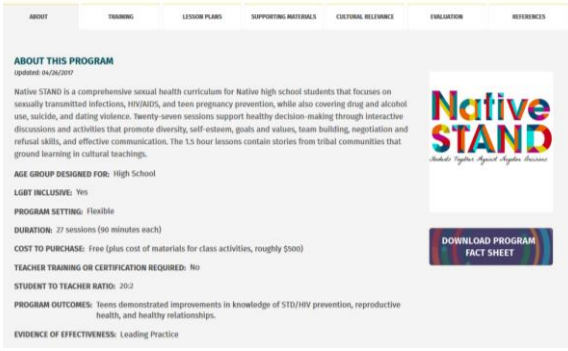
30 Second Spot:
https://vimeo.com/233006264


HEALTHY NATIVE YOUTH
HOME
CURRICULA
SUBMIT YOUR CURRICULA
RESOURCES
ABOUT
find curricula
RAISING HEALTHY NATIVE YOUTH
THROUGH CULTURALLY RELEVANT HEALTH EDUCATION
ENGAGING. RELEVANT. EFFECTIVE.


HEALTHY NATIVE YOUTH
HOME
CURRICULA
SUBMIT YOUR CURRICULA
RESOURCES
ABOUT
SEXUAL HEALTH CURRICULA
GIVE US FEEDBACK
COMPARE CURRICULA
FINDING THE RIGHT CURRICULA
MULTIMEDIA CIRCLE OF LIFE (MCOL)
NATIVE IT'S YOUR GAME
NATIVE STAND
COMPARE ALL


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

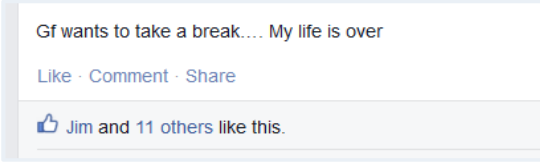

HEALTHY YOUTH
HOME
CURRICULA
SUBMIT YOUR CURRICULA
RESOURCES
ABOUT
COMPARE
GIVE US FEEDBACK
COMPARE
SHOW ALL
Check the programs you wish to compare. Then click the "Compare" button.
Name
Age
Program Setting
Duration
Cost
Student/Teacher Ratio
Certification Required
Evidence of Effectiveness
Endorsement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


ABOUT
TRAINING
LESSON PLANS
SUPPORTING MATERIALS
CULTURAL RELEVANCE
EVALUATION
REFERENCES
ABOUT THIS PROGRAM
Updated: 04/26/2017
Native STAND is a comprehensive sexual health curriculum for Native high school students that focuses on sexually transmitted infections, HIV/AIDS, and teen pregnancy prevention, while also covering drug and alcohol use, suicide, and dating violence. Twenty-seven sessions support healthy decision-making through interactive discussions and activities that promote diversity, self-esteem, goals and values, team building, negotiation and refusal skills, and effective communication. The 1.5 hour lessons contain stories from tribal communities that ground learning in cultural teachings.
AGE GROUP DESIGNED FOR: High School
LGBT INCLUSIVE: Yes
PROGRAM SETTING: Flexible
DURATION: 27 sessions (90 minutes each)
COST TO PURCHASE: Free (plus cost of materials for class activities, roughly $500)
TEACHER TRAINING OR CERTIFICATION REQUIRED: No
STUDENT TO TEACHER RATIO: 20:2
PROGRAM OUTCOMES: Teens demonstrated improvements in knowledge of STD/HIV prevention, reproductive health, and healthy relationships.
EVIDENCE OF EFFECTIVENESS: Leading Practice
Native STAND
DOWNLOAD PROGRAM FACT SHEET


HEALTHY YOUTH
HOME
CURRICULA
SUBMIT YOUR CURRICULA
RESOURCES
ABOUT
RESPONDING TO CONCERNING POSTS ON SOCIAL MEDIA
GIVE US FEEDBACK
COMPARE CURRICULA
ABOUT
TRAINING
LESSON PLANS
SUPPORTING MATERIALS
CULTURAL RELEVANCE
EVALUATION
REFERENCES
ABOUT THIS PROGRAM
Updated: 08/23/2017
Suicide prevention remains challenging among youth, as many do not disclose suicidal ideation to others before attempting suicide. However, emerging research suggests that nearly one-third of AI/AN youth see concerning messages on social media on a daily or weekly basis. This webinar training will prepare adults who work with Native youth to identify youth who post or view concerning posts on social media, and connect them to appropriate services.
AGE GROUP DESIGNED FOR: Middle School, High School, Young Adults
LGBT INCLUSIVE: No
PROGRAM SETTING: Flexible
DURATION: 1, 1-hour webinar
COST TO PURCHASE: Free
TEACHER TRAINING OR CERTIFICATION REQUIRED: No
STUDENT TO TEACHER RATIO: 40:1
PROGRAM OUTCOMES: An ongoing evaluation is assessing changes in educator knowledge, confidence, and
SMAHRT
Concerning Posts-Take Ac...

What are "Concerning Posts"?

Concerning posts include those that express depression or intent to hurt one's self or others, that have been posted on a social media site, such as Facebook, Instagram, Twitter, or Snapchat.



1. Watch the video training (30 min.)

Please click here to watch the training video.

Community Awareness Activity

Concerning Social Media Posts: Community Activity

Lesson Title: Help Youth who view Concerning Posts on Social Media
Time: 60 minutes

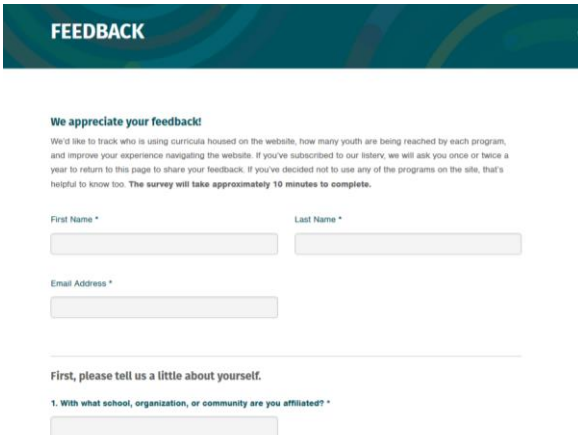
Community Objectives:

1. Understand what a 'concerning post' is
2. Identify themselves as a 'Trusted Adult'
3. Demonstrate and practice their understanding of the 'View Care Plan'

Materials:
- Access to *Responding to Concerning Posts on Social Media* Video: https://www.youtube.com/watch?v=n7tealJD3iI&feature=youtu.be
- A projector and audio equipment, if you're showing the video to a large group
- Copies of *Viewer Care Plan (pg. 4-5)*
- Copies of *Concerning Social Media Posts Role-Play Activity (pg. 6-20)*
- Pencils/pens

Preparation:
Explore the *Responding to Concerning Posts on Social Media* Video. Ensure audio equipment (speakers and projector) is functioning and video link is loaded, or


HEALTHY
YOUTH
HOME
CURRICULA
SUBMIT YOUR CURRICULA
RESOURCES
ABOUT
ADOLESCENT HEALTH RESOURCES
GIVE US FEEDBACK
Tips and Tools
Tips for Making your Clinic Teen-Friendly
A Teen-Friendly Reproductive Health Visit
Guidelines for Creating a Safe Clinical Environment for LGBT Patients
Answering Sensitive Health Questions
Websites for Educators
National Teacher Preparation Standards for Sexuality Education (PDF)
Future of Sex Education (FoSE) National Sexuality Education Standards
Sexuality Information and Education Council of the United States
Websites for Youth
We R Native
Innoemine
Generation Indigenous
Social Marketing Campaigns
To develop health promotion messages that resonate with AI/AN youth, the Northwest Portland Area Indian Health Board uses social marketing, an evidence-based planning process that improves the impact of health promotion messages. The model uses formative research to identify priority populations, segment the community into distinct audiences, pretest materials with the audience, and then monitors the campaign to assess its effectiveness.
We've used this community-driven process to design social marketing campaigns addressing health topics important to AI/AN communities, including:


FEEDBACK
We appreciate your feedback!
We'd like to track who is using curricula housed on the website, how many youth are being reached by each program, and improve your experience navigating the website. If you've subscribed to our listerv, we will ask you once or twice a year to return to this page to share your feedback. If you've decided not to use any of the programs on the site, that's helpful to know too. The survey will take approximately 10 minutes to complete.
First Name *
Last Name *
Email Address *
First, please tell us a little about yourself.
1. With what school, organization, or community are you affiliated? *


ABOUT THE PROGRAM
Health Categories (Check all that apply) *
Sexual Health
Healthy Relationships
Alcohol and Drug Prevention/Cessation
Tobacco Prevention/Cessation
Violence or Bullying Prevention
Suicide Prevention/Mental Health Promotion
Other Healthy Life-Skills
Physical Fitness
Nutrition

Take the Back-to-School Challenge

- A 3-month challenge to help students grades 6-12 develop skills for healthy relationships. Earn your class free school supplies!

- Step 1: Select a curriculum from HNY.
- Step 2: Implement it with a group of students
- Step 3: Complete the **Feedback Form** by Dec 1st: https://www.healthynativeyouth.org/about/feedback

Win Prizes!!!

- First 10 entries = **$250 in School Supplies**
- All Participants = **We R Native Promo Kits**

HEALTHY NATIVE YOUTH

www.healthynativeyouth.org
@healthyN8Vyouth
Listserve: Text "YouthNews" to 22828
Text Message: Text "Healthy" to 97779
fb.com/HealthyNativeYouth
native@npaihb.org

This project is funded by the Indian Health Service HIV and behavioral health programs. This work is also supported with funds from the Secretary's Minority AIDS Initiative Fund.

Executive Director Report

Legends Casino - Hotel
Toppenish, WA
October 2017

Joe Finkbonner, RPh, MHA

Personnel

New Hires

On-Call Office Assistants

- Gwen Allen
- Erik Ramone
- Ellee Biery
- Naomi Weiser

Taylor Ellis – CDC Public Health Associate

Personnel

Promotion

- Nora Frank – WEAVE -Promoted from Project Specialist to Project Coordinator

Temp

- Cathy Ann Ballew – TPTS2Tweens Site Coord.

Separation of Employment

- Collin McCormack, return to school

Personnel

Recognition

Stephanie Craig-Rushing, PRT Project Director

15 years of service

Meetings

AUGUST

- 8/2-8/3 Portland Area 638 Orientation, Portland
- 8/8-8/10 Portland Area Dental Meeting, Oregon Coast
- 8/16 Lunch with Diane Oaks, Arcora Foundation
- 8/30-8/31 Nike Native Fitness, Nike HQ

Meetings

SEPTEMBER

- 9/7-9/8 SAMSHA Meeting on Opioid crisis, Seattle, WA
- 9/11-9/13 Accreditation Meeting & Impact Days, Washington , DC
- 9/14 – 9/16 Arcora Foundation Board Retreat, Seattle, WA
- 9/18 – 9/21 ATNI, Spokane, WA
- 9/25 – 9/28 NIHB Annual Conference, Bellevue, WA

Upcoming Events

OCTOBER

- 10/16 – 10/17 NCAI, Milwaukee, WI

NOVEMBER

- 11/1 – 11/2 PHAB Board meeting
- 11/17 Invitation to speak at Indigenous Faculty Forum

Upcoming Events

DECEMBER

- 12/1 Arcora Foundation Board meeting & Alumni Lunch,
  Seattle, WA
- 12/6 – 12/7 PHAB Board meeting, Washington, DC

Other Events

- 8/18 - NPAIHB Staff Picnic, Oak Park, Portland, OR
- 8/25-8/26 - Hood to Coast Running & Walking Team
- 9/22 12th Annual Dancing In the Square Indian Day Celebration
- 10/4-10/6 NPAIHB Staff Retreat, Suquamish, WA
- Office Remodel completed

Questions…..

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

- Cow Creek: NPAIHB Quarterly Board Meeting, July 18-20, 2017.

July Technical Assistance Requests

- Tribal TA Requests = 4 (Stephanie), 2 (David), 3 Tommy
- 8 (Kauffman, CAPT, OHSU, IHS, NIHB, MT, CDC, Utah Navajo Health System, Inc.)

August Technical Assistance Requests

- Tribal TA Requests = 4 (Stephanie), 3 (David), 3 (Tommy)
- 7 (OHSU, CNAY, IHS, Salt Lake, Cook Inlet, Navajo, Utah Navajo Health System, Inc.)

September Technical Assistance Requests

- Tribal TA Requests = 3 (Stephanie), 4 (David), 3 (Tommy)
- 6 (NCSD, Southern Plains Tribal Health Board, OHSU, IHS, Navajo, Utah Navajo Health System, Inc.)

Project Red Talon / We R Native / Native VOICES

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

- Booth: We R Native – Navajo Nation Fair, Sept 5-6, 2017. Approximately 300 people in attendance.
- Call: Southern Plains Tribal Health Board re: We R Native. Sept, 2017.
- Call: Steven Hafner re: Violence Intervention Study.
- Call: w/ Teri at Tulalip re: Swinomish's OMH *Youth Spirit* Kick-off, Sept 19, 2017.
- Call: We R Native sister site w/ Utah Navajo Health System, Inc. July 14, 2017 and Sept 29, 2017.
- Call: *Youth Spirit* planning team, Sept 26, 2017.
- Meeting: NPAIHB Quarterly Board Meeting, Cow Creek, OR, July 18-20, 2017. Approximately 100 adult attendees.
- Meeting: Oregon Pediatric Society, Aug 9, 2017.
- Meeting: Steven Hafner re: Violence Intervention Study, Sept 27, 2017.
- Meeting: Swinomish's OMH *Youth Spirit* Kick-off Meeting, August 7, 2017.
- Meeting: We R Native sister site w/ Utah Navajo Health System, Inc. August 16, 2017.
- Presentation: Gen I and We R Native, 2017 NIHB Annual Conference, Bellevue, WA, Sept 27, 2017. Approximately 50 people in attendance.
- Presentation: We R Native - GenI Communication Bootcamp @ UNITY Youth Conference, Denver, CO. July 10, 2017. Approximately 40 AI/AN youth in attendance.
- Presentation: We R Native - UNITY Youth Conference, Denver, CO. July 9, 2017. Approximately 130 AI/AN youth in attendance.
- Presentation: We R Native – Youth Track. NPAIHB Quarterly Board Meeting, Cow Creek, OR, July 18-20, 2017. Approximately 38 AI/AN youth attendees.

- Presentation: WRN and HNY, 2017 IHS Diabetes Conference, Albuquerque, NM, Sept 21, 2017. Approximately 60 people in attendance.
- Presentation: Zunneh-bah (WRN Youth Ambassador) – Navajo Back To School Night, July 26, 2017. Approximately 60 youth in attendance.
- Webinar Training: Native VOICES video intervention, Cardea and WA DOH staff, July 11, 2017. Approximately 8 adult attendees.
- Webinar: Native STAND Cohort 1, Sept 7, 2017. Approximately 15 people in attendance.

Gen I / Bootcamps

- Meeting: w/ Shannon. August 31, 2017.

Native It's Your Game and Healthy Native Youth

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

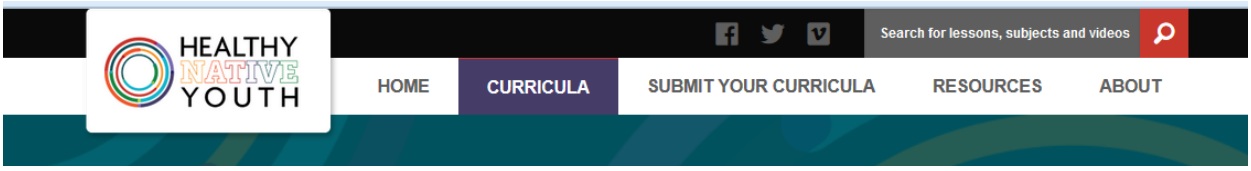
- Presentation: Concerning Social Media Posts and HNY, 2017 American Indian and Alaska Native National Behavioral Health Conference, Tulsa, Oklahoma, August 17, 2017. Approximately 50 people in attendance.
- Presentation: HNY and Concerning Social Media Posts, 2017 NIHB Annual Conference, Bellevue, WA, Sept 27, 2017. Approximately 50 people in attendance.
- Training: Native STAND, Cook Inlet Tribal PREP Grantees, Portland, OR, August 29-30, 2017.
- Webinar: Alaska - HNY Back-to-School Resources, Sept 14, 2017. Approximately 20 people in attendance.
- Webinar: HNY Back-to-School Resources, Sept 14, 2017. Approximately 30 people in attendance.

OHSU Native American Center of Excellence

- Meeting: OHSU-NPAIHB team meeting. July 24, 2017.
- Meeting: OHSU-NPAIHB team meeting. August 23, 2017.
- Meeting: OHSU-NPAIHB team meeting. Sept 6, 2017.
- Call: HRSA grantees meeting. Sept 26, 2017.
- Meeting: OHSU-NPAIHB team meeting. Sept 29, 2017.

Health Promotion and Disease Prevention

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



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

Last month, the **Healthy Native Youth** website received:

- Users = 574
- Sessions = 755
- Session Duration = 2m 50s

Last month, the **We R Native** website received:

- Page views = 12,371
- Sessions = 7,363
- Percentage of new visitors = 87.29%
- Average visit duration = 2:38
- Pages per visit =1.68

Text Message Services:

- *We R Native* has 4,997 active subscribers.
- The *Text 4 Sex Ed* service currently has 240 active subscribers. Broken down by opt-in path:
    - Sex (Facebook): 224
    - Condom (Text Message): 173
    - Snag, Banana (Instagram): 27
    - Hook up (twitter): 3
- The *Native Fitness* service currently has 232 active subscribers.
- *Hepatitis C* project has 100 active subscribers.
- *Healthy Native Youth* has 73 active subscribers.
- *THRIVE-DBT* has 34 active subscribers.

Twitter Followers = 4,744

YouTube: http://www.youtube.com/user/wernative#p/f<http://www.youtube.com/user/wernative>
The project currently has 551 uploaded videos, has had 118,257 video views, with 196,671 estimated minutes watched.

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

By the end of the month, the page had 46,393 Likes.

Instagram: http://instagram.com/wernative

By the end of the month, the page had 6,260 followers.

June Social Media Messages: Number/Reach of We R Native messages addressing…

Sexual health = 7 posts, 1 text message, 130,372 people reached
Bootcamp PSAs = 0 post, 0 people reached
Concerning Social Media Post Tips = 0 post, 0 people reached
Substance prevention = 6 post, 1 text message, 19,937 people reached
Suicide (general) = 6 post, 0 text message, 33,092 people reached
    #WeNeedYouHere Campaign (specifically THRIVE) = 6 post, 0 text message, 33,092 people reached
Mental health = 7 posts, 15,978 people reached
Youth leadership/empowerment = 12 posts, 3 text message, 83,337 people reached

July Social Media Messages: Number/Reach of We R Native messages addressing…

Sexual health = 1 post, 0 text message, 2,700 people reached
Bootcamp PSAs = 0 post, 0 people reached
Concerning Social Media Post Tips = 0 post, 0 people reached
Substance prevention = 1 post, 0 text message, 9,200 people reached
Suicide (general) = 2 post, 0 text message, 13,517 people reached

#WeNeedYouHere Campaign (specifically THRIVE) = 0 post, 0 text message, 0 people reached
Mental health = 7 post, 24,600 people reached
Youth leadership/empowerment = 6 posts, 4 text message, 58,162people reached

August Social Media Messages: Number/Reach of We R Native messages addressing…

- Sexual health = 2 post, 0 text message, 11,400 people reached
- Bootcamp PSAs = 2 post, 0 text message, 4,100 people reached
- Concerning Social Media Post Tips = 1 post, 0 text message, 13,900 people reached
- Substance prevention = 2 post, 0 text message, 10,200 people reached
- Suicide (general) = 1 post, 0 text message, 18,500 people reached
    - #WeNeedYouHere Campaign (specifically THRIVE) = 1 post, 0 text message, 5,900 people reached
- Mental health = 6 post, 0 text message, 9,400 people reached
- Youth leadership/empowerment = 18 post, 4 text message, 78,062 people reached

September Social Media Messages: Number/Reach of We R Native messages addressing…

- Sexual health = 0 post, 0 text message, 0 people reached
- Bootcamp PSAs = 2 post, 1 text message, 63,230 people reached
- Concerning Social Media Post Tips = 2 post, 0 text message, 18,000 people reached
- Substance prevention = 1 post, 0 text message, 625 people reached
- Suicide (general) = 13 post, 1 text message, 52,047 people reached
    - #WeNeedYouHere Campaign (specifically THRIVE) = 13 post, 0 text message, 47,040 people reached
- Mental health = 13 post, 1 text message, 98,039 people reached
- Youth leadership/empowerment = 26 post, 1 text message, 42,395 people reached

Native VOICES: Since their release, the Native VOICES videos have been viewed 3,272 times on YouTube and 2,082,318 times on Facebook.

Surveillance and Research

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 is partnering with Steven Hafner to carryout formative research to design a violence prevention intervention that will be delivered to Native young men via Facebook. The team is currently designing a text message and survey sequence with roll model videos for pilot tests this fall.

Youth Health Tech Survey: In 2016, the NPAIHB surveyed over 675 AI/AN teens and young adults on their media technology use and health information seeking practices and preferences. 78% of youth surveyed had regular access to a smartphone and 46% had regular access to a computer. Over 92% reported accessing the internet from a phone on a daily or weekly basis, and 50% reported going online from a computer as often. Over 62% reported getting health information from the internet on a weekly or monthly basis, and 66% reported getting health information from social networking sites as often. Read the complete report at: We R Social – Youth Health Tech Survey 2016

Other Administrative Responsibilities

Publications
- Working on Native VOICES Outcomes papers (w/ Steven and Jessica)
- Working on a *Texting 4 Sexual Health* paper; replying to reviewer comments (w/Patty)

Reports/Grants Submitted
- Received i-LEAD Grant!!! Hip hip!
- Received DVPI Grant!!! Hip hip!

Administrative Duties: Budget tracking and maintenance; Managed Project Invoices and Subcontracts; Staff oversight and evaluations

Clinical Programs-STI/HIV/HCV

Jessica Leston, Project Director
David Stephens, RN Case Manager

Contractors: Brigg Reilley-Epidemiologist, Carolyn Crisp-MPH, Crystal Lee-PhD (Navajo)

Quarterly Report: July – September 2017

Technical Assistance and Training

NW Tribal Site Visits
- Filming: HCV Media Campaign – Sophie Trettevick Indian Health Center, Neah Bay, WA – August 15, 2017
- Hepatitis C Onboarding – NARA, Portland, OR – August 16, 2017
- Filming at Cowlitz – Longview, WA – Augst 17, 2017

Out of Area Tribal Site Visits
- Alaska Viral Hepatitis - Studies and Elimination – Anchorage, AK August 7, 2017

July Technical Assistance Requests
- Tribal TA Requests = 10 (Jessica), 4 (David), 4 (Brigg)
- Other Agency Requests = 8 (CDC, IHS, OMH, HHS, VA, OHA, USET, OHSU)

August Technical Assistance Requests
- Tribal TA Requests = 10 (Jessica), 18 (David), 5 (Brigg)
- Other Agency Requests = 8 (CDC, IHS, OMH, HHS, VA, OHA, USET, OHSU)

September Technical Assistance Requests
- Tribal TA Requests = 10 (Jessica), 20 (David), 5 (Brigg)
- Other Agency Requests = 8 (CDC, IHS, OMH, HHS, VA, OHA, USET, OHSU)

HIV/STI/HCV
During the quarter, HIV/STI/HCV clinical project staff participated in sixty-four technical assistance calls, including:
- Conference Call: Voices sexual health data analysis – July 2, 2017
- Conference Call: IHS HIV/AIDS Team Call – July 4, 2017
- ECHO: Meeting with Hepatologist at OHUS reg collaboration – July 5, 2017
- Conference Call: Tribal PrEP – July 5, 2017

- Zoom: UNM HCV ECHO – July 5, 2017
- Call: Northwest Indigenous Conference Call Planning – July 7, 2017
- Conference Call: Voices sexual health data analysis – July 10, 2017
- Conference Call: IHS HIV/AIDS Team Call – July 11, 2017
- Adobe: IHS LBGTQ 2-Spirit Working group – July 11, 2017
- Zoom: UNM ECHO planning – July 11, 2017
- Zoom: UNM IHS HIV ECHO—July 12, 2017
- Zoom: Missoula EHR assistance – July 12, 2017
- Zoom: Lummi HCV ECHO – July 13, 2017
- Zoom: Alaska SES Brainstorm – July 18, 2017
- Conference Call: Tribal PrEP – July 19, 2017
- Zoom: UNM HCV Immersion Training, July 21, 2017
- Zoom: UNM HCV ECHO-July 19, 2017
- Call: Foundation for Health Generations – July 24, 2017
- Conference Call: IHS HIV/AIDS Team Call – July 25, 2017
- Zoom: Region X Presentation – NW ECHO – July 26, 2017
- Conference Call: Navajo Area HCV Elimination, July 27, 2017
- Conference Call: IHS HIV/AIDS Team Call – August 1, 2017
- Conference Call: Tribal PrEP – August 2, 2017
- Zoom: UNM ECHO – August 2, 2017
- Zoom: GP HCV/Pharm and Short Article – August 2, 2017
- Adobe: GPA Regional Inf Dis Updates – August 3, 2017
- Meeting: Fibroscan – August 3, 2017
- Conference Call: NIHB/NPAIHB SMAIF Advocacy – August 4, 2017
- Conference Call: Northwest Indigenous Conference Call – August 4, 2017
- Meeting: World Indigenous Peoples Conference on Viral Hepatitis – August 8-9, 2017
- Zoom: Hepatitis C Campaign Kickoff – August 11, 2017
- Conference Call: NCSD Annual Meeting: Education Session – August 11, 2017
- Conference Call: NCSD Annual Meeting: Social Media Session – August 14, 2017
- Conference Call: CA Area Office annual planning HIV and HCV—August 15, 2017
- Conference Call: Tribal PrEP – August 16, 2017
- Zoom: UNM HCV ECHO – August 16, 2017
- Zoom: PWID Update – August 17, 2017
- Teleconference—New England Journal of Medicine Interview, August 17, 2017
- Conference Call: IHS HIV/AIDS Team Call – August 22, 2017
- Zoom: NW ECHO– August 23, 2017
- Zoom: IHS HCV outreach and 2-day training—August 29, 2017
- Zoom: Missoula RPMS TA– August 29, 2017
- Conference Call: IHS HIV/AIDS Team Call – August 29, 2017
- Meeting: Fibroscan – August 29, 2017
- Conference Call: Tribal PrEP – August 30, 2017
- Conference Call: Introductory FibroScan / IHS call – August 31, 2017
- Meeting: Senator Merkely Staff – September 2, 2017
- Zoom: UNM ECHO – September 6, 2017
- Zoom: GP HCV Discussion with Winnebago – September 8, 2017
- Conference Call: Northwest Indigenous Conference Call – September 8, 2017
- Conference Call: Tribal PrEP – August 16, 2017
- Zoom: UNM HCV ECHO – September 20, 2017
- Zoom: PWID Analysis – September 26, 2017
- Training: HCV Clinical Updates and ECHO – September 22-23, 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.

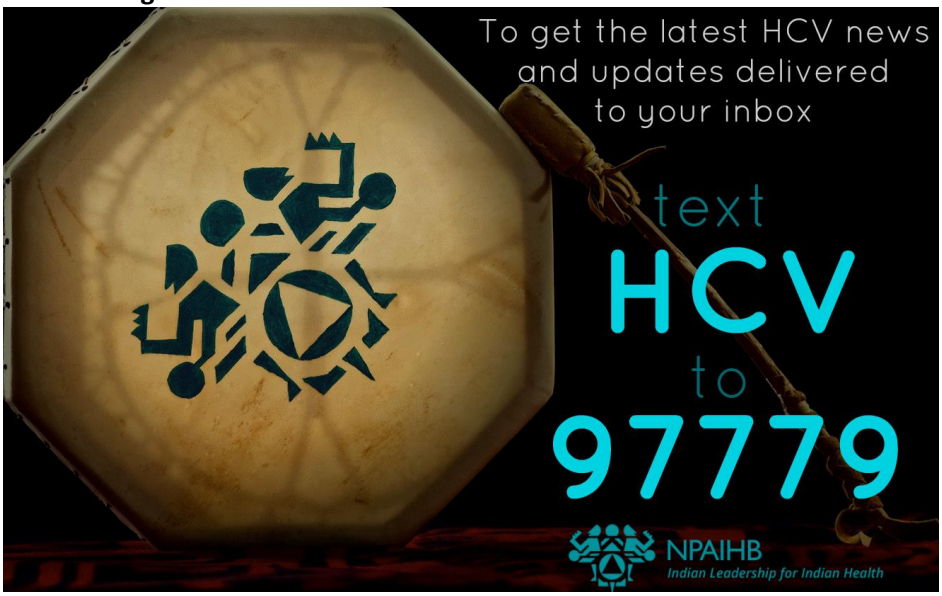
Goals: HCV has historically been difficult to treat, with highly toxic drug regimens and low cure rates. In recent years, however, medical options have vastly improved: current treatments have few side effects, are taken by mouth, and have cure rates of over 90%. Curing a patient of HCV greatly reduces 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

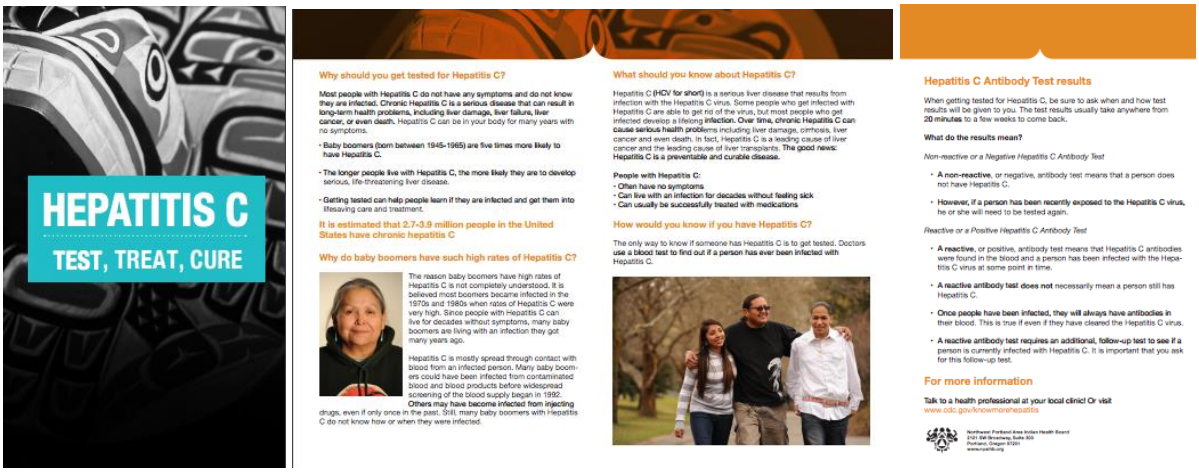
The project had a reach of 400 through our text message service and 1052 through constant contact in the month of September.

Currently, the program has strategic partnerships with: ANTHC, UNM, Cherokee Nation and IHS.

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.

Annual data on HCV screening for IHS sites nationwide has shown strong improvement, with an increase to 54% from 46% the prior year.

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.

- **7/13 and 7/25:** There were approximately 15 participants from 5 different sites that joined.
    - **Case Management:** 10 cases were presented and given recommendations for treatment by our Medical Expert from Cherokee Nation. **A total of 65 patients in total have received recommendations via the NW ECHO.**
- **9/27:** There were approximately 18 participants from 9 different sites that joined.
    - **Case Management:** 5 cases were presented and given recommendations for treatment by our Medical Expert from Cherokee Nation. **A total of 75 patients have received recommendations via the NW ECHO.**
- **8/23:** There were approximately 15 participants from 5 different sites that joined.

- **Case Management:** 6 cases were presented and given recommendations for treatment by our Medical Expert from Cherokee Nation. **A total of 90 patients have received recommendations via the NW ECHO.**

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 – Public Helath Reports
- Reilley B, Leston J. (2017) The Tale of Two Epidemics: Hepatitis C in Two Federal Health Organizations. New England Journal of Medicine
- Working on AI/AN HCV paper
- Working on AI/AN Opioid paper
- Working on Liver Cancer paper

Reports/Grants Submitted

- 1.359 Million in SMAIF Funds

Epicenter Biostatistician

Nancy Bennett

Conference Calls:

- DAWG (Data access work group) call
  - Review survey of data sources used by EpiCenters
- Staff retreat skype calls with facilitator

NPAIHB Meetings:

- All staff meeting (monthly)
- CPR/ First aid training
- Indian day planning meeting (monthly)
- Onboarding Meeting (monthly)
  - Went over definitions to include in the onboarding packet
  - Created check-list for all new hires
- Cow Creek BRFSS
  - Met with Sharon, heath director to go over initial variables to report on
- eMars (monthly or as needed)
  - presentation by Cayuse Technologies
  - created spreadsheet of flow of current report
  - finalized contract with Cayuse tech
- QI work group (monthly)
  - Facilitator gave QI group training on Quality Improvement techniques
  - Picked out first project – going to use the onboarding project to improve new hires experience
- Met with SAS (statistical analysis software) representatives to go over data needs of the tribes
- Portland Area Dental meeting (annual)
  - Planning the meeting
  - Created the program/agenda
  - Created web page
    - Put up presentations on web page
    - Put up pictures on web page

- Emergency Preparedness kick off meeting for 2018 meeting (bi-weekly)
    - Met with planning committee, determined possible dates for conference

Conferences/QBMs/Out of area Meetings

- Portland area dental meeting
    - Assisted in running the meeting
- SAS Annual west coast users meeting
    - Attended 3 days of instructional meetings

Miscellaneous

Reports:

Cow Creek BRFSS

- Added to code the additional variables
- Ran analysis on a few variables for Sharon to add to her PPT for board
- Working with contractor on the final report, analyzing variables, creating charts
-

Epicenter National Evaluation Project

Birdie Wermy, Project Specialist

Technical Assistance via telephone/email

July - August

- Ongoing communication with NPAIHB EpiCenter Director
- Ongoing communication with Tribal sites regarding project updates, information and technical assistance
- Email correspondence with the Lower Elwha K'lallam Tribe in person (August) and on 9.18 regarding surveys
- Email correspondence with UIHI regarding TIER 2 Evaluation Report in August and September

Reporting

July

- GHWIC All Hands call on 7.06 @ 10am
- DVPI Call on 7.18 @ 11am
- GHWIC C2 call on 7.20 @ 11:30am
- MSPI Call on 7.25 @ 11am

August

- GHWIC TEC workgroup call on 8.09 @ 10am
- GHWIC C1 ECHO Session @8:30am
- GHWIC C2 call on 8.23 @ 10am
- GHWIC TEC (Special) workgroup call 8.24 @12pm
- MSPI/DVPI Summary Report; TA Provider Session (8.15.17) on 8.30

September

- Oklahoma & Portland MSPI call on 9.14 @ 11am
- DVPI call on 9.19 @ 11am
- Portland MSPI call on 9.26 @ 11am
- GHWIC C2 call @ 10am

Updates

Birdie – continuing to provide evaluation TA to MSPI/DVPI service areas and GHWIC NW WEAVE Project

- Birdie also followed up Lower Elwha regarding data entry and analysis on surveys completed by the Tribe.
    - Birdie has created a survey in Survey Monkey and has begun data entry = 128 total surveys
- Birdie met with WEAVE-NW and went over GHWIC Tier 2 report
    - WEAVE-NW team sent documents to Birdie to be used in final report
- Birdie submitted the GHWIC Tier 2 Regional brief report on 9/2/0/2017

Challenges/Opportunities/Milestones

- Summary report was completed on 8.30 for the TA Provider Session I led on 8.15 in Tulsa, OK at the I.H.S. Behavioral Health Conference. There were a total of 17 participants and each objective was met during the session. I was able to meet new faces and answer questions regarding the TA on data collection and evaluation. The entire 50 minutes was used for the session and I met with grantees after the session as well.
- NPAIHB 8 week wellness challenge; a total of 11 staff participated in the challenge and logged their time(s) by Monday 8.28. All participants will receive a $25 gift card and entered into a drawing for a personal trainer session and admin leave. Providence will also hold a raffle for wellness items.

Meetings/Trainings

- Wellness meeting on 7.27 @ 10am
- I.H.S. Behavioral Health Conference 8.15-8.17.17
    - MSPI/DVPI TA Provider Session: Portland (Presenter Birdie Wermy)
- Wellness meeting on 8.24 @ 10am
- Met w/ WEAVE project on 8.25 to go over Regional Brief Report due 9.30
- Wellness Meeting on 9.14 @ 10am
- Indian Day meeting on 9.21 @ 11am
- NPAIHB Indian Day Celebration on 9.22 @12pm

Immunization and Institutional Review Board (IRB)

Clarice Charging, Project Coordinator

Meetings:

Electronic Monitoring Activity planning meeting, July 26, 2017
Indian Day planning meeting, August 29, 2017
NPAIHB staff meeting, September 11, 2017
Indian Day planning meeting, September 14, 2017
NPAIHB Indian Day, Pioneer Square, September 22, 2017

Quarterly board meetings/conferences/site visits/activities:

Tribal Health Directors, Joint meeting with California Rural Indian Health Board (CHRIB), Seven Feathers Casino and Resort, Canyonville, OR, July 17-20, 2017
NIKE Native Fitness, Nike Campus, Beaverton, OR August 30-31, 2017

Conference Calls:

Portland Area Immunization Coordinators, July 24, 2017

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

PA IRB Meetings:

PA IHS IRB committee meeting, July 20, 2017
PA IHS IRB committee meeting, August 10, 2017
PA IHS IRB committee meeting, September 13, 2017

During the period of July 1 – September 30, Portland Area IRBNet program has 140 registered participants, received 6 new electronic submissions, processed 11 protocol revision approvals, 3 publications/presentations, and approved 1 annual renewal.

Provided IT and IRB regulation assistance to Primary Investigators from:

Cow Creek Band of Umpqua Tribe of Indians
Port Gamble S'Klallam Tribe
NPAIHB
Confederated Tribes of Warm Springs Tribe
Healing Lodge of the 7 Nations
OHSU
Coquille Tribe
Confederated Tribes of the Umatilla Indian Reservation
Seattle Children's Hospital
Skokomish Tribe
Swinomish Tribe
Confederated Tribes of Grand Ronde
Wellpinit IHS Clinic

Injury Prevention Project/Public Health Improvement & Training

Bridget Canniff, Project Director
Luella Azule, Project Coordinator

Conference Calls

- 7/14, 8/11 Conference call: WPIPN (Luella)
- 7/20 Conference call: NCIPC (Luella)
- 8/15 Call with PHAB re: Tribal commentary article for special public health accreditation issue of the Journal of Public Health Management and Practice, due 9/15 (Bridget)
- 8/15 Conference call: TIPCAP grantee call with IHS and external evaluator, UC Denver, CAIANH (Bridget and Luella)
- 8/24, 8/31 Conference calls Tribal Public Health Emergency Preparedness Training Planning Committee (Bridget and Luella)
- 9/13, 9/14 Oregon Tribal Preparedness Coalition meeting with tribes and state agencies at Oregon Health Authority, Portland (Bridget)
- 9/19, 9/26 CDC Public Health Associate Program Supervisor training calls (Bridget)

Meetings/Conferences/Presentations

- 7/6, 11 Injury Prevention Newsletter Meetings (Tam, Nicole, Ashley, Bridget, Luella)
- 8/2, 8/22 Injury Prevention Meetings (Bridget and Luella)
- 8/31 e-MAR meeting with Cayuse Technologies (e-MAR committee, including Bridget)

Trainings/Webinars

- 7/7 Archived Webinar: The Federal Tribal Trauma Training Workshop Panel 1
- 7/12 Webinar: Prevent Falls
- 7/14 Webinar: Take Control of Your Health: You have the Power to Prevent a Fall
- 8/7 Webinar: Responding to Concerning Posts on Social Media (Luella)
- 8/9 Archived Webinar: Safe States Understanding Your Role in Injury and Violence Prevention Policy (Luella)
- 8/10 Webinar NCOA Fall Prevention (Luella)
- 9/26 Webinar: IHS Child Passenger Data (Luella)
- 9/27 Webinar: Hot Topics Big Date, Big Headache? How Non-statisticians Can Approach and Use Date for Performance Management (Luella)

Funding

- 8/3 Submission of CDC Component B application for Building Public Health Infrastructure in Tribal Communities to Accelerate Disease Prevention and Health Promotion in Indian Country (Bridget) – Not awarded (notified 8/29)
- 8/4 Submission of CDC Component A application for Building Public Health Infrastructure in Tribal Communities to Accelerate Disease Prevention and Health Promotion in Indian Country (Victoria and Bridget) – Awarded (notified 8/25)
- 8/23 Tribal Public Health Emergency Preparedness Training updated contract signed and submitted to WA DOH
- Assist Stephanie Craig Rushing, Colbie Coughlan, and Tara Fox with preparation and editing of DVPI application, submitted 8/30

Technical Assistance

July

- **IHS Headquarters:** respond to Nancy Bill's Fall prevention e-mail (Luella)
- **IHS:** provide link to NPAIHB Health News and Notes Injury Prevention special issue to Nancy Bill (headquarters), Matthew Ellis (IHS PAO), and Emily Harkness (evaluator)

Core Activities/Other (Bridget)

August

- 8/28 CDC Public Health Associate Program (PHAP) match confirmed – Taylor Ellis will be assigned to NPAIHB as a PHAP from October 2, 2017 through September 30, 2019 (Bridget)
- Compile and submit NPAIHB talking points to Joe Finkbonner for CDC Tribal Advisory Committee Northwest representative, Travis Brockie, on 8/7, for TAC meeting on 8/8-8/9
- Provide language on NPAIHB's Public Health Training Center subcontract with NWCPHP to Laura Platero on 8/31, for inclusion in letter to Sen. Merkley, in preparation for 9/1 meeting w/ Sen. Merkley's staff

September

- Draft commentary on tribal public health accreditation impact for inclusion in spring special issue of Journal of Public Health Management and Practice, edited by Public Health Accreditation Board
- Request from Northwest Center for Public Health Practice to serve on Equity Advisory Committee for the SHARE-NW project, funded by the Office of Minority Health

Email Outreach to Tribal IP contacts, and/or CPS techs, coalition committee

July
NOFO for Infrastructure for Rebuilding America (INFRA) grant information, Fall Prevention Webinar, Level 2 Intermediate Injury Prevention training, NSC Distracted Driving White Paper, NHTSA Save a Life (Heatstroke information)

August: Fire Arm Tragedy Prevention meeting (Tribal IP contacts), The Ultimate Car Seat Guide from Safe Kids Worldwide (CPS techs),

September: View Thunderclap – Child Passenger Buckle Kids Right, TSM – Vehicle Theft Prevention, Innovative Approaches to School based Suicide Prevention to Colbie, NCOA Facebook page— Preventing Falls: Tips for Older Adults and Caregivers, Taking a Stand Against Older Adult Falls

Medical Epidemiologist

Thomas Weiser, Epidemiologist (IHS)

Projects:
*Teaching: Summer Institute
*Hepatitis C
*Immunization Program-routine immunization monitoring
*IRB
*Children with Disabilities
*EIS Supervision
*Adult Composite Measure Project

Travel/Training:
NPAIHB quarterly board meeting, April 17-19 2017, Ocean Shores, WA
American Indian Health Commission (AIHC), May 17, 2017, Tumwater, WA
CSTE annual meeting, Boise, ID, June 5-7, 2017

Opportunities:
*IRB met in May and June and reviewed 2 new protocols, approved 8 protocol revision submissions, 6 publications/presentations, and approved 6 annual renewals.
*Immunization Coordinator's Calls-April, May and June. Among the topics discussed were: Flu updates, data reporting, discussion of current mumps outbreak in WA, updates from the field. Also met with AIHC Tribal Immunizations Workgroup and MCH workgroup.
*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.
*Children With Disabilities project: New code from Larry Lane will be tested. Also planning a new analysis with OR Medicaid data.
*Met with WA DOH and AIHC of WA to discuss new linkage projects such as the Communicable Disease linkage with WA DOH.

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

Clinic Duty:
Chemawa/March10, 2017
Chemawa/May 12, 2017

Projects:
*Opioid Epidemic
*Hepatitis C
*Immunization Program-routine immunization monitoring
*IRB
*Children with Disabilities
*EIS Supervision
*Adult Composite Measure Project
*MCH Assessment

Travel/Training:
*NPAIHB quarterly board meeting, July 18-19 2017, Canyonville, OR
*Warm Springs IHS Clinic, August 19-23, 2017

Opportunities:
*IRB met in July, August and September and reviewed 6 new protocols, approved 11 protocol revision submissions, 3 publications/presentations, and approved 1 annual renewal.
*Immunization Coordinator's Calls-July, August and September. Among the topics discussed were: Flu updates, data reporting, quarterly reports. Data exchange monitoring – to know if RPMS is exchanging with State.
*EIS Surveillance Project-Continued work on revising Hep C manuscript, on-call duty with State, new field investigation of possible cluster of CJD and completing work on Epi-Aid report.
*Children With Disabilities project: Met with Molly in September to discuss additional analysis.
*Opioid Epidemic: Completed report opioid-related visits and patients in EDM data, submitted to Dr. Rudd and Joe Finkbonner.
*MCH Assessment: Met with team to review final draft of manuscript.
*Summer intern, Karuna Tirumala completed drafting an abstract on contraceptive use and this was submitted to IRB and to the Indigenous Women's Health Conference. We are awaiting a more complete data set to include NHW patients for making comparisons that we would like to publish.

Publications:
*Manuscripts (Adult Immunization Composite Measure) sent to authors for local and Tribal approval. Fort Hall approved, Phoenix Indian Medical Center (PIMC) requested some further information/revision. Great Plains Area Indian Institutional Review Board (GPAIRB) is still reviewing.

Clinic Duty:
Chemawa/September 5, 9 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)
Ashley Swetzof, Intern

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 mini grantees continued to utilize the electronic platform, Native CARS Atlas to provide access what we know about improving child passenger safety, along with accessing tons of interactive tools that can help them create change within their own tribal community. Tribes have continued to work with their child passenger safety coalitions, recruiting members, holding meetings and planning activities. Some tribes collected vehicle observation data while others conducted focus group. Intervention activities selected by Tribes include 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. Tribes have reported on the implementation of these activities and their specific tasks on their timelines. Most notable this quarter included the completion of certification of child passenger safety technicians, distribution of car seats, car seat clinics and Child Passenger Safety trainings.

Back at the office Native CARS staff has keep the Native CARS Atlas updated and responded to individual sites requests. Native CARS have continued to make presentation at regional venues, such as the National Native Health Research Initiative Conference, 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
- Meeting with Tribal Site Coordinators
- Native CARS Mini-Grant Teleconference Calls – July – Sept
- NNHRI Conference, Denver, CO, September
- NIH Community Engage Research Mtg, WA DC, Sept

Program Support or Technical Assistance

- Communication with Jeff Nye/Julia Hammond regarding Atlas Revisions, July - Sept
- Meeting coordination, minutes and action item documentation, July - Sept
- Follow-up communication with mini grant sites, July – Sept
- Intervention Evaluation Review, July
- Atlas Module Revisions, April - June
- Media templates for Native CARS Atlas – Removing Tribal specific info for templates, July
- Final analyses – Change over time, intervention v. control, pre/post intervention risk factors, July – Sept
- Module 4 Feedback, July
- Resource page update for Atlas on Media section, July
- Data entry of Yakima Child Safety Seat Observation data, July - Aug
- Outcome paper & CBPR paper writing, July -Aug
- Research intervention plans and qualitative themes for each Native CARS tribe for CBPR Paper, July - Aug
- Native CARS Atlas presentation preparations for presentations at NNHRI Conference, Sept
- Began collection of Quarterly Updates via Phone Calls with Native CARS Sites, Sept
- OPHA Poster Presentation preparations, Sept
- Data Collection Tool Testing and Feedback, Aug
- Revised Health Data Literacy Course and Reviewed with Monika for Native CARS Section, Aug

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

This quarter the TOTS2Tweens Study and its partners focused on preparations for the qualitative phase of the study as well as preparing for one additional TOTS2Tweens Dental Screening. This quarter TOTS2Tweens collected qualitative interview at one partner site. Study team also began preparing for the next screenings to be held in Fall 2017 and worked as cleaning and conducting a preliminary analysis of quantitative data collected to date. The study also submitted an IRB qualitative phase modification and a renewal and progress report reporting on the last year of activities and its plan for this year.

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

Meetings - Conference Calls – Presentations – Trainings

- Continuation Mtgs, July - Sept
- Dental Examiner conference call, Sept
- Intern meetings, July - Sept
- Project Meetings – Every Wednesday
- Site specific meetings, July – Sept
- T2T analyses Mtg with Gerardo and Jodi, Sept

Program Support or Technical Assistance

- Meeting coordination, minutes and action item documentation, July - Sept
- KAB/Dental Form Management and Tally, July - Sept
- Preparation for Quinault Dental Screening, July - Sept
- Resubmitted protocol and individual forms and tools for qualitative phase, July
- Preliminary Analysis, July – Aug
- IRB Protocol Modification, July - Aug
- IRB Renewal Progress Report Submission, Sept
- Data Management & Preliminary Analysis, July-Sept
- T2T Data Cleaning and Re-coding review, July
- KAB Data Input, July - Aug
- Lummi Focus Group Preparation, Aug - Sept
- T2T Data Cleaning and Re-coding review for Nez Perce and Lummi, Aug - Sept
- Renewed NIH Human Subjects Training Certification, Aug
- Prepare slides and talking points for NNHRI, Sept
- Draft and submit NIMHD Carryover Request budget and Forms, Sept
- Set up travel, July – Sept
- Manage budget, order supplies, construct contracts and submit purchase orders, July - Sept
- Elicitation Interview Questionnaire review, September
- Edit invitation letter for Providers, Sept
- KAB/Dental Screening and Elicitation Interview follow-up for Shoshone-Bannock, Sept
- Drafted Annual NARCH meeting presentation, Sept

No. of Requests Responded to for Technical Assistance, including the following: Data Requests to Tribal and Urban Organizations, Communities or AI/AN Individuals
How many requested: 8
How Many NW Tribe Specific: 8
Phone Call Assisting with: 7 (Warm Springs, Swinomish, Yakima, Cheyenne Nation, Coeur d'Alene)
How Many Responded To: 7

No. of Tribal Epidemiology Center-Sponsored Trainings and Technical Assistance Events Provided to Build Tribal Public Health Capacity
Number of project trainings: 0
Training Titles: N/A
Number of individuals in attendance: N/A

SITE VISITS

- Yakima: Met with Regina Brown for Native CARS Atlas Observation data and subsequent analyses for Excel input, July
- Lummi Nation – TOTS to Tweens Elicitation Interviews – 9/6, 9/7, 9/8

Project Contact Information

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Tom Becker, Co-PI
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Northwest Native American Research Center for Health (NARCH)

Tom Becker, PI
Victoria Warren-Mears, Director
Tom Weiser, Medical Epidemiologist
Tanya Firemoon, Coordinator
Jacqueline Left Hand Bull

This report covers activities primarily related to NARCH 7 and 9.

The Summer Research Training Institute planning ended in July, and we welcomed 104 tribal guests from around the country to our summer training at the Board. Our last effort was the 14th such effort sponsored by the Board, with input from OHSU faculty and staff, as well as a host of consultants. We were successful in filling up our course instructors in just a few weeks prior to this reporting period—Ms. Zaback did a masterful job at getting the advertisements around the country. During the program, Ms. Firemoon 'ran the show' and stayed on top of many details. As earlier reported, we have implemented a new course this year, in tribal health care systems, under the guidance of Linda Frizzell, PhD. We continue to hire tribal instructors whenever possible.

Also under NARCH funding, we recruited additional fellows and hope to a support a larger group of Board-based scholars who will receive small scholarships to help advance their careers in Indian health. Our scholarship program continues to graduate new researchers, and seems to be very successful overall. We expect 5 or 6 American Indian or Alaska Native graduates this year. We have this past month added three new fellows who will receive partial or full scholarships…two MPH students (Navajo and Chickasaw) and two PhD students (Spencer and Brown). 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 8th funding cycle for NARCH has been awarded and is progressing as we expected. We have sent in our non-competing renewal request this past month for both of our Narch grants. We expect additional applicants if funding allows. We have also been awarded Narch 9 funding related to cancer prevention research training, and to asthma management in tribal children. Our funding stream continues to grow, and our current grants represent multiple millions in federal grant dollars directed toward Indian health.

Tam Lutz will attend the NARCH directors' meeting in Washington DC in three weeks. She will present on the history of the NARCH program in the Northwest. Apparently we are the 'poster child' for success in the national NARCH program and we hope to retain that distinction as we move forward in the next cycle of funding.

Northwest Tribal Comprehensive Cancer Control Project

Kerri Lopez, Director
Eric Vinson, Project Specialist
Antoinette Aguirre, Cancer Prevention Coordinator

Training/Site Visits/Technical Assistance

- QBM Youth Leadership Workshop – Cow Creek
    - 35 youth
    - Traditional foods/Native fitness games track
        - 14 youth and 6 adults
- Share resources and training opportunities with Oregon Tribal TPEP coordinators regularly
- Cow Creek – Follow-up information for BRFSS analysis
- Colville – information on activities in Portland for family support
- Klamath – Kiki logistics for community events
- Siletz – youth program site visit
    - Discussion of traditional policy
    - Youth marketing, resources and information
- Burns Paiute: Sent over sample Youth center commercial tobacco and/or nicotine delivery system use policy per request. Wants to work on improving 25ft rule that's already in place. Really wants to focus on enforcement of policy.
- NARA: Sent over tobacco materials per request: tobacco 101 PowerPoint for the substance abuse coordinators meeting and electronic copy of the binder from the Tribal Tobacco Cessation Training (Pharmacology, motivational interviewing, patient resources, example paperwork, module 1-5 from More Than 5A's)
- Grand Ronde: Sent over community readiness survey for Smoke Free Tribal housing on survey monkey per request for their End of Summer Tribal Housing BBQ event

Special projects

- Discussion of work plan and budget modifications
    - Working with CDC project officer
    - Revised work plan scope to reflect 35% reduction in budget – challenging and disappointing
- Completed Project Report to closeout 2012-17 funding period
- Poster presentation on AI./AN cancer survivorship

    - Creation and revision of diagram representing cancer care and Indian healthcare systems
- BRFSS Tribe 7
    - Multiple phone calls in revision process
    - Revise and review questionnaire
    - Computer CAPI entry
- BRFSS 6
    - Data cleaning
    - Preliminary analysis
    - More work to do
- BRFSS Tribe 5
    - Complete questionnaire
    - Protocol complete
    - Working IRB modification
    - Computer CAPI entry
- American Cancer Society – complete
    - Sole source contract for Colorectal Cancer Summit
    - Submitted to ACS leadership team for final approval
- Preparation for CRC focused Northwest Tribal Cancer Coalition meeting
    - Confirmation of hotel space and reservation of rooms for week of April 23rd
- Oral Contraceptives and Breast Cancer Risk
    - Contacted OHSU and received report on possible formulations that may increase breast cancer risk
    - NPAIHB intern looking at Oregon Medicaid data for types of Oral Contraceptives prescribed for AI/AN women
- Oregon CCO information
    - Treatment facilities available through Care Oregon
- Updated Tribal Youth Tobacco 101 PowerPoint
- Updated Tribal Youth Tobacco mini quiz and answer key
- Oregon HPV screening committee meeting
    - New web site and project management for workgroup
- Policy Toolkit workgroup
    - Draft toolkit
- Native Fitness XIV
    - Completed with 172 participants
    - Follow-up travel paperwork for trainers
- Smoking and chronic pain article – waiting for more information from Author regarding evidence to support conclusions
- Patient Reported Outcomes
    - Contacted primary author regarding integration into clinic EHR
- Screening for Psychosocial Distress Training Program
    - Distributed to Tribal Cancer Center and Tribal Cancer Navigators
- Information on Palliative care work in Portland Area sent to National IHS Elder Care initiative director for Spirit of EAGLES presentation

- Correspondence and analysis of 2017-22 tribal comprehensive grant funding
    - 30%-50% cuts in funding
- Assistance gathering Letters of support for EpiCenter grant application

Meetings/Conferences

- Portland Area Dental Meeting
    - Participated at dental conference
    - Presentation of setting up tobacco cessation protocol in your dental clinic
    - Effects of cigarette smoke, smokeless tobacco and HPV for dentists
    - Tobacco data – state, regional and local
    - Tribes shared what they are doing – and that they need to do something
    - Several clinical are doing tobacco cessation referral
        - Umatilla, NARA doing integrated programs
        - Grande Ronde wants to strengthen
- Cancer Education meeting
    - Presentation of poster on AI/AN Cancer Survivorship
- CDC Grantees meeting in Atlanta
    - Presentation on partnerships at coalition workshop training
- All Staff Meeting (3)
- Project Directors Meeting (3)
- NW Tribal Epi Center Meeting (2)
- Oregon Health Authority
    - Contract discussion
    - Upcoming contractors meeting planning
- NTCCP Team Meeting
- BRFSS Project Meeting
- On Boarding
- WeRNative Wellness Wednesday Meeting
- NNACOE Tribal Engagement Team Kick-off Meeting
- Oregon Colorectal Cancer Coalition Meeting

Conference / Webinar calls

- Cancer Education meeting – planning committee conference call
- American Association for Cancer Education Board conference call
- CDC program directors call
- CDC Tribal programs call
- American Association of Physicists in Medicine – Health IT workgroup call (2)
- Webinar: August Hot Topics

  - prevention specialist are using art and media projects to address marijuana-related health disparities and support health equity
- Webinar: Electronic Patient-Reported Outcomes: Why They Matter
- DCPC Tribal Bi-Monthly

Northwest Tribal Dental Support Center

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

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.

- NTDSC staff and consultants, in conjunction with the Portland Area Dental Consultant, have provided 15 site visits this fiscal year, the most of any previous fiscal year. Two hours of CDE were provided during five of the site visits. NTDSC has far exceeded their objective of providing 6-8 site visits this fiscal year.

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

- The work with ARCORA (The Foundation of Delta Dental of Washington), formerly known as the Washington Dental Service Foundation, on our Baby Teeth Matter Initiative (BTM) has continued. There was a BTM meeting in August. An additional four dental programs have asked to join this initiative during the coming year. Groundwork has also been laid for an Elder Initiative in collaboration with ARCORA and several Portland Area dental programs have asked to participate. A course will be offered in November which will focus on treating elderly patients and dealing with dental fears.

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

- NTDSC Prevention Consultant serves as the Portland Area dental representative on the national HP/DP 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 past year. Results are now available.

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. We hosted our yearly meeting in August 2017 which offered 17.5 hours of continuing dental education to participants. NTDSC provided a total of 28.5 hours of CDE this fiscal year to 223 participants, exceeding this grant objective.

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
Email: IdeaNW@npaihb.org

Current status of data linkage, analysis, and partnership activities

Northwest Tribal Registry (NTR) data linkages

- Linked with four Washington State Communicable Disease databases – General Communicable Diseases, Hepatitis B, Hepatitis C, Tuberculosis

Data Analysis Projects

- Tribal Health Profiles (THP) project
    - Completed second draft of Washington cardiovascular disease profile and sent to Washington State DOH partners for their review. Currently awaiting feedback.
    - WA Diabetes profile
        - Created InDesign document for diabetes profile
        - Began pulling prevalence and risk factor statistics from Washington Department of Health report
        - Used CHARS data to create charts and graphs for diabetes hospitalization rates and diagnoses
        - Began running numbers for diabetes mortality indicators
- Cancer Registry Data and Cancer Fact Sheets
    - Received analytic file from Cancer Data Registry of Idaho (data years 1992-2015)
    - Gynecological Cancers Analysis
        - Obtained data from Cancer Data Registry of Idaho and Oregon State Cancer Registry to conduct analysis
        - Working on final confidentiality agreement to obtain additional variables from the Washington State Cancer Registry
- Death certificate Data
    - No updates
- Birth certificate data
    - No updates
- Substance Abuse Analysis

    - Continued analysis and writing manuscript on opioid overdose deaths among Washington AI/AN
- Hospital discharge data
    - No updates
- Environmental Health Project
    - Sent Environmental Health Priorities survey to contacts at 9 Oregon Tribes
    - Compiled and submitted documents to support Great Lakes InterTribal Epidemiology Center's application to continue CDC finding for this project
- Maternal and Child Health Projects
    - Completed 23 interviews with 29 leaders and MCH professionals from Northwest Tribes.
    - Alyssa developed a qualitative codebook, and analyzed interviews with thematic analysis. Monika reviewed and also coded selected interviews, finding similar themes and adding additional codes to the analysis.
    - Alyssa compiled themes into an MCH Guiding Framework document that identifies priority issues and suggestions for future directions that the EpiCenter can take to support MCH among Northwest Tribes. The MCH workgroup and interviewees reviewed the document and provided feedback.
    - Monika and Alyssa, and members of the MCH Work Group attended the Future Generations Collaborative (FGC) Meeting, and discussed the MCH Framework, and the potential for sharing the information at the FGC Summit in September.
    - Sujata, Alyssa, and Monika developed a timeline to review with the MCH workgroup that includes next steps and action items for the EpiCenter, such as establishing a MCH Quarterly Call and disseminating the MCH Guiding Framework.
    - Monika took over coordination of the MCH Workgroup, and is working with members to finalize the framework
    - Alyssa prepared and presented slides describing the MCH Framework and key findings at the FGC Summit in Portland, OR on September 29, 2017

Data requests/Technical assistance

- Re-ran data on hospitalizations for falls among AI/AN and NHW for Bridget Canniff, created figures and developed text, reviewed draft of newsletter article
- Provided data on suicide deaths in Oregon to Monica Yellow Hawk (Klamath Tribes) for a SAMHSA Zero Suicide grant
- Sent February 2016 write-up on prescription overdose/opioid deaths & hospitalizations to Jessica Leston (for OMH grant application) and Tom Weiser (to provide to Dr. Rudd for a regional HHS update)
- Sent Ann Donovan (Suquamish Tribe) copies of cancer profile and 2010 health care plan report; asked for clarification regarding data request
- Sent Megan Hoopes SAS code for coding cancer data according to SEER standards
- Sent Birdie W. information on secondary data sources available for ID, OR, and WA
- Prepared and sent letter of support to Washington Department of Health's HIV program for grant application
- Provided updated data for resolution and letters of support for NPAIHB's DVPI grant application
    - Sent information and templates for data sharing agreements to Terry Mail (Colville Tribes)
    - Had conference call and sent follow up documents to staff at California Tribal Epidemiology Center re: record linkages
    - Sent Karol Dixon (Port Gamble S'Klallam Tribe) slides with background information on drug overdose/opioid epidemic among Northwest AI/AN for use in NIHB presentation

- Pulled Washington BRFSS data and ran updated mortality numbers on substance abuse/overdoses and mental health for AI/AN in Washington for Jamie Donatuto at Swinomish Tribe
- Sent information (separately) to Sheryl Lowe (Washington DOH tribal liaison) and Justin Iwasaki (Lummi Nation) on availability of data from NWTEC on opioid overdoses

Trainings Provided to Tribes/Tribal Programs

- SAMHSA Grantee Tribal Talking Circle
    - Prepared slides and provided 20 minute presentation on sources of data for substance abuse indicators
- 2017 Health Data Literacy Training in Spokane
    - Assisted with planning, outreach, and coordination for training held in September in Spokane
    - Updated slides and curriculum, and presented during training

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

- Sent written clarification to WSIRB about our use of CHARS and death record data and compliance with confidentiality agreement; received acknowledgement from WSIRB
- Submitted continuation application and progress report for the IDEA-NW project protocol to the Portland Area IHS IRB; received approval on 7/24
- Provided edits to revised data use agreement for Orpheus (Oregon Communicable Disease) linkages
- Reviewed and provided edits to data sharing agreement with Washington Health Care Authority for Medicaid linkages
- Renewed data use agreement for Oregon Medicaid linkages through August 2018

Grant Administration and Reporting

- Submitted OMH Year 5 Quarter 4 progress report
- CDC Tribal Public Health Infrastructure Grant
    - Ran updated leading cause of death numbers for ID, OR, and WA – sent Victoria tables and text
    - Sent Victoria paragraph describing burden of unintentional injuries
    - Reviewed and made edits to Project Narrative
    - Received Notice of Award and began revisions to budget and workplan
- Began work on timeline, planning, and research strategy for NIH Suicide Grant

Collaborations with other programs and other activities

- Monika continued work with WeRNative to help produce informational "Wellness Wednesday" videos/blogs on nutrition, exercise and culture
- Quality Improvement Workgroup (Sujata)
    - Attended Quality Improvement Training on 7/13
    - Worked on developing project screening questions and project charter worksheets to evaluate new QI projects
- Assisted with Nike Native Fitness (Monika)
- Worked with Soyeon Lippman and Amanda Morse (WA DOH) to organize "tour" of Washington's RHINO/ESSENCE syndromic surveillance data system for NPAIHB
- Sent Eric Vinson updates for NTCCP annual report
- Assisted with planning, coordination, set up and break down for Indian Day (Monika)

Data dissemination

- Submitted article on cardiovascular disease burden among Washington AI/AN for October Health News & Notes
- Alyssa submitted an abstract describing the process and findings from the MCH Framework for the Indigenous Women's Health Conference in Albuquerque, NM in March 2018

Travel

Linkages

- Washington Communicable Diseases (General Communicable Diseases, Tuberculosis, and Hepatitis B datasets) (Shoreline, WA) 7/25-26
- Washington Hepatitis C Linkage (Shoreline, WA) 8/14-16

Site visits

- NPAIHB/CRIHB Joint Quarterly Board Meeting, Cow Creek 7/18-20

Meetings, Trainings, and Conferences

- Health Data Literacy Course (Kalispel Tribe, Spokane, WA) 9/5-7

Other Meetings, Calls and Trainings

- Tribal Environmental Health call w/ GLITEC 7/12
- Call with David Shih (EIS officer at Oregon Public Health Division) re: linkage software 7/14
- Call with Washington Health Care Authority to discuss and clarify data request for Medicaid linkage 7/24
- Epicenter Project Director's meeting 7/27
- Health Data Literacy Workshop planning meetings 7/28, 8/4, 8/17, 8/24
- Call with Amanda Bruegl re: Gynecologic Cancers analysis 7/31
- Alyssa completed SAS Programming 1 Essentials Training 7/25
- Planning calls re: Tribal Talking Circle presentation 8/1, 8/23
- Call with GSEP coordinator 8/1
- RHINO Tour 8/10
- Meeting w/ Joe re: opioid data 8/17
- Call with WA DOH re: HIV grant 8/17
- Call with Karol Dixon re: opioid data 8/29
- SAMHSA Tribal Talking Circle Training 8/31
- SAS II Programming (Alyssa) Online self-paced
- Transition plan for MCH projects (Alyssa & Monika) 9/1
- Check in with Charlotte Kent re: MMWR manuscript 9/20
- QI Workgroup Meeting 9/20
- Meeting re: NIH Suicide Grant 9/22
- Indian Day Celebration in the Square 9/22
- Call with WSIRB re: gynecologic cancers project 9/25
- Call with CTEC re: data linkages 9/25
- Call with CDC re: 1704 Infrastructure grant 9/26
- Tribal Environmental Health Project conference call 9/26
- EpiCenter Project Directors Meeting 9/27
- Call with Alyssa re: FGC Summit presentation 9/27

- First Generations Collaborative Summit 9/29
- MCH Workgroup Meetings Ongoing, Bi-monthly

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

- Cow Creek Tribe, Canyonville, OR – July 17-20
- Klamath Tribes, Klamath Falls, OR – July 19-20
- Swinomish Tribe, La Connor, WA – September 26

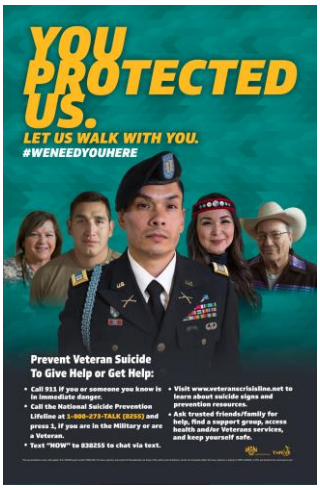
Out of Area Site Visits

- UNITY Conference, Denver, CO – July 8-11
- IHS Behavioral Health Conference, Tulsa, OK – August 14-17
- MSPI Grantee Meeting, Tulsa, OK – August 15
- National Action Alliance for Suicide Prevention AI/AN Task Force Committee meeting, Tulsa, OK – August 15
- Booth and presentation, Window Rock, AZ – September 5-10
- Zero Suicide (ZS) Tribal Academy, Albuquerque, NM – September 6-9
- ZS Faculty training, Washington D.C, – September 24-26

Technical Assistance & Training

During the quarter, project staff:

- Participated in 70 meetings and conference calls with program partners.
- Disseminated 109 boxes of the three suicide prevention campaigns for AI/ANs.
- The Native Veterans suicide prevention campaign, ***You Protected Us. Let Us Walk With You*** has been disseminated! Materials were mailed out for World Suicide Prevention Day on September 10. This Veteran campaign will be launched again before Veteran's Day on November 11.
- The 3 Lived Experience videos for Native Veteran's have been finalized and will be up on the NPAIHB website in October.



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

- Presentations (7)– Presented on the LGBTQ2S Rack Card to SAMHSA GLS Grantees on the Virtual Program Showcase, 30+ virtual attendees; presented the We Are Connected/LBGTQ2S campaigns at the UNITY Conference and Native Youth Communications boot camp, 110 youth, Denver, CO; Presented on the Concerning Post on Social Media webinar training, 75 participants at the IHS Behavioral Health Conference, Tulsa, OK; presented on 3 elements of Zero Suicide (ZS) at the ZS Tribal Academy, 80 participants, Albuquerque, NM; Adolescent health and Suicide Prevention resource presentation for Navajo Nation fair, 1,000+ attendees, Window Rock, AZ; Suicide Prevention presentation for Swinomish Suicide Prevention Youth Summit, 60 attendees, La Conner, WA and; THRIVE resources presentation for Swinomish Suicide Prevention Summit Adult Track, 5 attendees, La Conner, WA.
- Facilitation/Training (3) – facilitated a youth track at the NPAIHB/CRIHB Joint Quarterly Board Meeting, 42 youth participants, Canyonville, OR; hosted an Intro. to Zero Suicide training with Dr. Ursula Whiteside for the Klamath Tribes, 8 attendees, Klamath Falls, OR and; ASIST workshop for NARA Northwest, 20 participants, Portland, OR.
- Booth (1) – Indian Health Service Behavioral Health Conference, 400+ total attendees, Tulsa, OK

During the quarter, the THRIVE project responded to over 170 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 (including the new Veteran materials) are available on the web. Materials include: posters, informational rack and tip cards, t-shirts, radio PSAs, and Lived Experience videos. The Veteran Lived Experience videos will be available sometime in October.

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

- Suicide = 3 posts, 0 text, 32,017 people reached
    - #WeNeedYouHere Campaign = 1 posts, 5,900 people reached

Other Administrative Responsibilities

Staff Meetings

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

Publications

- Submitted three articles for the July NPAIHB Quarterly News & Notes, topics included:
    - The template for the *13 Reasons Why* miniseries informational letter to parents
    - An article on the social marketing media campaigns THRIVE has developed and information about reducing access to lethal means and firearm safety
    - An article around Trauma Informed Care and the Adverse Childhood Experience Survey (ACES) informational training THRIVE hosted along with the Oregon Pediatric Society in May 2017

Reports/Grants

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

Administrative Duties

- Budget tracking and maintenance: Ongoing.

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

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

Victoria Warren-Mears, Principal Investigator
Nanette Yandell, Project Director and Epidemiologist
Jenine Dankovchik, Evaluation Project Specialist
Nora Frank, Health Educator
Ryan Sealy, Tobacco Project Specialist
Birdie Wermy, National Evaluation Specialist

Meetings

Internal Meetings

- 05-Jul-17 WEAVE check-in (workplan)
- 06-Jul-17 Youth Leadership Workshop Planning Meeting
- 12-Jul-17 WEAVE check in (workplan)
- 12-Jul-17 Art Committee
- 12-Jul-17 Final Youth Workshop Planning Meeting
- 18-Jul-17 Tobacco meeting
- 25-Jul-17 Tobacco project check-in
- 26-Jul-17 Introduction of new employee
- 26-Jul-17 WEAVE check in (workplan)
- 28-Jul-17 Planning for upcoming HDL/Applications workshop
- 04-Aug-17 Health Data Lit Workshop Planning
- 16-Aug-17 WEAVE website design
- 17-Aug-17 Health Data Lit Workshop Planning
- 17-Aug-17 WEAVE gathering planning meeting
- 24-Aug-17 Health Data Lit Workshop Planning
- 19-Sep-17 policy considerations
- 20-Sep-17 Presentation Preparation
- 27-Sep-17 PSE call check-in
- 28-Sep-17 Art Committee

Meetings with Sub-Awardees

- 02-Aug-17 Planning call with Tashina for Presentation

Meetings with Funding Agency

- 06-Jul-17 GHWIC All Hands Quarterly Echo Session
- 20-Jul-17 GHWIC C2 Echo Call
- 23-Aug-17 Monthly C2 Call with CDC
- 21-Sep-17 GHWIC quarterly evaluation call
- 27-Sep-17 GHWIC C2 ECHO call

Meetings with Non-Tribal community orgs

- 03-Aug-17 WEAVE Gathering Planning Call with Elise

Meetings with other government partners

- 10-Jul-17 Behavioral Health Tribal Consultation Meeting with OHA
- 13-Jul-17 WEAVE policy tool kit
- 23-Aug-17 OHA Behavioral Health Collaborative Tribal Consultation Meeting

Meetings with Tribal Communities

- 02-Aug-17 Tribal Food Sovereignty Coalition Call

Other types of meetings

- 04-Aug-17 Future Generations Collaborative Meeting
- 07-Aug-17 Endocrinology ECHO

Summary of Meetings by Type

Internal:	19
Conference/committee:	0
Tribal Community:	1
Funding Agency:	5
Sub-Awardee:	1
Community (non-tribal):	1
Government Partner:	3
Other:	2
Total Meetings:	*32*

Site Visits

Date(s)	Tribe	Short Summary
07/17/17 - 07/20/17	Cow Creek Tribe	Quarterly Board Meeting
08/10/17	Swinomish Tribe	Site Visit with Swinomish
08/23/17	Klamath Tribe	Site Visit to Klamath Tribe

Total number of site visits this quarter: 3

Presentations

Date Given: 9/27/2017 **Type:** Tribal Meeting Presentation
Title: Program Sustainability
Presented at: GHWIC Component 2 ECHO session
Location:

Date Given: 9/27/2017 **Type:** Tribal Meeting Presentation
Title: Policy Toolkit for Tribal Communities
Presented at: National Indian Health Board
Location: Bellevue Washington

Total number of presentations given this quarter: 2

Professional Development

Date	Title
07/06/17	Introduction to ATLAS.ti
09/25/17 - 07/28/15	National Indian Health Board Conference
09/01/17 - 09/30/17	Test of activities

Total number of professional development activities this quarter: 3

Technical Assistance Given

Analysis of Tribe's own data

• 8/7/2017	Lummi	Conducted analysis of Lummi tribal youth tobacco

Grant writing

• 7/20/2017	NPAIHB	Assisted Bridget in writing evaluation section of CDC grant application
• 8/3/2017	NPAIHB program	Helped Bridget with writing evaluation section of grant application

Policy development

• 9/13/2017	Lummi	Editing Lummi Tobacco Survey

Report writing

• 9/21/2017	Lummi	Discussed youth tobacco report with Kathy Charles to clarify methodology and revisions she would like.

Sharing Resources (general)

• 7/7/2017	GHWIC Tribes	Tribal Digest & Resources
• 7/12/2017	Squaxin Island	Sujata was approached by Romy Mohelsky from ANTHC requesting a copy of our health data literacy curriculum which we shared with her
• 7/28/2017	GHWIC Tribes	Tribal Digest & Resources
• 8/4/2017	GHWIC C1 & C2 Tribes	Tribal Digest & Resources
• 8/11/2017	GHWIC C1 & C2 tribes	Tribal Digest and Resources
• 8/18/2017	GHWIC C1 & C2 Tribes	Tribal Digest & Resources
• 9/13/2017	Albuquerque Area Indian Health Board	Provided templates for RFA, budget, invoice, and surveys to Daytona
• 9/19/2017	California Rural Indian Health Board	Connected Tiffany Ta at CRIHB with Sujata to give guidance on conducting data linkage

Survey design & implementation

• 8/4/2017	Klamath	Assisted with creating a survey to evaluate the stop the pop campaign

Summary of Technical Assistance by Topic and Type

Types of TA given

One-off analysis of our data for Tribe: 0
Provided data report: 0
Provided fact sheet: 0
Analysis of Tribe's own data: 1
Guidance to analyze their own data: 0
Interpretation of analysis results: 0
Grant writing: 2
Report writing: 1
Evaluation planning: 0
Survey design and implementation: 1
RPMS/EHR support: 0
Focus group planning and implementation: 0

Topic areas covered

Heart disease/stroke: 5
Obesity: 5
Diabetes: 5
Tobacco: 8
Nutrition: 5
Policy, Systems and Environment Change: 8
Physical Activity: 5
Data use: 3
Evaluation: 3

Policy development: 1
Health education: 0
Sharing Resources (general): 8
Other: 0

Total number of times TA was given: *14*

Trainings

In-Person

- 7/18/2017 Youth Leadership Workshop- Traditional Foods & Fitness
- 8/30/2017 Nike Native Fitness
- 9/6/2017 Health Data Literacy & Community Health Applications

Webinar

- 7/25/2017 Health Systems Webinar

Total number of trainings given this quarter: 4

Western Tribal Diabetes Project

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

Trainings / Site Visit

- Diabetes Management System Training
  - NPAIHB; Two NW tribes, Albuquerque Area
- Cow Creek – youth leadership summit
  - 35 youth from CA, OR, WA, tribes
  - Youth marketing, digital storytelling, suicide prevention, leadership
- Cow creek
  - Participated in Cancer Prevention Poker walk
- Siletz – youth program site visit
  - Discussion of traditional policy
  - Youth marketing, resources and information
- Portland Area Dental Meeting
  - Participated at dental conference
  - Presentation of setting up tobacco cessation protocol in your dental clinic
  - Effects of cigarette smoke, smokeless tobacco and hpv for dentists
  - Several clinical are doing tobacco cessation referral
  - Umatilla, NARA doing integrated programs
  - Grande Ronde wants to strengthen
- NARA – follow up for tobacco resources
  - Additional tobacco curriculums, second wind training information

Technical Assistance

- Albuquerque Area; ta requesting help with combining two separate search logics into one. TA how to utilize KONG via QMAN
- Consolidated Tribal Health Project, sent Doris Sloan the Audit Logic Descriptions from our Shortcut & Reference Manual
- Ft. Berthold Diabetes Program, Aberdeen Area; ta finding taxonomies in register; ta to run a meds list report and found the Logic codes were missing in RPMS. Added codes to recover A1C.
- Ft. Berthold Diabetes Program, Aberdeen Area; ta to find A1C's over 11. Suggested using QMAN to find all patients with A1C over 11 in the past year.
- Lower Elwha; TA for lab work not communicating with EHR and RPMS. Finding that their server does not recognize certain codes when filling prescriptions. Suggested looking into taxonomies along with how the Pharmacist spells out prescription name.
- Lower Elwha; ta with providers not being recognized in EHR and DMS register. Have never done this, ta about creating a Taxonomy for provider and seemed to work in finding certain prescriptions.
- Makah; requesting TA, searching for youth with names, insurance, and ethnicity. Suggested a QMAN search to create template, then using PGEN to follow up with insurance.
- Pueblo of Isleta Health Center; requesting TA for QMAN search regarding patients over 64 living with diabetes. Emailed step by step process.
- Quinault, (2) ta regarding finding nail care in QMAN, sent the file for nail care codes; TA for QMAN search; How many patients have had foot care?; How many patients have had Dilated Eye exams? Gave TA on both questions, ta requesting help within the comments section in PM screen
- Web audit ta for Albuquerque data specialist
- Web Audit Meeting with ADC's

Special projects

- Native Fitness 14 – Nike world headquarters
    - 170 participants
    - From 65 SDPI programs and tribal fitness centers across the nation
    - 22 work shop sessions
    - Edited NF XIV booklet
    - Created name tags for Native Fitness
    - Created 163 resource flash drives for Native Fitness
- NF preparation
    - Final list – name tags, ES list
    - USB resource data, information
    - Final invoice -
- Volunteer meeting for NF assignments
    - Registration assignments

    - Workshop assignment
    - Early registration
- Finalized Nike Logistics
    - Meeting with Kaman, Lisette, and Kurt
- Diabetes in Indian Country Conference; Albuquerque 3 staff attended
    - Attended all plenary and multiple workshops
    - Speaker bios and presentations submitted
    - Presented on Health status report with community leaders, RPMS/DMS usage (what does out data mean), RPMS/DMS practical usage, Beyond RPMS (non RPMS packages),
    - Attended PAO regional SDPI meeting
    - Staffed WeRNative's booth on September 19
    - Created Adobe Connect sessions for presentation practice run
    - Attended the Native Play training
- October QBM Newsletter
- Helped TOTS biostatistician combine two histogram charts in Excel (it couldn't be done in STATA or SASS)
- Finished the Health Status Report for Northwest Tribes
- Met with Portland Area ADC
    - Finalize presentation for NF
    - NF SDPI update presentation
    - Presentation on sugar sweetened beverages
    - Developed presentation for IHS Dental meeting
- Diabetes Conference Data Workgroup meeting
- Completed invoice for training to Great Plains Area
- Created the HSR Trends report using Portland Area Audit data, and the HSR Comparison

Meetings/Conferences

- NPAIHB All Meeting (3)
- Project Directors Meeting (3)
- Wellness meeting (3)
- Tribal Epicenter director meeting (2)
- Portland Area SDPI Steering Committee Meeting
- Staff Retreat committee meeting
- On Boarding (2)
- NNACOE Team Meeting (2)
    - Partner update, IRB submission, contract set up
    - Assignment for dissemination plan of project
- Helped WeRNative promote their Wellness Wednesday
    - Created Chair-aerobics exercise
- Attended NPAIHB/CRIHB quarterly board meeting

    - Tribal health directors meeting, youth summit, cancer prevention, community dinner, clinic tour
- Met with Portland Area ADC
    - Discussion of NF – Scott Robison key note
    - NF SDPI update presentation
    - Upcoming national SDPI conference
- NCO
    - Zenger farms
- Finalized Youth Track - QBM
- Wellness meeting
- Finalized Newsletter for July QBM

Conference Calls:

- iCare: Office Hours - eLearning
- National diabetes data workgroup
- Diabetes in Indian Country planning committee conference call
- ADC web audit call
- National diabetes data workgroup
- Diabetes in Indian Country planning committee conference call
- ADC web audit call

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PORT GAMBLE S'KLALLAM TRIBE

TRIBAL UPDATE

NPAIHB QBM

OCTOBER 11, 2017

PGST HEALTH SERVICES

Only Indian Health Care provider in Kitsap County, Washington

Primary Care & Urgent Care, Outpatient

- FT Family Medicine, FT PA, .2 FTE Pediatrician
- 4 RNs, 1 LPN, 5 CHRs, 4 MAs

Dental

- 2+ Dentists, 1 Dental Hygienist, 4 Dental Assistants
- Discussions for DHAT, now and training

User Pop: 1695

PGST WELLNESS

Currently part of Children & Family Services
Substance abuse & mental health counseling
15 FTEs: 5 MH, 4 CD, MA, transport, office manager
Group & individual counseling
Suicide prevention
MAT

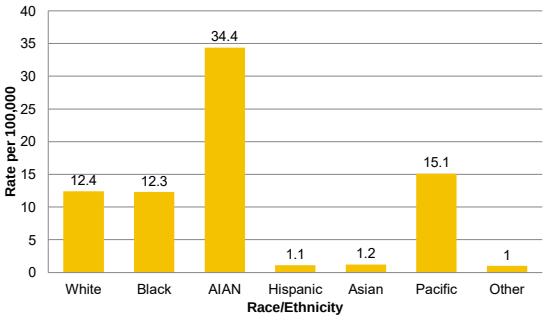
BEHAVIORAL HEALTH INTEGRATION

Active effort

- 98% Wellness pts are PC
- Tribal Council support
- Qualis PALs – state Medicaid Transformation
- Joint Business & Finance Office
- Cross training medical assistants
- Vision/Strategic planning session
- LCSW in primary care clinic

Opioid work as an example

Rates of Opioid Overdose Deaths by Race/Ethnicity, WA State 2011-2015



Source: WA DOH Death Certificates
Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3 or T40.4

STATE & REGIONAL DATA

2015 Drug Injector Survey

- 22% overdosed in past 12 months
- 52% witnessed overdose in past 12 months
- 47% said they or someone else had called 911
- 46% carry naloxone
- 50% hooked on rx opiates prior to heroin
- 51% interested in getting help to cut down or quit but only 2 people in treatment (in our county)

http://adai.uw.edu/pubs/infobriefs/2015druginjectorhealthsurvey.pdf

1036 Valid Responses Statewide (WA)

QUICK DETOUR

OPIATES OR OPIOIDS?

Opiate refers to natural substances that come from opium.

Opium poppy

- Morphine
- Codeine

Opioids are medicines/drugs that bind to the same receptors as opiates, but do not occur naturally.

Semi-synthetic opioids

- oxycodone & hydrocodone

Synthetic opioids

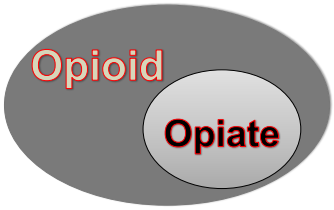
- fentanyl & methadone

CHEMICAL COUSINS

Morphine
Codeine
Thebaine
→ Opiates

Diacetylmorphine (Heroin)
Hydrocodone (Vicodin)
Oxycodone (Oxycontin)
Oxymorphone (Opana)
Hydromorphone (Dilaudid)
Tramadol
→ Semi-synthetic opioids

Fentanyl
Methadone
→ Synthetic opioids



Opioid: natural, synthetic, or semi-synthetic substances

Opiate: naturally occurring substances within the opioid class

OPIOID SUMMIT

Opioid Summit: 3-County Coordinated Response

January 30, 2016
Discuss results from assessment and planning phase
Move from planning to action

2 Opioid Plans: Review WA State Plan & 3-County

14+ PGST tribal council & staff attended

Continue to be involved

- Olympic Community of Health
- Medicaid Demonstration
- Project plans, weekly calls

2017 WASHINGTON STATE INTERAGENCY OPIOID WORKING PLAN

Priority Goals	Goal 1: Prevent opioid misuse and abuse	Goal 2: Treat opioid dependence	Goal 3: Prevent deaths from overdose	Goal 4: Use data to monitor and evaluate
Priority Actions	Improve prescribing practices	Expand access to treatment	Distribute naloxone to people who use heroin	Optimize and expand data sources

http://www.doh.wa.gov/YouandYourFamily/PoisoningandDrugOverdose/OpioidMisuseandOverdosePrevention

OUR RESPONSE

How to make this meaningful for PGST?

Executive Director called f/u opioid meeting

Tribal council members, police department, wellness staff, chief medical officer, youth workers and more

Reviewed state and county plan and adopted our own Tribal Healing Opioid Response (THOR)

THE PLAN

Goal 1: Prevent Opioid Misuse and Abuse	Lead Department	Partner Department
1A: Promote best practices for prescribing	Health	Wellness, CHR
1B: Raise awareness of risks including overdose; reduce stigma	Wellness	Re-entry, Court, Health
1C: Prevent opioid misuse in communities, particularly with youth	Chi-e-chee, Youth, Education	Wellness, Health
1D: Promote safe storage and disposal of prescription medicine	Health	Police
1E: Decrease the supply of illegal opioids	Police	Court

Goal 2: Expand Access to Opioid Use Disorder (OUD) Treatment	Lead Department	Partner Department
2A: Expand capacity of health providers to recognize signs of opioid misuse	Health, Wellness	Police
2B: Increase access to & utilization of best practices OUD treatment in communities	Wellness	Health, Reentry
2C: Increase access to & utilization of best practices OUD treatment in the criminal justice system	Reentry	Wellness, Police
2D: Increase capacity of syringe exchange programs to provide overdose prevention training including naloxone and to engage clients in supportive services	Health	Wellness
2E: Reduce withdrawal symptoms in newborns	Children & Family	Health, Wellness, ECE, Chi-e-chee

Goal 3: Prevent deaths from overdose	Lead Department	Partner Department
3A: Educate community to know how to recognize and respond appropriately to an overdose	Chi-e-chee	Human Resources, Wellness, Health
3B: Increase availability of overdose reversal medication naloxone	Health	Police, Wellness, Natural Resources

THE WORK

PREVENTING DIVERSION

Drug take back

- Secure box in lobby of tribal government building
- Police pick up

Medication lock box

- In coordination with health services

COMMUNITY ENGAGEMENT

General Council

- March 2017

Opioid Town Hall

- December 2016
- October 12, 2017

MEDICATION ASSISTED TREATMENT

Staffing: 2 MDs, 1 ARNP, supported by MA

Suboxone & Vivitrol

Program Structure

- Counseling, individual and group
- Random call backs

CHRONIC PAIN MANAGEMENT

Opioids don't work

- Tachyphylaxis: rapidly diminishing response
- Hyperalgesia: abnormally heightened sensitivity to pain

Opioid Pain Agreement

Patients think opioids work, already dependent

Education, leadership, patients, THOR…

Dramatic decrease in rx

- 18% decrease one year, 75% seven years
- Multiple reasons, further evaluation needed

HARM REDUCTION

Narcan

- Tribal Code: Good Samaritan provision
- Police, NR, patients, every home
- Standing Orders, Policy
- Unexpected delay – account set up

Needle Exchange

- Successful
- Message: exchange, not supply

SUCCESS

Examples abound

- Transition to MAT
- Non-opioid treatment only
  - Exercise, mental health, non-opioid meds, etc.
- PRN opioids only
- Decreased dosage

Prevention is better

- Surgeon General's Report on Alcohol, Drugs, and Health

YOUTH PREVENTION

Youth Services

Serves K-12 grades and young adults

Monday-Saturday

6 staff

Support groups, culture, recreation, leadership, outings, mentoring, etc.

YOUTH PREVENTION ACTIVITIES

Tae Kwon Do
Fitness Initiatives
Hiking
Basketball
T-ball
Skate Camps
Prevention weekend
Red ribbon week
Youth Prevention Summit
Youth Leadership Group
Youth Annual Honoring
Youth Employment workshop
College trips

Thrive conference
Youth & Elder Socials
Cultural classes;
Beading
Cedar/wool weaving
Cooking traditional fish
Archery
Regalia making
Canoe journey
Pow-wow's
Autism Acceptance Walk
Child abuse Prevention Walk
Places of Importance

COMMUNITY PREVENTION

CHI-E-CHEE

(Klallam word for "the workers")

Vision

Committed to working together to provide a safe, healthy Tribal community with bright futures for our youth and future generations.

Mission

The mission of the Port Gamble S'Klallam Tribe's Chi-e-chee is to promote healthy families through the elimination of alcohol, tobacco and other drug abuse in the Port Gamble S'Klallam community, in accordance with the Tribe's culture, values, and traditions.

Executive Director suggested Chi-e-chee as lead group for THOR

10/11/2017
Port Gamble S'Klallam Tribe
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ONGOING PROCESS

Monthly Tribal wide meetings

Review progress, update plan

1. Discuss what are we doing
2. What do we want to do?
3. How much does it cost?
4. Who is on point?

Appointed a lead staff person to THOR

THOR Logo

Next: community engagement, town hall, funding

10/11/2017
Port Gamble S'Klallam Tribe
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FUNDING & COLLABORATION

Right thing to do

Significant cost & commitment

Leadership

Collaborations with other departments

FIND FUNDING

10/11/2017
Port Gamble S'Klallam Tribe
30

TRIBAL SPECIFIC DATA & EVALUATION

Tribal Specific Data Pull

- Needle exchange, opioid dependence, rx

Requested technical assistance

- NPAIHB Epi Center
- Kitsap County
- Olympic Community of Health

Evaluation

- How will we know it is working?
- What do we measure?

Jeffrey Veregge

Art // Design // Mischief

Port Gamble S'Klallam Tribe
Artist & Designer
jeffreyveregge@gmail.com
www.jeffreyveregge.com
360-516-0406

AVAILABLE RESOURCES & LINKS

1. **THOR plan**
2. **THOR Community Handout (July 2017)**
3. **Opioid Pain Agreement (draft)**
4. **Narcan Standing Orders**
5. **Narcan Training Guide**
6. **PGST Good Samaritan code**
7. **Helpful Links:**
   - https://aims.uw.edu/
   - https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf

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PORT GAMBLE S'KLALLAM TRIBE

THANK YOU!

Karol Dixon
Health Services Director
360-620-4378
karold@pgst.nsn.us



Tulalip Health System

JIM STEINRUCK, HEALTH ADMINISTRATOR

NPAIHB QUARTERLY BOARD MEETING – OCTOBER 10-12, 2017 – YAKAMA NATION

1

Tulalip Health System

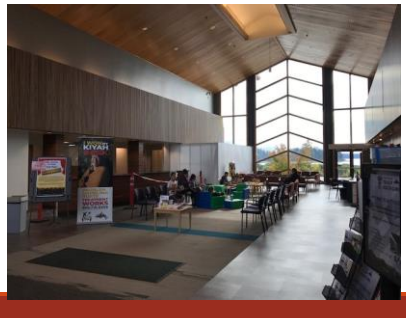
- THS Development
- Integration of Services

2

Tulalip Health System

- THS Development
- Integration of Services
- Clinic Remodel
- Whole Person Care
- "Mind, Body and Spirit"

3



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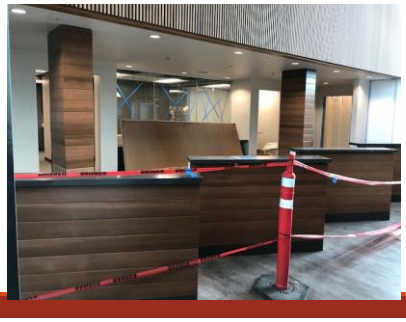

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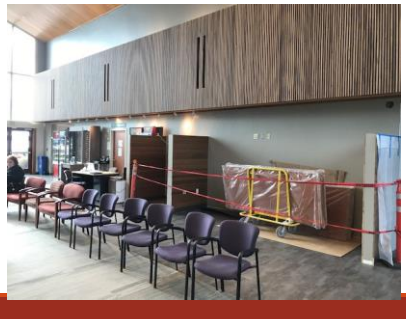

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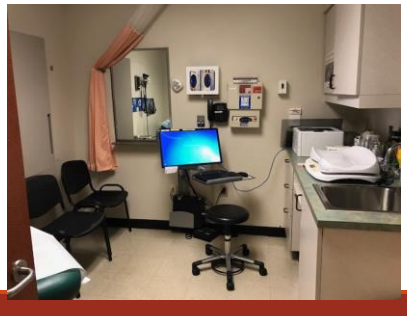

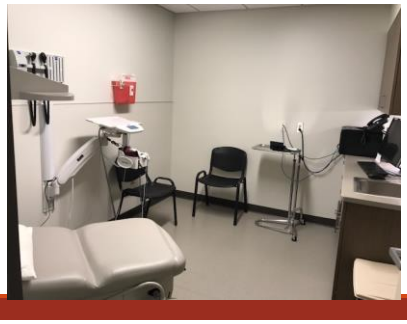

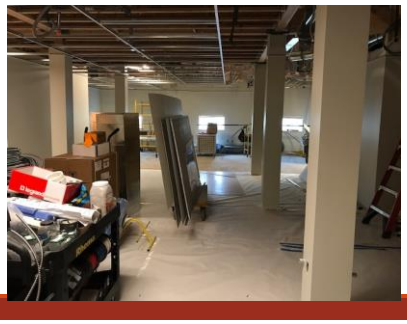

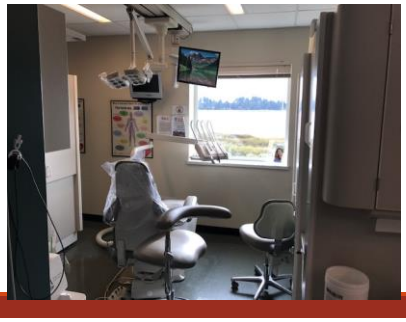

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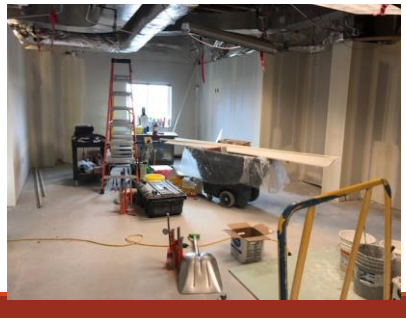

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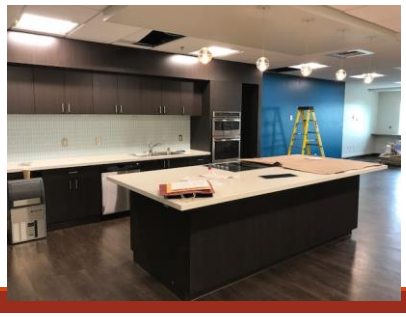

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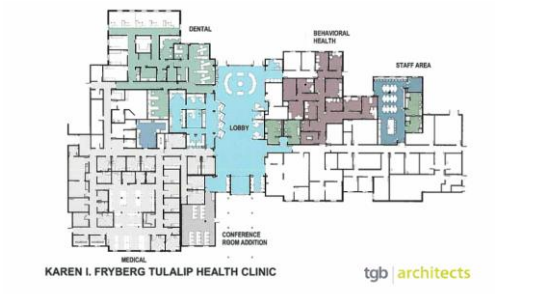

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Tulalip Health System

THS Development

Integration of Services

Clinic Remodel

Whole Person Care

"Mind, Body and Spirit"

Expansion of Community & Public Health Services and Relocation

14

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Tulalip Health System

- THS Development
  - Integration of Services
- Clinic Remodel
  - Whole Person Care
  - "Mind, Body and Spirit"
- Expansion of Community & Public Health Services and Relocation
- "Wrap Around Care"
  - Comm/Public Health, Tribal Hospital Liaison, PRMCE , Comm. Nursing

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Tulalip Health System

- THS Development
  - Integration of Services
- Clinic Remodel
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  - "Mind, Body and Spirit"
- Expansion of Community & Public Health Services and Relocation
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  - Comm/Public Health, Tribal Hospital Liaison, PRMCE
  - Comm. Nursing
- Consolidated Healthcare Transport System

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Tulalip Health System

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  - Comm. Nursing
- Consolidated Healthcare Transport System
- Revamping the way we recruit "healthcare team members"

18

Tulalip Health System

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- Expansion of Community & Public Health Services and Relocation
- "Wrap Around Care" Comm/Public Health, Tribal Hospital Liaison, PRMCE Comm. Nursing
- Consolidated Healthcare Transport System
- Revamping the way we recruit "healthcare team members"
- AAAHC Accreditation "Journey" (12-24 month process)

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- AAAHC Accreditation "Journey" (12-24 month process)
- Customer, Provider and Staff Engagement Program (PRMCE contract assistance) Re-branding

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Tulalip Health System

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- Expansion of Community & Public Health Services and Relocation
- "Wrap Around Care" Comm/Public Health, Tribal Hospital Liaison, PRMCE Comm. Nursing
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- Revamping the way we recruit "healthcare team members"
- AAAHC Accreditation "Journey" (12-24 month process)
- Customer, Provider and Staff Engagement Program (PRMCE contract assistance) Re-Branding
- Major Services Provided

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Major Services Provided

Medical (Acute and Scheduled Care)	WIC
Dental	Nutrition (RD)
Lab	Diabetes Care
Clinical Pharmacists	Wisdom Warrior (CDSM)
Imaging/Diagnostics	Behavioral Health and Recovery (Kids→Elders)
Complimentary Health	Community/Public Health
Vision Services	

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Tulalip Health System

THS Development Integration of Services	Clinic Remodel Whole Person Care "Mind, Body and Spirit"	Expansion of Community & Public Health Services and Relocation	"Wrap Around Care" Comm/Public Health, Tribal Hospital Liaison, PRMCE Comm. Nursing	Consolidated Healthcare Transport System
Revamping the way we recruit "healthcare team members"	AAAHC Accreditation "Journey" (12-24 month process)	Customer, Provider and Staff Engagement Program (PRMCE contract assistance) Re-Branding	Major Services Provided	Recruitment of Clinical Specialists to physically practice in our clinic

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Register Now for Our Fall Conferences!

"Steering Toward Success: Achieving Value in Whole-Person Care" is a free, one-day conference designed to help primary care practices, behavioral health providers and interested stakeholders who are transitioning to whole-person care. **Be sure to register soon – the Tacoma venue is almost full but space is still available at our October 26 conference in Moses Lake!**

- Best Western Plus Lake Front Hotel, Moses Lake October 26, 2017
- Hotel Murano Tacoma, September 25, 2017

Don't miss this opportunity to learn best practice strategies and the latest information on practice transformation including value-based care, and physical and behavioral health integration from some of the State's leading experts. CME credit is available!

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CHAIRMAN'S REPORT
OCTOBER 2017

I attended several meetings this quarter:

On August 9th and 10th, I attended the Portland Area FAAB meeting in Seattle, Washington.

On August 15th, I attended the IHS behavioral health listening session; then on the 16th, I attended the IHS Contract Support Costs workgroup meeting in Tulsa, Oklahoma. At the listening session I talked about the importance of programs like We R Native for our youth. Since the CSC policy was finalized, the workgroup reviewed the CSC worksheets, implementation of the CSC policy, and discussed CSC appropriations for FY 2018.

On August 30th and 31st, I attended the Nike Native Fitness event at Nike Headquarters in Beaverton. This is a great partnership and fun event.

On September 18th through 21st, I attended the ATNI annual meeting in Spokane, Washington. I had the opportunity to take the PULS Cardiac

Test while I was at the conference. This test detects a person's risk for a heart attack because even healthy people with good cholesterol levels may be at risk.

On September 25th through the 28th, I attended the NIHB Tribal Health Conference in Bellevue, Washington. The conference was well attended with over 600 people in attendance. There were some good speakers in the plenary sessions like Mark Trahant and Gov. Jay Inslee. Chairman Cladoosby from Swinomish talked about their new Opioid treatment center and asked IHS employees to stand and make a commitment to incorporate DHATs into the IHS system.

Elders Committee

Tuesday October 10, 2017
Legends Casino – Hotel, Toppenish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Twila Teeman	Burns Paiute	
2	Patty Kinswa-Gaiser	Cowlitz Tribe	Pattygaiser@gmail.com
3	Dan Gleason	CHEHalis	DDAN 360-789-1014
4	Luella Azule	NPAIHB-YAKAMA	lazule@npaihb.org
5	Andy Joseph Jr.	Coluille	andyjoseph@coluilletribes.com
6	Clorice Charley	NPAIHB Staff	
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Elder Committee Meeting Minutes

October 10, 2017

Legends Casino and Hotel

Toppenish, WA

Members: Patty Kinswa – Gaiser, Cowlitz Tribe, Janice Clements-Warm Springs Tribe, Twila Teeman – Burns Paiute Tribe, Louella Azule – Confederated Tribes of The Umatilla Indian Reservation/NPAIHB staff, Andy Joseph – Colville Tribe, Dan Gleason – Chehalis Tribe

NPAIHB Staff: Clarice Charging

Dan opened the meeting with a prayer.

Dan asked for a motion to approve October 2017 minutes. Patty motioned. Andy seconded. Motion approved.

Updates:

Burns Paiute: Elders and youth are working together on their language project. Elders meet twice a month and recently traveled to Fort Bidwell, Nevada for their Indian Day celebration that honored Indian boarding school elders.

Colville: Tribal council approved the rest home budget that allows elders to travel on day trips. A gazebo and a barbecue will be built, and tv's and bus for the home will be purchased.

Cowlitz: Elders planted a community garden this spring to distribute vegetables among their members and for their lunches. Elders attended a Mariners game,

travelled to Puyallup Elders for a luncheon and enjoyed time at Ilani Casino. Several elders fished on the Columbia River accompanied by Natural Resource staff members. Elders also traveled to Canada as invited guests of Scowlitz First Nation. Cowlitz elders lunch will be this Friday, October 13th at Saint Mary's Mission in Toledo, Washington. Come join us!

Louella Azule is now part-time at the board and will be the Injury Prevention Coordinator. Louella's Public Health responsibilities have been assumed by Taylor Ellis, CDC appointee, Taylor is assigned to the board for two years.

Chehalis: Elders have had lunch with Puyallup and Tulalip and they are going to Cowlitz this coming Friday. Next week they will visit Nisqually elders. They visited Pikes Place Market in September, and have attended six Mariner base-ball games, sitting in the Chehalis Tribes's box. Medicare staff came and provided information on Medicare and how to sign up and answered any questions. Lunch was served.

Public Health Committee

Tuesday October 10, 2017
Legends Casino – Hotel, Toppenish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Victoria Warren-Mears	NPAIHB-NWTEC	503-416-8614
2	Karen Hansen	Kootenai Tribe	
3	Cindy Harris	Sauk-Suiattle	
4	Keile Little	Coquille Tribe	
5	Jim Steinruck	Tulalip Tribe	
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Public Health Committee Meeting Minutes

October 10th, 2017

In attendance:

Kelle Little, Coquille Tribe

Cindy Harris, Sauk-Suiattle Tribe

Karen Hanson, Kootenai Tribe

Jim Steinruck, Tulalip Tribe

Victoria Warren-Mears, Staff

Discussion focused on Public Health Updates from the Tribes in Attendance:

Coquille is entering into a new collaboration with Coos, Curry and Douglas Counties, along with the Cow Creek Band of Umpquah to work on enhancing immunization rate. Kelle is serving on several public health assessment groups for the state of Oregon.

Sauk-Suiattle Tribe – Cindy has been with the Tribe now for a year and has begun work to refocus direction for public health efforts; their vaccination program is very active and they have initiated a wisdom warriors program, which is assisting with re-vitalization of health efforts.

- Staff referred Cindy to the WEAVE program for additional support of planning and policy efforts.

Karen Hansen reports that her service area has two cases of active Hepatitis C, both of whom are still using. One individual is frequently incarcerated.

- Information regarding the Project ECHO HepC calls was provided to Karen, should it be beneficial and possible to consult to initiate treatment on these patients.

Tulalip Tribe – Public Health Services have been moved to a building which was recently renovated, including WIC services. Jenna Bowman has been hired as the director of public health, she has been actively seeking the input of the community around public health needs/wants.

The Tulalip health system has integrated medical and behavioral health and recovery services

Health Transportation has been initiated under the public health program

Collaborations with the county are being strengthened including sanitation, septic, sewer and water run off issues.

Community Health Nursing is being strengthened, including exploring provider home visits in the post hospitalization period.

The Tulalip clinic is undergoing a renovation.

The Tribe also was the recipient of a small award from NIHB to explore public health accreditation.

Veterans Committee

Tuesday October 10, 2017
Legends Casino – Hotel, Toppenish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	DON HEAD NTDP Specialist	NPAIHB	503-228-4185 dhead@npaihb.org
2	Cindy Harris HSS Director	Sauk-Suiattle	360-436-0131 ext 223
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Veteran's Committee Meeting, Toppenish, October 10, 2017

In attendance:
Cindy Harris, THD Sauk-Suiattle
Karen Hansen, Kootenai
Kelle Little, Coquille
Jim Steinruck, Tulalip
Don Head, NPAIHB , staff

The action items from the April 2017 meeting were read.

On July 12, 2017, the Department of Veteran's Affairs conducted a Round Table discussion in Phoenix, AZ. The main purpose of this Round Table was to discuss the restructuring of reimbursement agreements with IHS and Tribal Health Programs. The restructuring involves moving from an all-inclusive reimbursement rate to a value-based reimbursement rate. This could reduce the payments reimbursed to the tribes for the care delivered to AI/AN veterans. There was another Round Table scheduled for August in Alaska, but this did not occur.

This provides an opportunity to request a Round Table to be conducted in the Portland Area. A letter from the Northwest Portland Area Indian Health Board requesting a Northwest Round Table discussion will be sent to Secretary Birdwell. The proposed Round Table can be combined with the January 2018 Quarterly Board Meeting that is scheduled to be held in Portland, OR, to facilitate tribal involvement.

On July 19, 2017, Terry Bentley, Tribal Government Relations Specialist, presented an update of the VA Office of Tribal Government Relations to the Joint Quarterly Board Meeting . This update covered the top priorities identified by consultation in 2016 and upcoming activities and events.

On October 2, 2017, the Department of the Veteran's Affairs released the 2016 Tribal Consultation Report, 2017. This report is entitled "Honoring Our Heroes: Building Partnerships to Connect Native Veterans to Care and Benefits." The report goes over the three main tribal consultations that occurred in 2016:

- Accreditation by the VA of tribal organizations to better serve AI/AN veterans;
- Top priorities identified by AI/AN veterans;
- The proposal to consolidate non-VA care into a standardized system under the Veteran's Choice program

Action Items
Don Head will work the Board's Health Policy Analyst to draft a letter to Secretary Birdwell, requesting that a Round Table discussion happen in conjunction with the January 2018 Quarterly Board Meeting in Portland, OR.

Behavioral Health Committee

Tuesday October 10, 2017
Legends Casino – Hotel, Toppenish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Caroline M. Cruz	HEHS DM CTWS	caroline.cruz@wstribes.org
2	Daryl Scott	Warm Springs BHC	daryl.scott@wstribes.org
3	Bev Hawks	Spokane Tribe	bhawks@spokanetribe.com
4	Charlotte Williams	Muckleshoot	charlotte.williams@muckleshoot.nsn.us
5	Lisa Guzman	Kalispel Tribe	lguzman@camashealth.com
6	Regina Brown	Yakama Nation MCH	regina.brown@ihs.gov
7	[illegible]	Yakama Nation MCH	faelucei@gmail.com
8	Nicholaus Lewis	Lummi Nation	nicholausL@lummi-nsn.gov
9	KERI ELLIS	LOWER ELWHA	keri.ellis@elwha.org
10	Shawna Gavin	CTUIR	shawnagavin@ctuir.org
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NPAIHB Behavioral Health Committee – Meeting Minutes

Toppenish, WA – October 2017

Participants: Caroline Cruz, Darryl Scott, Bev Hawks, Charlotte Williams, Lisa Guzman, Regina Brown, Nickolaus Lewis, Keri Ellis, Shawna Gavin, Fae Garcia, Stephanie Craig Rushing

- **Introductions**
- **Update on NARA's Youth Treatment Center**
  - NARA is ready for referrals. They have an intake packet.
  - For referrals, contact Cheryl Peterson (971-678-9358): http://www.naranorthwest.org/projects/youth-outpatient-addictions-treatment/
  - Located in Gresham; Open to youth ages 12-18
  - Referrals must go through the Tribe's behavioral health program
  - 18 beds: 9 male, 9 female
  - Funding: IHS, State of OR, and 3rd party billing
  - Not a detox facility.
  - **Action Item**: Invite NARA to the next QBM to present, or schedule a site visit to tour their facility.
- **Adult Inpatient Opportunities**
  - American Addictions Centers – Locations in CA, WA, FL, TX
  - We ended up sending two patients to CA. Both are doing really great. They took our insurance.
  - At NIHB, talked to Mark Le Beau. They are interested in opening a house for AI/ANs.
  - **Question:** Has anyone else used them?
  - **Action Item**: Invite someone from American Addictions Centers to present at the next QBM. Contact: John Keating
- **Acupuncture for Substance Use (Subutox)**
  - Umatilla and Lower Elwha have both offered acupuncture
  - And AAC uses **Color Therapy**
  - **Action Item**: Invite someone to present at the next QBM about holistic treatment services. Ask: Becky Greer or Sandy Sampson

- **We discussed Tribal Best Practices**
    - Oregon mandates use of evidence-based practices for mental health and treatment. So OR Tribes created a repository of Tribal Best Practices.
    - They are updating the policies right now.
    - If other Tribes are interested, we could add them to library; allowing NW Tribes to code for reimbursement. For example:
        - Sweats – Billable in OR (some tribes us a consent form to reduce liability)
        - Baby Boards – Have been shown to reduce SIDS. (though parents need training on the proper procedure)
    - www.HealthyNativeYouth.org could house the Best Practices, if Tribes are interested in adding other treatment/healing practices.
- **Lack of Psychiatrists in the NW**
    - Need more psychiatrists, but didn't discuss possibilities
- **I-LEAD Grant –** We discussed leadership skills/training that we want youth to have before joining the public health workforce. Ideas included:
    - Intergenerational training – for Millennials – for success and interaction in the workplace
    - Do the Meyers-Briggs personality test, to learn about different styles
    - Public speaking = Reading your audience
    - Facilitation skills, practice facilitating a small or large group

Legislative/Resolution Committee

Tuesday October 10, 2017
Legends Casino – Hotel, Toppenish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Christina Peters NBTI Director	NPAIHB	206 324 4364 cpeters@npaihb.org
2	Gerald Hill, MD	Klamath Tribes	gerald-l-hill@quail.com 541 827-7007
3	Karol Dixon	Port Gamble S'Klallam Tribe	360-620-4378 Karold@pgst.nsn.us
4	Greg Abrahamson Tribal Council	Spokane Tribe	509 458-6507 Gregg@Spokanetribe.com
5	Patrick Anderson Health Director	Makah Tribe	patrick.anderson@ihs.gov
6	Andy Joseph J.	Colville Tribe	andy.joseph@colvilletribe.com
7	Julie Reed PRC/CHS MANAGER	SNOQUALMIE TRIBE	425-888-6551 ext. 6237 julie.reed@snoqualmietribe.us
8	Jason Davis Financial Spec. (FSDEA)	IHS	503-414-7795 jason.davis@ihs.gov
9	Sarah Freeman Sullivan Health Policy Consultant	NPAIHB	703-203-6460 SKSullivan16@outlook.com
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Legislative Committee Report
October 10, 2017

Attendees: Andy Joseph, Jr. (Colville), Greg Abrahamson (Spokane), Karol Dixon (Port Gamble Sklallam), Gerald Hill (Klamath Tribe), Patrick Anderson (Macah), Julie Reed (Snoqualmie), Jason Davis (Indian Health Service)

Staff/Other: Sarah Sullivan (Consultant), Christina Peters

Three resolutions were considered by the Legislative Committee:

1. **RFA-MH-18-410: Addressing Suicide Research Gaps: Understanding Mortality Outcomes (R01)**

   This resolution endorses and supports efforts by staff of the EpiCenter, under the guidance of the Executive Director, to pursue funding through the "NIH - Addressing Suicide Research Gaps: Understanding Mortality Outcomes" funding opportunity.

   Action: Committee discussed suggested edits to the resolution. Staff will edit the resolution for consideration by the full Board. A motion was made (Spokane) and second (Snoqualmie) to pass the resolution with edits to the full board for consideration, then unanimous vote occurred approving same.

2. **Support for the Tribal Epidemiology Center (TEC) to Apply with Oregon Health & Science University (OHSU) for NIH Science Education Partnership Award (SEPA) Funding PAR-17-339**

   This resolution supports efforts of staff of the NWTEC in partnership with Oregon Health & Science University, under the direction of the Executive Director, to apply for the NIH SEPA program.

   Action: Committee discussed suggested edits to the resolution. Staff will edit the resolution for consideration by the full Board. A motion was made (Klamath) and second (Colville) to pass the resolution with edits to the full board for consideration, then unanimous vote occurred approving same.

3. **Adverse Childhood Experiences and Toxic Stress**

   Patrick Anderson requested a resolution urging the American Medical Association to adopt a policy statement addressing adverse childhood experiences and toxic stress.

   Action: Staff will draft a resolution for consideration by the full Board

Other:

Christina Peters discussed the process Alaska used to establish a CHAP certification board in Alaska. This process serves as a framework to establish a CHAP certification board in the Portland Area/Northwest. Christina informed the group that the IHS process for CHAP Advisory Board nominations is starting. The NPAIHB staff would like to push

for the Portland Area to be a pilot for the CHAP program in the lower 48. The Board is also looking into partnering with a tribal college to build a training program. Christina opened a discussion on a future decision of how a CHAP Board will be represented from each tribe.

Youth Committee

N. STAR

Tuesday October 10, 2017
Legends Casino – Hotel, Toppenish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Kim Thompson	Shoalwater Bay	kzillyette@shoalwaterbay-nsn.gov
2	Lottie Sam Tribal Council	Yakama Nation	(509) 930-0867/ Lottie_Sam@yakama.com
3	Sharon Stanphill	Cow Creek	(541) 672-8533 SStanphill@cowcreek.com
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Youth Committee Tuesday October 10, 2017
Legends Casino – Toppenish, WA

Attendees

Kim Thompson Shoalwater Bay
Lottie Sam Yakama Nation
Sharon Stanphill Cowcreek
Nanette Star NPAIHB

Talking Points

- July Joint QBM Youth Leadership Workshop
    - Approximately 40 youth attended the Youth Leadership Workshop
    - Overall youth were very excited about the workshop and the opportunity to share what they had worked with all delegates was a great beginning to connect the youth with the Board.
    - January QBM Youth Committee will start discussing the planning options for youth to join the Board in July.
    - 21 respondents to the evaluation: https://www.surveymonkey.com/results/SM-PBYYVYJ88/

- I LEAD new grant opportunity and objectives
    - The Board just got awarded with this collaborative opportunity and will include Youth Ambassadors and a NPAIHB Youth Council to review board resolutions and to provide updates to the board. The details on how this process will work are forthcoming.
    - Youth job shadowing and mentor program will also connect youth with leaders across tribal communities.

Action Items

- Polished report of the Youth Workshop Evaluation to the January QBM (Nanette).
- We R Native will join in the Youth Committee in January
- Email I-LEAD workplan and any information that Board Youth Committee can review or participate in prior to January QBM (Nanette and We R Native)

Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Notes

October 10, 2017

Start Time: 12:00 pm

Members Present: Cassandra Sellards-Reck, Shawna Gavin

Staff Present: Jacqueline Left Hand Bull

- Personnel update was reviewed.
    - _5___ new hires of “on-call” staff
    - _1___ promotions/transfers
    - _1___ temp
    - _1___ resignation at the of the summer by a college student staff
- No open positions; Joe and/or Victoria mentioned earlier in the day that there would be 3 new positions open in the near future.
- Stephanie Craig Rushing has been employed by the NPAIHB for 15 years
- Background checks were conducted for all new staff and the temp.
- There was discussion about the potential need for “suspicion training” although the Program Operations manual describes the Drug Free Workplace policy of the NPAIHB.

Adjourned at 12:35 p.m.

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

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Portland, OR 97201
(503) 228-4185
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www.npaihb.org

Resolution # 18-01-02

Support for the Tribal Epidemiology Center (TEC) to Apply with Oregon Health & Science University (OHSU) for NIH Science Education Partnership Award (SEPA) Funding PAR-17-339

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 (Portland Area Tribes); 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 American Indian/Alaska Native (AI/AN) 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 Patient Protection and Affordable Care Act, Indian Health Care Improvement Act 25 US Code (18) § 1621m, Epidemiology centers states:

a. "Functions of (Tribal Epidemiology Centers or) TECs: In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area—

- make recommendations for the targeting of services needed by the populations served; and
- make recommendations to improve health care delivery systems for Indians and urban Indians;

WHEREAS, there is a lack of AI/AN students entering the health professions as evidenced by 0.7% of medical school admissions being AI/AN students, and an overall decrease of admissions since the 1980s; and

WHEREAS, it is known that a provider–patient concordance in race and ethnicity leads to improved understanding, cultural awareness, and enhanced culturally relevant care; and

WHEREAS, the education of youth in science can positively influence the decision of youth to pursue science and health careers which are of benefit to AI/AN people; and

WHEREAS, the Oregon Health & Science University (OHSU) has a long history of preparing students for medical, nursing, and allied health careers, including *On Track OHSU!*, which is a career-building program for underrepresented minority students, created in 2013 through a directive of OHSU's Provost. The program builds long-term relationships with partner communities and school-to-job pathways for students, with the goal of increasing the number of underrepresented students in Oregon's professional health services and sciences sector. In addition to the Woodburn community and the Jefferson cluster in North Portland, *On Track OHSU!* currently serves The Confederated Tribes of Warm Springs; and

WHEREAS, the Northwest Tribal Epidemiology Center has a 20-year history of leadership in providing epidemiology services and technical assistance to the Portland Area Tribes, and has a multiple year partnership with Oregon Health & Science University in providing Summer Institute Training and health track of the THRIVE conference, among others; and

WHEREAS, OHSU proposes to partner with the Board to expand *On Track OHSU!* and ensure mutually beneficial support of more AI/AN youth to enter science careers.

THEREFORE, BE IT RESOLVED that the Board supports efforts of staff of the NWTEC in partnership with Oregon Health & Science University, under the direction of the Executive Director, to apply for the NIH SEPA program.

CERTIFICATION

NO. 18-01-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 24 **for,** 0 **against,** 0 **abstain on** October 12**, 2017.**

Andrew C. Joseph Jr.

Chairman

October 12, 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
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Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

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RESOLUTION # 18-01-03
RFA-MH-18-410: Addressing Suicide Research Gaps: Understanding Mortality Outcomes (R01)

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 non-governmental "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, 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 NPAIHB's suicide prevention project (*Tribal Health: Reaching out InVolves Everyone* (THRIVE) has worked with tribes and tribal organizations throughout the U.S. for eight years to improve mental health outcomes for AI/AN teens and young adults through improved surveillance and culturally-relevant interventions; and,

WHEREAS, the Improving Data and Enhancing Access-Northwest (IDEA-NW) project has over fifteen years' experience conducting record linkages with vital records, hospitalizations, and other data systems to improve the accuracy and availability of health data for Northwest Tribes;

WHEREAS, American Indian and Alaska Natives are disproportionally impacted by higher rates of suicide, compared to non-Indian people; and

WHEREAS, improved data are needed to understand the behavioral, social, environmental, and healthcare-related factors that put AI/ANs at increased risk for suicide mortality;

WHEREAS, this funding opportunity supports THRIVE's and IDEA-NW's mutual goals to improve collection of suicide-related data in order to guide the development and delivery of culturally-relevant interventions for AI/AN; and

WHEREAS, this funding opportunity will support partnerships between Tribes, tribal organizations, and local and state health departments to build and sustain suicide surveillance efforts;

WHEREAS, the goals of this grant opportunity are consistent with the goals and objectives of the NPAIHB, the NW Tribal EpiCenter, the NW Suicide Prevention Tribal Action Plan, and the NW Adolescent Health Tribal Action Plan; and

THEREFORE, BE IT RESOLVED, that the NPAIHB endorses and supports efforts by staff of the *EpiCenter,* under the guidance of the Executive Director, to pursue funding through the "*NIH - Addressing Suicide Research Gaps: Understanding Mortality Outcomes*" funding opportunity.

CERTIFICATION

NO. 18-01-03

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 24 **for,** 0 **against,** 0 **abstain on** October 12**, 2017.**

Andrew C. Joseph Jr.

Chairman

October 12, 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
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

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RESOLUTION # 18-01-04

Urging the American Medical Association to Adopt a Policy Statement on Adverse Childhood Experiences and Toxic Stress

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 non-governmental "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, historical trauma was perpetrated on American Indian/Alaska Native (AI/AN) people for centuries, leading to a destruction of communities, loss of language and culture, changes in traditional diet and increasing behavioral impacts; and

WHEREAS, adverse childhood experiences, physical and emotional abuse, chronic neglect, caregiver substance abuse and behavioral health challenges, exposure to violence, and/or economic hardship without positive adult relationships, may lead to disproportionate toxic stress over a life span and occurs across generations in tribal communities; and

WHEREAS, toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support; and

WHEREAS, many AI/AN people, and many people in communities across the nation, have had adverse childhood experiences and have experienced disproportionate levels of toxic stress; and

WHEREAS, the potential consequences of toxic stress in early childhood for the pathogenesis of adult disease are considerable; and

WHEREAS, at the behavioral level, there is extensive evidence of a strong link between early adversity and a wide range of health-threatening behaviors; and

WHEREAS, at the biological level, there is growing documentation of the extent to which both the cumulative burden of stress over time and the timing of specific environmental

insults during sensitive developmental periods can create structural and functional disruptions that lead to a wide range of physical and mental illnesses later in adult life; and

WHEREAS, other associations have adopted policy statements to address adverse childhood experiences and toxic stress of patients; and

WHEREAS, a policy statement by the American Medical Association to adopt a more proactive leadership role in educating patients, teachers, policy makers, civic leaders, and the general public about AI/AN adverse childhood experiences and the long-term consequences of toxic stress among AI/AN people and the potential benefits of preventing or reducing sources of significant adversity in early childhood would improve the health of AI/AN people and the health of our tribal communities.

THEREFORE BE IT RESOLVED, that the Board urges the American Medical Association to adopt a policy statement addressing American Indian and Alaska Native adverse childhood experiences and toxic stress in Indian country.

CERTIFICATION

NO. 18-01-04

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 24 **for,** 0 **against,** 0 **abstain on** October 12**, 2017.**

Andrew C. Joseph Jr.

Chairman

October 12, 2017

Date

Gregg J. Abrahamson

Secretary