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SUBMITTED VIA consultation@ihs.gov

August 1, 2018

RADM Michael D. Weahkee,
Acting Director
Indian Health Service
5600 Fishers Lane, Mail Stop: 08E86
Rockville, MD 20857
ATTN: IHS Behavioral Health Funding

RE: Tribal consultation on the funding mechanism to distribute behavioral health initiatives that are currently distributed through grants

Dear Acting Director Weahkee:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I submit the following comments on the funding mechanism to distribute behavioral health initiatives currently distributed through grants, in response to IHS Dear Tribal Leader Letter (DTLL), dated May 18, 2018. Established in 1972, the NPAIHB is a non-profit, Tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, representing the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on health care issues. In the Portland Area, 75% of the total IHS funding is compacted or contracted and includes 6 federally operated service units, 16 Title I Tribes, 26 Title V Tribes, 3 urban facilities, and 3 treatment centers. NPAIHB works closely with the IHS Portland Area Office, operating a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center.[1] NPAIHB appreciates the opportunity to provide comments to IHS on the funding mechanism to distribute critical behavioral health initiative funds.

BACKGROUND

In the ongoing effort to meet behavioral health challenges in Indian Country, there is also a trend toward tribal management and delivery of behavioral health services in American Indian and Alaska Native (AI/AN) communities. Northwest Tribes have been at the forefront of contracting or compacting via the Indian Self Determination and Education Assistance Act (ISDEAA), Public Law

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.l. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; 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."

93-638, to provide services directly to their citizens. Currently, more than 50 percent of the mental health programs and more than 90 percent of the alcohol and substance abuse programs are Tribally operated. This evolution in behavioral health care delivery and management is changing the face of behavioral health services in Indian Country. Where IHS was previously the principal behavioral health care delivery system for AI/AN people, there is now a less centralized and more diverse network of care provided by IHS, tribal, and urban Indian health programs (I/T/Us).

The documented connections between behavioral health issues and chronic diseases underscore the need for holistic and integrated solutions. Finding solutions will require sustained collaboration between Indian health programs and policymaking bodies, as well as a willingness to thoughtfully engage in deep issues such as historical and intergenerational trauma and cultural renewal, and a readiness to include entire communities in healing work. The importance of integrated perspectives that include cultural and traditional practices and community-wide healing and wellness must not be underestimated.

The Consolidated Appropriations Act of 2018 encourages IHS to provide behavioral health grant funding through contracts and compacts authorized by ISDEAA rather than through grant instruments to ensure that Contract Support Costs (CSC) are available. The behavioral health initiatives funding includes the Substance Abuse and Suicide Prevention (SASP) Program, also known as the Methamphetamine and Suicide Prevention Initiative (MSPI), the Domestic Violence Prevention Initiative (DVPI), and the Zero Suicide Initiative (ZSI).

Currently, the total funding amount appropriated for all IHS behavioral health initiatives nationally is $59.2 million. Of this total amount, the IHS funds approximately $51.9 million through grants and federal awards that includes $5.9 million for urban Indian organizations. The remaining $7.3 million supports IHS national management.

Substance Abuse and Suicide Prevention (SASP) Program (a/k/a MSPI)

The SASP (a/k/a MSPI) funding opportunity provides culturally appropriate prevention and early intervention strategies aimed at reducing suicide and substance use and misuse among AI/AN youth up to age 24. Funded projects work to implement evidence-based, practice-based, and emerging practices to build resiliency, foster positive development, and promote family engagement.

There are 175 federal, tribal and urban projects funded in four purpose areas for the FY 2015 to FY 2020 funding cycle. The four purpose areas have been established to help funded projects with: (1) community and organizational needs assessment and strategic planning; (2) suicide prevention, intervention, and postvention; (3) methamphetamine prevention, treatment, and aftercare; and (4) Generation Indigenous (Gen-I) initiative support. Sixteen of the 175 projects funded for the FY 2015 to FY 2020 funding cycle were awarded to the IHS Portland Area which represents $1,658,647, or 6%, of total funding ($27,972,274) for these initiatives.

NPAIHB receives funding under MSPI Purpose Area 2 to conduct regional suicide prevention trainings and technical assistance. NPAIHB also receives MSPI Purpose Area 4 funding to host four annual Generation Indigenous Social Marketing Bootcamps, which generate youth-led media campaigns to prevent youth suicide. As a part of the Generation Indigenous

(Gen-I) initiative, NPAIHB works with AI/AN youth from across the U.S. on leadership skills, social marketing, and health activism. The workshops are 2 full days with a focus to engage and educate participants about youth-driven social marketing campaigns designed to prevent youth suicide and substance abuse and promote cultural identity and resilience. NPAIHB Tribal Health: Reaching Out Involves Everyone (THRIVE) staff provide technical assistance to tribes interested in implementing suicide screening and evidence-based suicide care within their healthcare system. THRIVE staff respond to field training requests for ASIST, QPR, AMSR, SafeTALK, etc.; send prevention materials; compile crisis protocols and/or adapt them to circulate protocol templates; and provide travel scholarships or stipends for tribal events. THRIVE staff also provide technical assistance to Northwest Tribes to improve their ability to track, prevent, and treat suicide.

Domestic Violence Prevention Initiative (DVPI)

The Domestic Violence Prevention Initiative (DVPI) is a congressionally mandated, nationally coordinated grant and federal award program for tribes, tribal organizations, federally operated programs, and urban Indian organizations providing violence prevention and treatment services. The DVPI promotes the development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to domestic and sexual violence from a community-driven context. The DVPI expands outreach and increases awareness by funding projects that provide victim advocacy, intervention, case coordination, policy development, community response teams, sexual assault examiner programs, and community and school education programs. The DVPI is comprised of 83 projects funded through two purpose areas for a five-year funding cycle from FY 2015 to FY 2020. The IHS Portland Area received $609,712, or 5%, of $12,967,278 for FY 2018 DVPI Tribal Grants and Program Awards.

NPAIHB receives DVPI funding to provide technical assistance to Northwest Tribes to improve their ability to carry out crisis intervention, counseling, advocacy, behavioral health, or case management services. Technical assistance includes dissemination of campaign and educational materials in addition to identifying curricula or activities tribes can use to increase awareness or improve the prevention of domestic and sexual violence.

Zero Suicide Initiative (ZSI)

The Zero Suicide Initiative (ZSI) Program model is a comprehensive approach to suicide care which aims to reduce the risk of suicide for all individuals seen in health care systems. The ZSI program is funded nationally at $3,600,000 with a three-year funding cycle from FY 2017 to FY 2020. The IHS Portland Area does not receive any ZSI funding, thus, nor does NPAIHB.

RECOMMENDATIONS FOR FY 2018 TO FY 2022

Generally, NPAIHB recommends that IHS hold all current grantees harmless from any behavioral health initiative funding mechanism changes that IHS may consider as a result of this tribal consultation and opposes any decrease in funding for current grantees in order to redistribute funds.

NPAIHB also makes these specific recommendations:

Funding Mechanism

NPAIHB recommends that current grantees continue to receive funds they have been awarded. Current grantees should also have the option to transfer their behavioral health initiative grant funds to ISDEAA contracts or funding agreements. This option will provide current grantees the authority to choose the funding mechanism to receive their behavioral health initiative funding for the remaining period of their grant cycle. Tribes are sovereign nations with inherent authority to govern and protect the health, safety, and welfare of tribal citizens, and are in the best position to understand the behavioral health needs and priorities of their communities. Tribes have developed successful and innovative behavioral health initiatives that could be implemented in ISDEAA contracts and compacts. ISDEAA contracting and compacting affords tribes the most flexibility to tailor health care services to the need of their communities. Under this authority, tribal capacity expands, knowledge and recognition of local issues increases, and greater community engagement results in the ability to meet local needs.

In addition, transferring the grants to ISDEAA contracts and compacts will allow current grantees to receive CSC funding to assist in covering administrative costs associated with managing these behavioral health programs. This is consistent with the Congressional intent to maximize tribal resources available for the delivery of health care programs. The current funding mechanism for behavioral health initiatives prevents tribes from collecting the full costs of administering the program, thereby reducing direct services. Additionally, this option will avert the need to continually apply for grants and alleviate burdensome and duplicative reporting requirements by relying instead on accreditation, audit, and other evaluation procedures that tribes and tribal organizations already have in place.

NPAIHB further recommends that IHS remove the reporting requirements for funding transferred through Title V funding agreements because reporting requirements cannot be included unless there are statutory requirements. Upon transfer of the funds from grants to other Title V agreements IHS should withdraw any additional requirements other than those provided in ISDEAA or subsequent legislation.

Lastly, NPAIHB recommends that for Title I direct service tribal facilities that the grants be awarded through a non-competitive streamlined and simplified grant process.

Distribution Methodology and Funding Formula

NPAIHB recommends that IHS continue to utilize the national distribution methodology used as a standard to allocate funds to all twelve IHS Areas so that the funds can promptly be allocated into funding agreements and to prevent changes that could complicate the funding distribution process requiring further tribal consultation. We believe that the national distribution methodology is an equitable funding formula based on population and it takes into consideration quantifiable metrics including tribal size adjustment, user population, poverty and disease burden.

NPAIHB recommends for future funding distribution, funds should be allocated to each Area and the tribes and tribal organizations should decide through tribal consultation the appropriate distribution methodology to further distribution of these funds. IHS, tribes, and tribal

organizations in each Area should be able to collaborate in order to determine the most effective means to allocate resources within the Area to the individual programs. Hence, each Area could choose to allocate funds as tribal shares that are added to base funding, or use another method developed based on the input of IHS, tribes, and tribal organizations in that Area.

NPAIHB recommends using the Tribal Size Adjustment (TSA) formula for future behavioral health initiative funding cycle increases. The TSA formula provides a base amount for smaller tribes as well as an adjustment factor for tribes serving larger populations. We recommend that IHS begin to utilize the TSA formula distribution in FY 2021 and notify tribes about their approximate expected distribution amount in FY 2020. Utilizing the TSA will allow for smooth transition from the grant mechanism to the formula fund distribution and give tribes adequate time to plan for any changes. If there are any increases in behavioral health initiative funding provided by Congress in FY 2019 or FY 2020 those funds should be distributed based on the TSA formula instead of an increase in current grant awards.

Demonstrating Effectiveness

NPAIHB recommends continuing the funding provided to Tribal Epidemiology Centers (TECs) to assist tribes in their Areas with data reporting, determining national, local, and regional outcomes, and conducting evaluation activities—activities that can demonstrate effectiveness and continue to raise national awareness of these issues. To the extent other data or information is needed to demonstrate effectiveness, we believe the TECs can work with individual programs to compile that information and produce reports that address this impact if funded.

IHS National Management Set-Asides

NPAIHB recommend that set-asides directed to IHS national management, such as IHS Project Officers, Coordinators, Grants Management Specialists, and Consultants, be reallocated to the Areas using the national distribution methodology. The current structure fails to account for key differences between Areas: the need for these services provided by Headquarters and individual Areas varies across the Indian Health system and not all Areas benefit equally. Additionally, removing the burdensome reporting requirements associated with these initiatives will also eliminate the need for personnel and consultants to aid with such reporting. A better course is to address the need for any other services currently provided with these funds at the local and Area levels. Each Area should conduct an independent assessment on whether to set-aside funds for Area-wide staff to assist with implementing behavioral health programs. Therefore, we recommend that IHS reallocate to the Areas the funding associated with the administrative set-asides using the national distribution methodology.

While NPAIHB strongly supports continued funding to TECs, NPAIHB does not support the continuance of the current administrative set-asides provided under contracts and cooperative agreements with national organizations. Like the national management funds described above, these contracts do not benefit all tribes, so national funds should not be devoted to these contracts. And to the extent that existing procurement contracts have been obligated, we recommend that these agreements not be renewed. Setting aside funds to "raise national awareness" of substance abuse and mental health issues currently has limited value, especially in the midst of a very public

nation-wide opioid epidemic. Instead, IHS should direct those funds to direct services where they are needed most.

Lastly, we recommend that any additional funding that is made available as a result of discontinuing support for IHS program administration, cooperative agreements and contracts be added to program amounts for IHS, tribal and tribal organization service providers. As we are not advocating for major changes in the distribution methodology and our recommendations would only lead to increased funding for service providers, not reductions, we do not believe the current multi-year grant cycles prevent these changes from taking place at once. Any administrative cost savings from a reduction in grant administrative oversight should be evaluated and made available to contracting and compacting tribes no later than FY 2022.

Fully Fund CSC for Behavioral Health Initiatives

NPAIHB requests that IHS request additional CSC funds in the President's Budget Request for FY 2020 and beyond to support fully funding CSC needs related to these recurring funds. It is important to request an accurate amount of funds to support new distribution of increases long-term. CSC funds support ancillary services necessary to fully support the delivery of care and maximize funds appropriated by Congress. This is consistent with Congress' intent to maximize tribal resources available for the delivery of health care programs. Given the current grant funding mechanism, tribes must use part of their awards to fund administrative costs, which causes an average 25% reduction across the board in amounts available for programming. But, this change would reverse that trend and allow tribes and tribal organizations to dedicate the full award amount to service delivery.

The current grant management and application process is cumbersome and time consuming and inappropriately limits payments of CSC. Eliminating the competitive grant process and bureaucratic administrative process will enable I/T/U programs to serve more behavioral health patients and implement long-term strategic plans.

CONCLUSION

We thank you for this opportunity to provide comments and recommendations on the funding mechanism to distribute behavioral health initiative funds, and we look forward to further engagement with IHS to meet critical behavioral health challenges in Northwest Tribal communities. If you have questions or would like more information about our recommendations discussed above, please contact Laura Platero, Government Affairs/Policy Director at (503) 407-4082 or by email to lplatero@npaihb.org.

Sincerely,

Andrew C. Joseph Jr.

Andy C. Joseph, Jr.
NPAIHB Chairperson
Colville Tribal Council Member