Portland Area
Indian Health Service

FY 2020 Budget Formulation Submission

Budget and Narrative

Portland Area Budget Formulation Representatives

Tribal Representatives

Andrew Joseph, Jr., Primary Representative
Colville Tribal Council Member,
NPAIHB Chairperson,

Steve Kutz, Alternate Representative
Cowlitz Tribal Council Member
NPAIHB Delegate

Technical Representatives: Northwest Portland Area Indian Health Board

Joe Finkbonner, Executive Director

Laura Platero, Policy Analyst

IHS Representatives

CAPT Ann Arnett, Executive Officer

Nichole Swanberg, Acting Financial Management Officer

Preliminary Process

On November 30, 2017, Portland Area Tribal Leaders, Health Directors, representatives from the Northwest Portland Area Indian Health Board, along with leadership of the Indian Health Service - Portland Area Office met to discuss their recommendations for the FY 2020 Indian Health Service (IHS) budget. The meeting was held at the Embassy Suites, Portland Airport.

The session included an overview of the Federal, HHS and IHS budget formulation process, Area health statistics and review of previous Health priorities, budget priorities as well as Hot Issues for the Portland Area Tribes. The meeting agenda is included as an attachment to this report.

Summary of FY 2020 Budget Recommendations

The Portland Area Tribes submitted two recommended budget marks at the national-level for FY 2020 both at a 36% percent increase ($1.5 billion). In one recommendation, Portland Area Tribes requested a -$221 million reduction to Health Care Facilities Construction (HCFC) FY 2020. The Portland Area tribes do not currently have facilities on the approved priority list and would not likely see resources from this line item.

The Portland Area Tribes submitted National budget recommendations at the 36% level, as well as an increased distribution due to the reduction to HCFC.

Summary of Portland Area National Budget Recommendations		
	National +36%	**National +36% with reduction to HCFC**
Current Services (Fixed Costs)	**+$189.1 million**	**+$189.1 million**
Binding Obligations	**+$275 million**	**+$175 million**
Purchased and Referred Care	**+$922.7 million**	**+$1.056 billion**
Affordable Care Act & Indian Healthcare Improvement Act	**+$173.1 million**	**+$198.2 million**
Long Term Care	**+$92.1 million**	**+$105.5 million**
Restoration of Pay Act	**+$90 million**	**+$103.1 million**
Facilities	**+$97.3 million**	**-$110.3 million**
Regional Referral Center	**+$57.4 million**	**+$65.7 million**
Information Technology & Electronic Health Record	**+$32.3 million**	**+$37 million**
Behavioral Health	**+$61.1 million**	**+$70 million**
Total Current Service and Program Increases	**$1.9 billion**	**$1.9 billion**

CURRENT SERVICES

Fund Pay Costs, Inflation and Population Growth: +$189.1M

Portland Area Tribes continue to underscore the fact that IHS funded programs have had to absorb significant inflationary cost increases over the past twenty years. Federal and tribal programs struggle to absorb the real resource loss associated with inadequate funding for inflation, pay act increases and population growth. Therefore, Portland Area Tribes believe these mandatory costs must be the first consideration in the budget formulation process.

Portland Area Tribes support fully funding federal and tribal pay costs, inflation, and population growth. The fundamental budget principle for Portland Area Tribes is that these mandatory fixed costs must be funded in order to maintain the current levels of care and employee satisfaction. Otherwise, the tribes are concerned that the agency may reduce services and lose its ability to recruit and retain a qualified workforce.

BINDING OBLIGATIONS

Staffing for New Facilities, Healthcare Facilities Const. & CSC: +$175M

The IHS worksheet for budget formulation suggests funding increases of $75 million for staffing, and $100 million for Health Facilities Construction. Portland Area Tribes do not support funding for facilities construction and related staffing under the premise that the facilities construction priority system disadvantages Portland Area Tribes in the overall IHS resource allocation process. Additionally, the funding does not equitably benefit tribes nationally and has an adverse impact on available funding for inflation, pay costs, and population growth. Portland Area Tribes reduced the facilities funding reserved for Binding Obligations and redirected this funding to cover program increases. The Portland Area Tribes do support the $100 million increases to Contract Support Costs to ensure that tribes receive full funding to provide adequate support to contracted or compacted programs.

PROGRAM INCREASES

Purchased & Referred Care Funding: +$1.056B

At the National 36% level, Portland Area Tribes recommend a program increase for the Purchased and Referred Care (PRC) program of $1.056 billion. The PRC program is extremely important for Portland Area Tribes since the Portland Area IHS does not have hospitals or specialty care centers so Tribes must rely on the PRC program for tertiary and inpatient care. The PRC program makes up approximately 30% of the Portland Area budget overall. When less than adequate inflation and population growth increases occur, Portland Area Tribes must make difficult decisions about cutting health services to absorb these mandatory costs.

Fund ACA and IHCIA Amendments +$198.2M

The Affordable Care Act (ACA) included amendments to and a permanent reauthorization of the Indian Health Care Improvement Act (IHCIA). Both the ACA and IHCIA include many authorities that are beneficial for IHS, Tribal, and Urban (I/T/U) Indian health programs. The IHCIA also provides authority to develop a grant program for technologically innovative approaches to assess/prevent/treat youth suicide.

At the National 36% level, Portland Area Tribes recommend $198.2 million to further implement the ACA and carry out new IHCIA authorities. For this purpose, $2.2 million for H&C and $109.2 million for the PRC line items would assist tribes to purchase health premiums for their tribal members under Section 152 of IHCIA. The Portland Area Tribes also request legislation that gives the IHS federally operated programs authority to purchase health insurance premiums for tribal members when beneficial to the program. In addition to the authority to reprogram dollars similar to how tribally contracted or compacted programs can reallocate funding within their contracts to maximize resources and support innovation to improve healthcare delivery. $56.4 million to be provided to the Urban Indian Health Program line item to allow them to also purchase insurance premiums for their users.

To support additional provisions of the IHCIA the Portland Tribes recommend a $30.4M increase to preventive health to support more education and grant programs directed towards prevention such as section 111 to establish a Community Health Aid program or section 133 for prevention and control of communicable diseases. The increase is broken out $10.1 million for Public Health Nursing, $10.1 million for Health Education and $10.1 million for Community Health Representatives for these type of activities.

Long Term Care +$105.5M

The IHCIA Section 124 provides authority for IHS to carry out hospice care, long-term care, assisted living, and home and community based services in tribal communities. However there is also an additional need for facilities and infrastructure to comprehensively support these types of programs, which can be cost prohibitive.

At the 36% level, the Portland Area recommends $105.5 million to develop long term care programs with funding directed to develop staffing programs to carry out home and community based services that are reimbursable under Medicaid and through qualified health plans on the Insurance Marketplaces. The Portland Area Tribes believe this will allow these programs to become self-sustaining and help mitigate future pressures on the system as the user population continues to age, without major investments in facilities.

Restore Pay Act Increases: +$103.1M

At the 36% mark, Portland Area Tribes recommend an additional $103.1 million to restore past-years' pay costs that were not funded due to the federal moratorium on pay act increases. The IHS and tribes must continue to reward their employees in order to retain them. Otherwise, the system will be in a cycle to continually recruit and replace personnel that leave the system. Additionally, reductions under sequestration in FY2013 have not been fully restored, further eroding the purchasing power of the agency. Nationally there has been increased competition to recruit and retain qualified and competent providers, creating an increased need for recruitment and retention pay as well as additional market pay to attract applicants.

Facilities: -$110.3M

Portland Tribes acknowledged that past-years' budgets have not included increases necessary to address the ongoing backlog of facilities infrastructure. For example, the

Maintenance & Improvement (M&I) line item has not been increased in over seven years. While the M&I program received $100 million under the American Recovery and Reinvestment Act (ARRA), there was a backlog of over $380 million of maintenance and improvement projects. The M&I line item also had its base budget eroded due to the sequestration in FY 2013. The Sanitation & Facilities program realized a reduction of $16 million in FY 2012 and has never received an increase to restore the lost funding or an increase to address the growing backlog of projects. The Equipment line item has also been marginally funded over the last ten years. Because of these issues, the Portland Area recommends increases as follows: $67.7 million for the M&I account; $30.6 million for the Sanitation and Facilities program, and $15 million for Equipment, while also applying a -$221.8M reduction to Health Care Facility Construction, under the principle that the Portland Area tribes do no currently have any approved facilities on this list so would not benefit from any general increases to this fund.

Regional Referral Center: +$65.7M

The tribes recommended a $43.7 million increase in Health Care facility Construction to fund a Portland Area Regional facility for specialty care. The Area is also requesting an additional $8.1M in Hospitals and Health Clinics for a staffing package, an additional $4 million in the Facility Support Account for operations and $9.9 million in Medical Equipment. The current IHS Health Care Facility Priority system does not provide a mechanism for funding specialty referral centers. The Portland Area Facilities Advisory Committee recommends that the first specialty referral center be constructed as a demonstration project under section 141 of the Indian Health Care Improvement Act for tribes to test alternative health care models and means.

Information Technology, Electronic Health Records & Health Information Exchange: +$37M

In recognition of the Veterans Administration's (VA) decision to move to a new health record system, which will leave the IHS's current Registration and Patient Management System (RPMS) without system support, the Portland Area Tribes recognize there will need to be a substantial investment in IT infrastructure and software in order to transition to another system. The Tribes recommend a $37 million increase to the Hospitals and Health Clinics line item to cover this initiative. It's recommended that the software replacement have features to integrate behavioral health as well as work with standardize Health Information Exchange (HIE) platforms to ensure data can be seamlessly shared across health systems.

Behavioral Health: +70M

The provisions of IHCIA allow for many expansions to the Behavioral Health programs but most of them have not received substantial funding since enacted. The Portland Area tribes recommend $35M increases to both the Mental Health and Alcohol & Substance Abuse line items respectively. Funding increases would help to implement section 702 to expand behavioral health care for prevention and treatment and section 704 to provide more comprehensive care through detox, psychiatric hospitalization and community based education and rehabilitation programs. The Area tribes would also like to see section 705 of IHCIA funded to expand the usage and dissemination of a Mental Health Technician Program

to better serve patients in their communities, as well as section 715 to expand Behavioral health research grants to allow tribes to find more innovative, effective approaches to address issues like Indian youth suicide.

Portland Area Health Priorities

The FY 2020 Portland Area health priorities, established through tribal consultation are as follows:

1. Cancer

American Indian and Alaska Native (AI/AN) have higher mortality rates than the general population from specific cancers and have more devastating outcomes after diagnosis. It is also the leading cause of death for AI/AN aged 55-64 according to the 2014 IHS trends report. One factor contributing to this is the limited access to cancer screening. At least four cancers cervical, breast, lung and colorectal, have widely accepted standards of care for screening and early diagnosis that are an integral part of primary care services. However, limitation in access to these preventive services (such as mammograms, pap smears and CT scanning) is a major impediment to cancer prevention in Indian Country. Another major contributor to this increased mortality among AI/ANs is that most receive their care through limited primary care facilities that lack adequate resources to coordinate care and provide the sophisticated and specialized cancer treatment that is available to the wider population.

2. Behavioral Health (Mental Health, Alcohol/Substance Abuse, Suicide, Domestic Violence and Sexual Assault)

This category summarizes the need for additional funds to support many programs that share the common goals of: healthy lifestyles and quality of life. This request identifies the need to improve programs' ability to reduce health-related complications, prevent the onset of unhealthy lifestyles, and educate our communities to deal with behavioral health issues. There is a need to enable the I/T/U programs to expand access to multiple programs for services and implement a comprehensive, integrated network of care. Tribes are active in this area, but with the small funding increases, measurable improvements are predicted to occur slowly. Tribes are effective in sharing information from community to community, yet the development and associated implementation of effective models is more difficult due to the lack of significant funding increases.

a. <u>Mental Health and Suicide Prevention</u>

Suicide is of great concern to many AI/AN communities. Data suggest that suicide is a significant problem throughout Indian Country, particularly among Native youth, males, veterans, and elders. According to the 2014 trends in Indian Health In comparison to other U.S. Races AI/AN have a 60% greater chance of suicide. The Portland Tribes strongly encourage IHS to provide additional funding to reduce suicide rates among AI/AN and to increase tribal capacity to prevent suicide throughout Indian Country. Adequate provision of Mental Health resources is needed to treat depression and chronic mental illness and to prevent the second leading cause of death for AI/AN adolescents and young adults. AI/AN suicide mortality in this age group (10-29) is 2-3 greater than that for non-Hispanic whites. In addition AI/AN in the northwest are more likely to report depression or poor mental health than non-Hispanic whites and

less likely to report receiving mental health treatment, despite screening for depression in Portland Area clinics which meets or exceeds the IHS GPRA standard in most facilities. Greater access to mental health treatment and adoption of integrated behavioral health and primary care is needed. The Northwest Portland Area Indian Health Board (NPAIHB) project, THRIVE (Tribal Health Reaching out InVolves Everyone) has had a substantial impact by providing training and technical assistance to Northwest tribes to prevent suicide.

b. Alcohol and Substance Abuse

While much has been done to address the opioid epidemic throughout the country, funding and access to inpatient treatment programs for AI/ANs with alcohol, methamphetamine, or opioid abuse are still needed. Also needed is appropriate aftercare and outpatient follow-up. For example, the use of methamphetamine is causing tremendous cost to the Indian health care system. Studies show that to be effective, Tribes need to pay for 180-day inpatient treatment, as well as follow up care. This highlights the need for increased funding for inpatient services and after care.

c. Intimate Partner Violence and Sexual Assault

According to the US Department of Justice, AI/AN women are 2.5 times more likely to be raped or sexually assaulted than women in the USA in general; 34.1% of AI/AN women – or more than one in three – will be raped during their lifetime; it is widely accepted that these statistics do not accurately portray the extent of the sexual violence against AI/AN women. Tribes emphasized the need for tribal clinic facilities to have funding for personnel specifically trained to provide treatment for this population. Authorities under IHCIA Section 707, for Indian Women Treatment Programs would assist in providing more comprehensive care that address cultural, historical, social and child care needs of Indian women.

3. Diabetes

Depending on the region, AI/ANs are two to four times as likely, compared to all other races to have diabetes. There are many factors that contribute to the diabetes crisis; change in dietary choices and an increase in sedentary lifestyle have been key factors that are driving obesity to record levels. The consequences of uncontrolled diabetes can affect the functioning of many different organ systems, primarily through chronic damage to blood vessels resulting in heart attacks, strokes, kidney failure, blindness, and amputations. Priorities include funding for screening of younger populations for “pre-diabetes”, targeted interventions to reduce diabetes in all ages, as well as screening and aggressively treating high blood sugar. AI/AN not only have an increased prevalence of diabetes, they also have high rates of complications and a higher rate of mortality as a result of diabetes.

4. Injury Prevention

Unintentional injuries are the leading cause of death for AI/AN’s from age 1 to 44. Injuries are the second leading cause of hospitalizations for AI/AN’s. The age adjusted injury death rates for AI/ANs were 1.6 times those of non-Hispanic whites from 2005 to 2015. The leading causes of AI/ANs injury death were motor vehicles (40%), homicide (13%), and suicide (13%) followed by drowning, fire/flames, and falls. For all injuries combined, the male to female ratio of death

rates for AI/AN's was three to one. Prevention strategies to reduce alcohol use and increase use of restraints for all passengers can be shown to reduce death from motor vehicles. In addition many AI/AN's also have multiple risk factors that contribute to death by homicide and suicide including, lower education and income, unmarried status, unemployment, parent psychopathology, childhood adversities, and presence of diverse mental disorders.

5. Cardiovascular, Heart Disease, Stroke

The prevalence of risk factors for cardiovascular disease (CVD) (i.e., hypertension, current cigarette smoking, high cholesterol, obesity, and diabetes) among AI/AN is significant, with 63.7% of AI/AN men and 61.4% of AI/AN women having one or more CVD risk factors. In the Northwest, AI/AN have a higher self-reported prevalence of CVD and stroke and higher mortality from CVD and stroke compared to non-Hispanic whites. Although, heart disease was once relatively uncommon in AI/AN populations, it is now the leading cause of death among AI/ANs who are aged 65 years and over. The sharp rise in diabetes prevalence unquestionably plays an important role in the increasing rates of heart and other cardiovascular diseases in Indian Country, both through blood vessel damage and through the close relationship of diabetes and obesity, high blood pressure and poorly controlled blood cholesterol levels. However, over time, screening rates for these key predictors of cardiovascular health has increased in Portland Area and the proportion of patients with these diseases are benefitting from treatment with greater percentages having blood pressure and cholesterol in the healthy range. Despite the advances in treatment, deaths from stroke are the second highest and from CVD the third highest for the "West" region (Portland and California Areas) compared to other regions. From a physiologic point of view, all of these problems cannot be reasonably separated and should be viewed as comorbidities.

6. Health Promotion/Disease Prevention (Childhood obesity)

AI/AN people are challenged with health conditions and chronic diseases that are related to lifestyles choices resulting in obesity, physical inactivity, poor diet, substance abuse, and injuries. Health promotion and disease prevention (HP/DP) efforts can effectively reduce these health risks. IHS recognizes the value of prevention and has named HP/DP as an agency priority for several years. National health reform efforts also recognize the financial benefits and improved quality of life by supporting prevention programs.

Two in five AI/AN children are overweight and one solution is to support tribal communities in developing long-range, culturally competent, multidisciplinary, effective overweight and obesity treatments and preventative interventions for the diverse AI/AN population. The NPAIHB, Toddler Overweight Tooth Decay prevention (TOTs) program has proven effective in improving outcomes by reducing access to sugared beverages, increasing education and awareness as well as providing resources and support to encourage breastfeeding. Other topics in this area include immunizations, maternal child health, motor vehicle injuries among infants and toddlers and adolescent high risk behaviors. In the Northwest, childhood immunization rates have declined over the past decade and are currently among the lowest in all IHS, depriving Native children of one of the most effective public health interventions. More funding is needed to develop effective messages for parents of infants to address concerns about the safety and effectiveness of immunizations and to strengthen data systems to ensure accurate reporting.

One major success in the area of promoting healthy children is the Native Children Always Ride Safe (CARS) program that empowers communities to address motor vehicle injuries by helping communities address child seat restraint use through strengthening legislation, education and enforcement. In addition major goals of programs like We R Native, Project Red Talon and Native Voices have included outreach to youth to reduce risk behaviors like tobacco and substance abuse. These programs are designed to empower youth to be proactive to address suicidal ideation among peers, practice safe sex and stand up to bullying. These programs are developing evidence-based resources that demonstrate intervention and prevention can improve health outcomes.

7. Elder Health – Long Term Care

The treatment and medication management that is unique to the elder population requires the development of specialized geriatric capabilities within the I/T/U health care system. The care of elders is a culturally inherent trait for AI/AN's that provides an important part of maintaining cultural knowledge and wisdom to strengthen families and communities. It was the consensus of the Portland Area Tribes that with the expanded authority of Long Term Care under the Indian Health Care Improvement Act, under section 124 this program needs to be supported and fully funded.

- Elder care accounts for approximately 18% of ambulatory visits for acute complaints, chronic disease follow-up or hospitalization.
- There is a need for expanded inpatient and outpatient clinical services. Expansion needs to include basic primary and secondary tertiary care, increased recruitment and retention for gerontology specialists, nurse practitioners, and social workers with specialized training in elder care.
- The growth of the elder population has increased and will continue to grow as the baby boomers age.
- Long-term care is not funded nor is it a service that IHS currently provides.

8. Oral Health

Oral health is inextricably linked with overall health. AI/AN children in each age group have markedly higher rates of tooth decay (caries or cavities) and periodontal (gum) disease. Tooth decay among AI/AN children is four times that of white children in the US. "More than 1 out of 3 AI/AN children (37%) between 1-5 years of age have untreated decay. More than half of AI/AN children (54%) between 1-5 years of age have experienced tooth decay. Decay experience means that a child has had tooth decay in his or her lifetime, such as fillings, crowns, or teeth that have been extracted because of decay or present untreated tooth decay or cavities. Left untreated, tooth decay can have serious consequences, including needless pain and suffering, difficulty chewing (which compromises children's nutrition and can slow their development), difficulty speaking and lost days in school. Because of their young age, many children with decay must be treated in a hospital setting under general anesthesia at a cost exceeding $6,000 per child."

A major factor behind this unacceptable state of dental health is the continuing crisis in access to dental care at facilities serving AI/AN populations. Significant and widespread shortcomings in dental facilities and staffing have resulted in long waiting lists of patients requiring even the

most basic dental services. Often the inability to access routine services at the local facility results in the need for emergency room care, using up PRC funds in a highly inefficient manner. Portland Area Tribes support increased use of fluoride varnishes and other sealants, aggressive educational programs (for instance, to reduce sugared beverages consumption), water fluoridation and expansion of the Dental Health Aide Therapist (DHAT) program to stretch limited resources and ensure preventative care is provided as much as possible.

9. Maternal Child Health

Serious health disparities among pregnant AI/AN women and their children have been documented in numerous publications. AI/ANs experience some of the highest disparities in infant mortality in light of current medical and public health interventions within the Portland Area and across the country. For example, in Washington State in 2011, "infants whose mothers were American Indian/Alaska Native have over twice the mortality of infants whose mothers were white". Causes of death and risk factors for infant mortality within this population include congenital anomalies, Sudden Infant Death Syndrome (SIDS), and unintentional injuries, especially motor vehicle crashes. As of 2015, AI/AN women in Washington had the highest rate of maternal mortality (8.1%) compared to other races.

Chronic maternal stress and acute life events during pregnancy may contribute to the racial disparity in infant mortality. AI/AN women experience a disproportionate number of stressful life events during pregnancy. An analysis of the Washington State Pregnancy Risk Assessment Monitoring Survey (PRAMS) from 2002-2006, showed a greater proportion of AI/AN women reported each stressor in the PRAMS survey (partner, emotional, traumatic or financial-related) compared to white women, and were 2.6 times more likely to experience five or more stressful life events during pregnancy than white women.

The rates of fetal and neonatal death, low birth weight, and babies born with developmental problems are also far higher among AI/AN women than the general US population. A concern in WA State is the increasing rates of pre-term birth, LBW and VLBW infants born to AI/AN women which have increased by 20%, 32% and 70% respectively from 2005–2015. All of these outcomes are heavily impacted by the health status of the mother and whether or not prenatal care has been received. Another challenge facing AI/AN programs is the higher incidence of infants born to mothers abusing opioids with AI/AN children having up to 3 times the risk of developing neonatal abstinence syndrome resulting in higher costs for initial care and potential for negative health outcomes in the future. There is good evidence to support the fact that women who receive medical care during their pregnancy are healthier, have better outcomes for themselves and give birth to healthier children.

10. Liver Disease

According to the American Journal of Public Health publication on mortality caused by Chronic Liver Disease (CLD), AI/AN's experience higher incidents of chronic liver disease as well as increased mortality over non-Hispanic whites. A majority of deaths are attributed to cirrhosis of the liver due to Alcoholic Liver Disease (ALD) or infection of hepatitis C. Looking at specific age groups and genders shows even higher disparities. With 25 to 44 year old women being 15 time more likely to die of CLD than whites. With a lack of access to specialty care and other social determinates AI/AN have a much poorer health outcome when faced with these

types of chronic diseases. In addition more funding in the area of substance abuse can reduce the prevalence of ALD in the user population.

Hepatitis C has been an IHS National priority because AI/AN have an increased risk of infection and complications, including death from hepatitis C. In the Portland Area, AI/AN have 2 to 4.5 times the risk of dying from hepatitis C compared to non-Hispanic whites. Implementing screening recommendations, improving access to new, highly effective treatment and providing risk mitigation strategies such as syringe and needle exchange and medication assisted therapy for opioid addiction are all critical to reducing morbidity and mortality from Hepatitis C and improving health outcomes.

11. Other Chronic Disease

Respiratory disease was among the most prevalent infectious diseases among the leading causes of death and hospitalization across the life-span for AI/AN. In the first year of life, influenza and pneumonia and bacterial sepsis are the 8th and 9th leading causes of death, compared to non-Hispanic white infants. AI/AN infants have almost 5 times the risk of death from influenza and pneumonia. Poverty, overcrowding and poor sanitation are more common for AI/AN people and also contributing risk factors for infectious diseases. Other chronic health conditions such as asthma, chronic obstructive pulmonary disease and co-morbidities like diabetes which are also more common for AI/AN people greatly increases the risk and severity of infectious diseases.

Other chronic disease Portland Tribes are concerned with includes autoimmune disease, which is a broad category of diseases (sometimes also termed rheumatic diseases), which includes conditions such as rheumatoid arthritis, systemic lupus erythematosus, ankylosing spondylitis, Sjogren's syndrome, etc. Certain subpopulations of Tribes have a much higher incidence of certain autoimmune diseases. For example a 1991 study of AI/AN women in a Tribe in Washington State found the prevalence of rheumatoid arthritis to be 3.4% (compared to 1.5 % in women overall in the US population). Overall, AI/AN experience not only higher rates of rheumatic diseases but tend to have more severe forms of disease and onset at younger ages. While much study has focused on the genetic association between rheumatic disease and the AI/AN race, more needs to be done to understand the impact of environmental factors. At the clinical level, increased access to specialists to help manage patients with rheumatic diseases is needed as well as disease modifying anti-rheumatoid drugs which are both effective and can be very expensive.

Conclusion

It is important to reiterate the consensus of the Portland Area Tribes effort to address all of the health priorities that continue to impact the service population in their budget request. The priorities and budget requests outlined in this document represent a consensus building process that began many years ago.

The Portland Area's budget request clearly demonstrates a commitment to maintain the health programs by funding current services. The Portland Area Tribe's recommendations fund initiatives to eliminate the health disparity that exists for AI/ANs, and suggest that health care needs and national priorities should be tied to performance outcome measures like GPRA

and considered in budget formulation. The Portland Area Tribes are aware that there are many ancillary costs associated with such things as organ transplants and long term care that do not categorically fit our Health Priorities but are reflected in Purchased Referred Care and Catastrophic Health Emergency Fund budget line items.

Portland Area Tribes encourage the IHS to continue addressing issues associated with providing consistent levels of health care across the IHS system. Fully funding the budget will further the goal of the IHS and the Portland Area Tribes to elevate the health status of AI/AN's.

FY 2020 IHS Budget Formulation Meeting
Embassy Suites Portland Airport
7900 NE 82nd Avenue, Portland, OR 97220
Thursday, November 30, 2017
8:00 a.m. – 4:00 p.m.

	Facilitator	CAPT Ann Arnett, Executive Officer, PAIHS
8:00 a.m. - 8:30 a.m.	**Tribal Leader Invocation** **Welcome**	TBD Dean Seyler, Director, PAIHS
8:30 a.m. - 9:45 a.m.	**IHS Budget Consultation Overview** • Federal Budget Process Overview • FY 2020 PAO Budget Formulation Overview	Nichole Swanberg, Acting, FMO, PAIHS Rena Macy, Budget Analyst, PAIHS
9:45 a.m. – 10:15 a.m.	**Health Priorities** • Review FY 2019 Health Priorities • Set FY 2020 Health Priorities	Laura Platero, Government Affairs/Policy Director, NPAIHB CAPT Stephen "Miles" Rudd, MD, FAAFP, CMO/Deputy Director, PAIHS CAPT Thomas Weiser, MD, MPH Medical Epidemiologist, PAIHS
10:15 a.m. - 10:30 a.m.	**BREAK**	
10:30 a.m. – 11:30 a.m.	**FY 2020 Budget Priorities** • Set recommendations for IHS funded programs for Area representatives who will attend the National Budget Formulation Work Session. *(will inform entries for worksheet)*	Steve Kutz Cowlitz Indian Tribe, Council Member Laura Platero, Government Affairs/Policy Director, NPAIHB
11:30 a.m. – 12:00 p.m.	**Hot Issues** • Identify emergent issues that Tribes want to highlight for budget submission *(Becomes Appendix A – National Recommendations)*	Steve Kutz Cowlitz Indian Tribe, Council Member Laura Platero, Government Affairs/Policy Director, NPAIHB
12:00 p.m.- 1:00 p.m.	**LUNCH - On your own**	
1:00 p.m.- 2:45 p.m.	**FY 2020 Budget Recommendations** • National Level Recommendations – Worksheet completion o Planning Base - 36% increase over FY 2017 enacted.	Steve Kutz Cowlitz Indian Tribe, Council Member Laura Platero, Government Affairs/Policy Director, NPAIHB
2:45 p.m. – 3:00 p.m.	**BREAK**	
3:00 p.m. – 3:30 p.m.	**Tribal Representatives** • Determine two (2) Tribal Representatives to serve at the National Budget Formulation Work Session. **Survey** • Complete Survey. Results from Area Budget Evaluation Survey are used for the next budget cycle. **Follow-up Tasks** • 12/13/2017 - Area to Submit Budget Worksheet to HQ. • 1/5/2018 - Budget Narrative, Hot Issues, Area Report Slides and Representatives to HQ. • 2/15 & 2/16/18 - IHS FY 2020 National Budget Formulation Work Session *(DC Area)*.	CAPT Ann Arnett, Executive Officer, PAIHS
3:30 p.m. 4:00 p.m.	**Wrap-up and adjourn**	