Health Care for All: Sustaining the Oregon Model of Health Care Coverage, Quality, and Cost Management

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STATE OF OREGON
Office of the Governor
KATE BROWN

Vision

Governor Brown's vision is for all Oregonians to have quality, affordable health care, regardless of who they are or where they live.

Executive Summary

Oregon is a national model for health care reform. For nearly a decade, Oregonians have been involved in intense efforts to create a person-centered, coordinated, community-based health care system that focuses on improving individuals' health while also improving the quality of health care they receive, controlling costs, and eliminating health disparities. Under Governor Brown's leadership, 94 percent of all Oregonians and 100 percent of children now have access to quality health care coverage.

But coverage alone does not create health. Governor Brown's vision means that we must also improve the conditions in which Oregonians and their families are born, live, learn, work, and age. A central goal is to ensure that as we work toward improving the health of Oregonians, we fully integrate

health equity, tribal, and racial justice into our focus on social determinants of health. The pathway to improved health includes increasing connections between health care and early learning, human services, social supports, and affordable housing to address social factors that influence health.

A key strategy to achieving lower costs, better outcomes and better health is to reduce the silos in health care. Physical health, mental health, substance use disorder treatment, and oral health services are too often delivered in separate, fragmented ways. By integrating these services, we can expand access to appropriate treatment at the right time and at the right place, and maximize the opportunity to achieve better health outcomes.

Finally, a healthy population requires a 21st century public health system with the capacity and resilience to provide foundational public health services across the state, such as communicable disease control, chronic disease prevention, and emergency preparedness.

To continue Oregon's leadership in providing essential health insurance coverage at a reasonable cost, the Governor's plan to sustain health transformation focuses on the following strategies:

1. *Ensure Oregonians' access to health insurance coverage*
2. *Improve overall health outcomes through CCO 2.0*
3. *Control long-term cost growth in health care spending*
4. *Use reinsurance to keep rates affordable in the private market*
5. *Increase investments in mental health and addiction prevention and treatment*
6. *Modernize public health*
7. *Increase capacity, retention, and diversity in Oregon's health care workforce*
8. *Create better health through good jobs*

Background

When people have access to health care, communities are healthier. More people can work, go to school, and contribute in other ways to their local economy. Employers benefit from a healthier workforce, lower insurance costs, and less absenteeism. Fewer people turn to social services. In 2010, nearly 1 in 6 Oregonians lacked health insurance coverage. Oregon's lawmakers, stakeholders, and advocates have worked for more than a decade to ensure that there are comprehensive health insurance options available for Oregonians and because of that work, today, 94 percent of all Oregonians have health coverage.

Between Medicaid, the Public Employees' Benefit Board (PEBB) and the Oregon Educators' Benefit Board (OEBB), the state purchases health care coverage for approximately 1.2 million Oregonians. There are over 115,000 Oregonians who also purchase federally-subsidized coverage through the state's Health Insurance Marketplace, which allows individuals to obtain affordable quality health insurance coverage. Each of these sources of coverage have been key to bringing Oregon's uninsured rate down from 17 percent in 2010 to 6 percent in 2017.

In 2017, Governor Brown further broadened coverage by signing "Cover All Kids" into law, which extended eligibility for medical assistance to all Oregon children residing in families with incomes up to 300 percent of the federal poverty level.

Coverage alone is not enough. Meaningful improvement in health requires having the same kind of access to mental health and substance use disorder treatment as we have for physical health care.

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Every one of us has a friend, a loved one, or a neighbor who has experienced a mental health issue or substance use disorder. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2016 "one in five people experiencing homelessness had a serious mental illness, and a similar percentage had a chronic substance use disorder."[1] While we have made significant progress in Oregon in recent years and have led the nation in innovation in some important ways, we have much work to do to ensure timely access to mental health and substance use disorder treatment.

We must also improve access to oral health care in Oregon. Tooth decay is the leading chronic disease for children and teenagers as well as one of the leading causes of school absenteeism.[2] Dental problems are also a leading cause of avoidable emergency department use. Oregon data show dental problems were the second most common emergency department diagnosis for adults aged 20 to 39 in 2010.[3] Poor oral health can affect the ability to get and keep a job.[4] By creating strategies to coordinate and connect oral health services with physical health services, we create effective opportunities to get

1. SAMHSA website housing and homelessness page. https://www.samhsa.gov/homelessness-housing.

2. The Children's Dental Health Project, "The State of Dental Health, School Years and Beyond." https://www.cdhp.org/state-of-dental-health/schoolandbeyond.

3. Sun BC, et al. "Emergency department visits for non-traumatic dental problems: a mixed-methods study." American Journal of Public Health 2015; 105:947-955.

4. Frakt, Austin. "How Dental Inequality Hurts Americans." *New York Times*. February 19, 2018, NYTimes.com.

individuals out of emergency rooms and into the right setting for care, saving costs and improving outcomes.

Although there is more work to do to improve affordability and sustainability, this expanded coverage has brought important benefits by dramatically improving access to care, improving the quality of care, containing costs through prevention and early intervention, and by creating more than 23,000 new health care jobs across Oregon.[5] Medicaid coverage is an effective tool to fight poverty: in a 2017 study of social programs' impact on poverty, Medicaid accounted for a 3.8 percentage point reduction in the poverty rate, with even higher rates of alleviating poverty among people of color. The study showed that Medicaid coverage reduced poverty rates of Latinos by 6.1 percentage points and African Americans by 4.9 percentage points.[6]

In the next chapter of health care transformation and innovation, Governor Brown is prioritizing the need to improve the social conditions of communities across Oregon.

Medicaid and Coordinated Care Organizations (CCOs)

Oregon has a long history of bipartisan support to provide effective and accessible health insurance coverage for as many Oregonians as possible. The goal is to improve health care quality, measure health outcomes, and involve the community in setting health care priorities.

5. 95PercentOregon.com Employment page. https://www.95percentoregon.com/increased-employment.html.

6. Remler, DK, Korenman, SD., Hyson RT., "Estimating The Effects Of Health Insurance And Other Social Programs On Poverty Under The Affordable Care Act", Health Affairs, 36, No. 10 (2017): 1828-1837. DOI: 10.1377/hlthaff.2017.0331.

> **"Although there is more work to do to improve affordability and sustainability, this expanded coverage has brought important benefits by dramatically improving access to care"**

In 2012, as part of a Medicaid 1115 waiver, Oregon received $1.9 billion in additional federal funding over five years in exchange for a commitment to improve health care access and quality—as well as reduce increases in per capita health care spending—by focusing on population health, prevention, care coordination, and primary care.

Oregon met those commitments successfully by creating Coordinated Care Organizations (CCOs), a new form of managed care organization defined by a broad governance structure, global budgets, accountability, transparency, and flexible spending. They are based in the community and charged with coordinating the physical, mental, addiction, and oral health services of low-income Oregonians served through the Oregon Health Plan. Additionally, they are required to work with their Community Advisory Councils to develop and implement Community Health Improvement Plans. In 2012, contracts were awarded to 16 regional CCOs with the expectation that they would make improvements in care while also living within a fixed global budget that could grow by no more than 3.4 percent per capita per year.

If CCOs stay within their budget target, meet their quality goals, and provide the required Medicaid services, they have the flexibility to implement innovative quality improvement programs and invest in health-related services that align with their Community Health Improvement Plan such as housing supports, food security, and community activities that support a healthy population. With flexible spending investments in community-based social services, CCOs have effectively redefined "physical health" to focus on a much broader definition of "community health."

The state also set up an incentive pool to reward CCOs for meeting or exceeding targets on 17 quality measures, including:

- Cigarette smoking prevalence
- Controlling high blood pressure
- Depression screening and follow-up
- Prenatal and Postpartum care visits
- Developmental screening for children

Oregon's health system transformation efforts were based on best practices nationally—focusing on patient-centered primary care and bringing together behavioral health, primary health care, and oral health care—and they have worked. Oregon's Medicaid reforms and the CCO model have saved taxpayers an estimated $2.2 billion between 2012 and 2017.[7] CCOs are continuing to make progress on quality.

7. Oregon Health Policy Board January 16, 2017 Board Retreat Materials. https://www.oregon.gov/oha/OHPB/MtgDocs/January%2016,%202018%20OHPB%20Retreat%20Board%20Packet.pdf. See page 57.

An independent analysis of Oregon's 2012-2017 Medicaid waiver supports these findings, showing that Oregon has spent less per Medicaid member than neighboring Washington, and that it has reduced emergency room visits and "low value" care.[8] The latest metrics report shows improvements in several areas including dental sealants for children, adolescent well-care visits, effective contraceptive use, developmental screenings in the first three years of life, and in health assessments for children in foster care.[9]

Today, almost 1 in 4 Oregonians receive their health care through the state's Medicaid system, the Oregon Health Plan.

Current Landscape: Medicaid and the Oregon Health Plan

In September 2017, Governor Brown asked the Oregon Health Policy Board (OHPB) to provide recommendations to the Oregon Health Authority (OHA) for how the state and CCOs can advance health care transformation to further improve health outcomes, increase value, and hold down costs.

Specifically, the Governor asked for recommendations focused on:

- Addressing social determinants of health and equity
- Increasing value and pay for performance
- Improving the behavioral health system
- Maintaining a sustainable cost growth

8. Kushner, J. et al. "Evaluation of Oregon's 2012-2017 Medicaid Waiver." OHSU Center for Health System Effectiveness, 2017.

9. Oregon Health System Transformation: CCO Metrics 2017 Final Report. June 26, 2018. https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/2017-CCO-Metrics-Report.pdf.

OHPB established work groups to address each of the Governor's outlined priority areas, held ten community meetings around the state with more than 500 attendees, established an online survey for broader public input, and obtained input from more than 25 Medicaid and/or health-related committees over the course of the year. In total, OHPB has received input from an estimated 2,500 Oregonians. OHPB's final recommendations are expected to be delivered to OHA in October 2018, in time to be included as appropriate in the CCO request for applications, expected to be issued in January 2019 for new five-year contracts effective January 1, 2020.[10]

The next phase of Medicaid transformation in Oregon, CCO 2.0, will be in large part defined by the new CCO contracts.

Current Landscape: Addiction Treatment and Recovery

The chronic disease of substance use disorder (SUD) continues to plague Oregon families from all backgrounds. Nationally, the abuse of tobacco, alcohol, and illicit drugs is estimated to be responsible for more than $740 billion annually in costs related to crime, lost work productivity, and health care.[11] Not only is this disease costly to our state, but it has significant detrimental impact on children and families.

Parents and caregivers who suffer with SUD expose their children to adverse childhood experiences, thus increasing the probability that kids will suffer from the same chronic illness, among other health issues.[12] According to recent case reviews, nearly 75 percent of Oregon foster care placements involved parental substance use.[13] We must break the cycle of addiction passed through generations. While Oregon has made great strides in reducing both over-prescription of opioids

10. Draft recommendations are posted at https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx.

11. National Institute of Drug Abuse, https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs

12. Choi, N. G., DiNitto, D.M., Marti, C.N. & Choi, B. Y., Association of Adverse Childhood Experiences with Lifetime Mental and Substance Use Disorders Among Men and Women Aged 50+ Years, International Psychogeriatrics 29(3), 359-372, doi: 10.1017/S1041610216001800

13. Preliminary data from the Child Welfare (CW) Capacity Project analysis – part of the CW Research Agenda – shows 71.9 percent of parents were involved with drugs or alcohol at the specific time of removal and 78.8 percent of parents had a drug or alcohol induced mental state which prohibited care of the child. Publication forthcoming.

and overdose related to opioid use disorder, much work remains to be done. As overdose deaths from prescribed medications fall, we are seeing a corresponding rise in those deaths related to illicit substances such as methamphetamine and fentanyl.[14] As Oregon fights the ongoing opioid epidemic, we cannot lose sight of the need to address addiction related to all dangerous substances, including alcohol.

14. Oregon Prescription & Drug Overdose Data Dashboard, "Oregon Drug Overdose Deaths," The Oregon Health Authority, https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx.

> **"As Oregon fights the ongoing opioid epidemic, we cannot lose sight of the need to address addiction related to all dangerous substances, including alcohol"**

Finally, we cannot ignore the connection between substance use disorders and mental health disorders. Research shows about half of those who are diagnosed with a substance use disorder have also experienced mental illness.[15] In addition, a recent review by the National Institute on Drug Abuse (NIDA) cites evidence that 60 percent of adolescents in community-based substance use disorder treatment programs also meet diagnostic criteria for mental illness.[16]

But fragmentation in the health care system has created artificial silos between physical health, mental health, and addiction treatment and services, which makes it harder for individuals to get their needs met while providers face barriers in information sharing and

15. Santucci K. Psychiatric disease and drug abuse. Curr Opin Pediatr. 2012;24(2):233-237. doi:10.1097/MOP.0b013e3283504fbf.

16. National Institute on Drug Abuse (NIDA), "Common Comorbidities with Substance Use Disorders", Feb. 2018. https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/1155-common-comorbidities-with-substance-use-disorders.pdf/.

communications. Arcane billing rules that don't recognize whole-person treatment continue to present unneeded challenges to access. This means that Oregonians who struggle with substance use disorders and mental health challenges face barriers getting the services and support

> **"It is past time for us to address the systemic and operational barriers that prevent individuals and their families from getting the right support at the right time"**

they need every single day. While Oregon's health care systems have worked toward a new model of care that coordinates physical and behavioral systems of care, it is past time for us to address the systemic and operational barriers that prevent individuals and their families from getting the right support at the right time.[17]

Current Landscape: Oregon Health Insurance Marketplace

In 2018, more than 156,000 Oregonians signed up for private health insurance through the Oregon Health Insurance Marketplace. More than 115,000 Oregonians have qualified for federal tax credits that make health premiums more affordable for moderate-income individuals and families. On average, Oregonians who bought health coverage through the Marketplace and received subsidies for 2018 plans had their premiums reduced by $410 per month—on average, by more than 70 percent.[18]

17. Oregon Health Authority, "Behavioral Health Collaborative Report", 2016. https://www.oregon.gov/oha/HPA/CSI-BHP/Documents/Behavioral-Health-Collaborative-Report.pdf, p. 3.

18. Centers for Medicare & Medicaid Services 2018 Marketplace open enrollment period public use files. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html.

The Oregon Reinsurance Program, created during the 2017 legislative session, protects and stabilizes all insurance companies within the individual market, which insures nearly 200,000 Oregonians in every corner of the state. The positive effect of the Oregon Reinsurance Program provides relief for Oregonians and helps reverse some of the health insurance rate increases related to uncertainty caused by actions at the federal level. For 2018 and 2019 plan years, the program helped reduce individual market rates by approximately 6 percent, thereby strengthening our health insurance markets and assuring access to affordable health coverage.[19]

Stable and strong insurance markets contribute significantly to Governor Brown's priorities of supporting Oregon's families and children's access to quality health care. Lower rates also have a positive economic impact for small businesses and a thriving statewide economy.

Since 2017, federal actions designed to dismantle the Affordable Care Act continue to impose uncertainty and risk on Oregon's insurance markets. The repeal of the individual mandate, coupled with new federal regulations designed to expand association health plans and short-term, limited-duration health insurance policies, fragments a healthy and robust ACA risk pool and indirectly raises health insurance premiums. In the absence of state action, these federal policy changes could lead to large premium increases and market destabilization. As such, Oregon must continue to find solutions to stabilize our health insurance markets and ensure affordable access to health insurance coverage for all Oregonians.

19. https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=2832 and https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=2170.

RECENT ACCOMPLISHMENTS

Since entering office in 2015, Governor Brown has significantly created value in Oregon's health care system. Some of the most noteworthy achievements include:

Expansion of access to health care coverage and access to care to 94 percent of adults and 100 percent of children in Oregon

Passed "Cover All Kids" in 2017, ensuring that every child in Oregon has access to the health care they need to stay healthy, learn, and play.

Secured a Medicaid funding package to preserve coverage for a million Oregonians on the Oregon Health Plan. The package was later affirmed with strong support by the voters in a special election in January 2018.

Guaranteed access to reproductive health care via the Reproductive Health Equity Act (RHEA), which extends access to the full range of reproductive health services and postpartum care to people who can become pregnant, protects care for people with private and employee-sponsored health care through no cost sharing or copays, and prohibits discrimination in the provision of reproductive health services.

Provided stability for 80,000 Oregon children in the Children's Health Insurance Program (CHIP) whose access to health care was threatened in the face of Congressional inaction.

Addressing addiction prevention, treatment, and recovery

Created the Opioid Epidemic Task Force in 2017 as part of a statewide effort to combat opioid abuse and dependency. The Task Force consists of medical experts, drug treatment specialists, and government officials. Their mission is to identify and implement efforts to address the growing opioid misuse and abuse across the state. Among other things, the Task Force has prioritized reducing the number of narcotic pills in circulation, improving access to high-quality treatment, facilitating data sharing and the promotion of cutting-edge education efforts.

Declared substance abuse and addiction to be a public health crisis in Oregon and calls for the Alcohol and Drug Policy Commission (ADPC) to create a state plan around addiction, prevention, treatment, and recovery in Executive Order 18-01. Signed into law a related bill (HB 4137) requiring that the ADPC provide the legislature with recommendations for a strategic plan for addiction prevention and recovery.

Controlling health care costs

Signed cost containment measures directly affecting the Public Employees' Benefit Board (PEBB) and Oregon Educators' Benefit Board (OEBB) into law, including limiting annual premium increases and per member per month costs to no more than 3.4 percent.

Signed a prescription drug price transparency act (HB 4005) into law that creates transparency and accountability for rising drug costs and created the Task Force on the Fair Pricing of Prescription Drugs.

Signed SB 419 into law, which established the Joint Interim Task Force on Health Care Cost Review to explore opportunities to limit the growth of health care expenditures. The central recommendation of the Task Force is that the state establish a statewide health care spending target for the annual rate of growth of total health care expenditures in Oregon.[20]

Eliminated "double-coverage" for PEBB and OEBB-covered employees who enroll as a member on an OEBB or PEBB plan when they are already enrolled as a dependent on another OEBB or PEBB plan.

Reducing health care disparities and expanding focus on social determinants of health

Required that CCOs spend a portion of their annual net income or reserves on services designed to address health disparities and the social determinants of health (HB 4018).

20. A draft final report of the Joint Interim Task Force on Health Care Cost Review is available at https://olis.leg.state.or.us/liz/2017I1/Downloads/CommitteeMeetingDocument/149994.

Protecting Oregonians from unreasonable health insurance rate increases

Signed the Oregon Reinsurance Program into law in 2017 to stabilize the individual health insurance market.

Supporting tribal health

Directed the Oregon Health Authority to work closely with Oregon's nine tribes to maximize a federal opportunity to claim 100 percent federal funding for health care services provided outside of tribal health facilities under specific care coordination agreements.

Supported tribal-directed care coordination to ensure sustainability, better care networks, and culturally-appropriate care for Oregon tribe members.

Protecting people with pre-existing conditions

Governor Brown has continued to work with governors of other Medicaid expansion states to lobby the federal government to maintain coverage for Oregonians with pre-existing conditions.

The Governor's Strategies:

To continue Oregon's leadership in providing essential health insurance coverage at a reasonable cost, the Governor's plan to sustain health transformation focuses on the following strategies:

ONE: Ensure Oregonians' access to health insurance coverage

TWO: Improve overall health outcomes through CCO 2.0

THREE: Control cost growth in health care spending

FOUR: Use reinsurance to keep rates affordable in the private market

FIVE: Increase access to mental health and addiction treatment

SIX: Modernize public health

SEVEN: Increase capacity, retention, and diversity in Oregon's health care workforce

EIGHT: Create better health through good jobs

ONE: Ensure Oregonians' access to health insurance coverage

When people have access to health care, communities are healthier. More people can work or go to school. Employers benefit from a healthier workforce, lower insurance costs, and less absenteeism, fueling local economies. Fewer people turn to social services, and there are fewer households facing unaffordable, crushing medical bills. Oregon's uninsured rate has been reduced from 17 percent to 6 percent. Under Governor Brown's leadership, we will:

Convene our health care partners in a consensus-driven approach to secure long-term, sustainable funding for the Oregon Health Plan (OHP) to maintain health care coverage for 99 percent of adults and 100 percent of kids by optimizing federal funds, funding the program from a broader revenue base, and providing a longer and more stable funding timeline.

Continue access to the full spectrum of reproductive health care including access to information about sexual health, preventive care, preconception, contraception, prenatal and postpartum care, and abortion for all people.

Continue support for a primary care model, including Patient-Centered Primary Care Homes (PCPCH), that weaves together physical, behavioral, and oral health; focus on improving access to quality care in underserved communities and rural Oregon.

Ensure all Oregonians in every part of the state have access to affordable, quality health care coverage by using the state's purchasing power and continuing to protect against unreasonable insurance rate increases.

Support the development of capacity and diversity of our physical health, mental health, addiction treatment, and oral health workforce across the state, with an emphasis on underserved and rural communities.

Continue the Compact of Free Association Premium Assistance Program.[21]

TWO: Improve health outcomes through CCO 2.0

Finalize the next round of Coordinated Care Organization contracts, focusing on strengthening connections to community-based services that address social determinants of health, reducing health disparities, improving access to mental health and addiction services, and integrating care.

Deliver effective, integrated care. Physical, behavior, and oral health providers cannot coordinate effectively without fundamental functional changes in the health care delivery system. Create a long-term plan that weaves together physical, behavioral, and oral health in a way that creates effective communication capabilities between systems, facilitates referrals, and addresses transparent payment and billing issues.

Take action on the social determinants of health by spurring sustainable community innovation and flexible investments in OHP to ensure that low-income Oregonians have access to the supports and services that allow them to live long, healthy lives. We can do this by strengthening connections to public health, early and life-long learning, human services, long-term supports, services, quality jobs, and affordable housing, thereby improving overall community health.

21. The Compact of Free Association is an international agreement establishing and governing the relationships of free association between the United States and the three Pacific Island nations of the Federated States of Micronesia, the Marshall Islands, and Palau.

Increase funding to help the chronically homeless get off the streets, and increase access to addiction and mental health treatments and other critical medical care. The Oregon Health Authority (OHA) and Oregon Housing and Community Services (OHCS) are collaborating to invest in permanent supportive housing to create at least 200 new units of housing with supportive services across Oregon. In 2019, the Governor is proposing to use $20 million of bond proceeds for the construction of the new units.

Identify, promote, and expand programs that integrate mental health, addiction, and oral health services into primary health care to further improve health outcomes and reduce long-term costs.

Increase accountability around equity by increasing efforts to collect consistent, reliable race and ethnicity data to identify health disparities early on. Require CCOs to collaborate and consult with culturally-specific communities and tribes to leverage community-driven solutions for better health outcomes and care coordination.

THREE: Control growth in health care spending

Without strong cost controls, health care will continue to outstrip the growth of the state revenue and personal income. We must deliver care differently to reduce cost growth below 3.4 percent in Medicaid, PEBB, and OEBB, to ensure that costs do not outpace economic growth.

Build on Oregon's success of setting a cost growth target in public programs by creating a statewide all-payer cost growth target based on the total cost of care to contain costs across the entire health system. Build on Oregon's data and transparency efforts to identify opportunities to contain costs that are growing faster than the budgets of families, businesses, and state government.

Expand the use of value-based payment tools that reward providers for better care and decrease costs across all payers, including Medicaid, PEBB, and OEBB and commercial insurance by reducing the use of low value care and volume-based reimbursement.

Ensure that CCOs invest savings in services that address social determinants of health, such as housing supports, transportation and food security.

Contain prescription drug costs by paying for value, partnering with other states, and aligning how we pay across state health programs; further explore options to control prescription drug costs through collaboration with stakeholders including prescribers, CCOs and other payers, and technical experts. Follow recommendations emerging from the Fair Pricing of Prescription Drugs Task Force (HB 4005).

Implement a universal home visiting program for new parents to increase school readiness and improve health outcomes for children and families.

Establish an Office of Child Health within the Oregon Health Authority.

FOUR: Use reinsurance to keep rates affordable in the private market

We must continue to find solutions to stabilize the growing private individual insurance market, currently serving 218,000 Oregonians.

Continue the Oregon Reinsurance Program, which provides relief for Oregonians and helps reverse some of the health insurance rate increases related to uncertainty caused by actions at the federal level. For 2018 and 2019 plan years, the program helped reduce individual market rates by approximately 6 percent, strengthening our health insurance markets and assuring access to affordable coverage.

FIVE: Increase access to mental health and addiction treatment

Use OHA's contracting authority for CCOs, local mental health authorities (LMHAs), community mental health programs (CMHPs), and local public health authorities (LPHAs) to establish baseline expectations for standards of care and access, accountability for outcomes, and transparency while promoting and supporting local control and innovation.

Reduce administrative burden and system complexity. Move toward value-based payment with shared financial risk based on clear accountability and span of control.

Continue investing in addiction and recovery treatment that focuses on a two-generation approach (parents and children).

Expand in-home intensive behavioral health services for children and youth with specialized needs.

Assess barriers to effective use of peer-delivered services; establish clear standards for effective and appropriate use of peer-delivered services as part of CCO 2.0.

Reduce risk factors for suicide for Oregon youth and adults by implementing an Oregon Youth Suicide Intervention and Prevention Plan and an Adult Suicide Prevention Plan.

Increase access to non-opioid alternative pain treatments, continuing to monitor opioid use through the Prescription Drug Monitoring Program.

SIX: Modernize public health

Ensure Oregon has a 21st century public health system to handle 21st century public health challenges.

Strengthen clean drinking water protections, reduce communicable disease risks, increase immunization rates, increase prevention of and help communities to address environmental health threats, such as wildfire, across the state.

Enhance state investments in public health community capabilities that include prevention of communicable diseases, emergency preparedness, and prevention services.

Create enduring partnerships with tribal, health equity, and culturally specific partners to inform and lead the development of Community Health Improvement Plans (CHIPs) and Community Health Assessments (CHAs).

SEVEN: Increase capacity, retention, and diversity in Oregon's health care workforce

Realizing the goals of improved health, improved health care, and lower costs as we work to eliminate health disparities will require a dynamic health care work force that is ready to meet the needs of an increasingly diverse population and new systems of care.

Emphasize cultural responsiveness and language accessibility.

Require integration and utilization of traditional health workers and health care interpreters within CCOs and primary care to ensure enhanced delivery of care and improve outcomes.

Use OHA's contracting authority for CCOs, local mental health authorities/community mental health programs, and local public health authorities to establish baseline expectations, cultural competency training, and language access.

Ensure that rural and frontier Oregonians have their unique needs met by increasing accessibility through Project Echo, telehealth, and by supporting provider loan repayment and loan forgiveness programs.

EIGHT: Create better health through good jobs

Good jobs are formidable tools for narrowing health disparities and containing health care costs. Having a good job influences health both directly and indirectly, as there are myriad links between income and health, such as the ability to buy better houses in walkable neighborhoods, consuming healthier food, and investing in educational opportunities—all of which improve health outcomes.[22]

Governor Brown launched Future Ready Oregon in 2018 to provide skill and job training to students and adults, helping to close the gap between the skills that Oregon's workers have and the skills that Oregon's growing businesses and rural communities need by:

22. The Urban Institute and the Virginia Commonwealth University's Center on Society and Health, Income and Health Initiative: Brief Two, "Can Income-Related Policies Improve Population Health?" April 2015, pp 1-10.

- Increasing career-connected learning opportunities in all schools and community colleges.

- Expanding registered apprenticeship opportunities in health care and other high-growth occupations.

- Developing the core competencies needed across the health care industry for non-licensed, non-certified health care occupations (e.g., traditional health workers) and connect this training pathway to the broader health care career pathway, ensuring workers have on and off ramps as they continue to develop their skills.

- Supporting the health workforce caring for our communities by increasing workforce development and licensing opportunities in rural and underserved areas.

U.S. SENATE PASSES TRIBAL SOCIAL SECURITY FAIRNESS ACT IN WIN FOR TRIBES

Bill Provides Tribal Council Members with Social Security Parity

On September 6, 2018, the Senate passed The Tribal Social Security Fairness Act of 2018, which is expected to be signed into law by the President in the coming days. The bipartisan bill – co-sponsored by Senators Maria Cantwell (D-WA) and John Thune (R-SD) and recently passed in the House – allows tribal council members the option of paying into and receiving Social Security benefits based on their government service. NAFOA has long advocated for such a change and we are grateful to the champions within Congress for supporting Indian Country.

"I have worked on this issue for a number of years because it is important to encourage our youth to serve our

Resources:

H.R.6124 - Tribal Social Security Fairness Act of 2018

NAFOA's One-Pager

communities and we should do that by eliminating barriers to service. No one should be punished by the federal government for serving their community," Muckleshoot Tribal Council Chair Virginia Cross said. "The Tribal Social Security Fairness Act helps to remove barriers to tribal service for our young leaders."

Background

Generally, employees pay a percentage of their income through payroll taxes to fund the Social Security program and, in doing so, earn what are known as "credits." When that employee retires, he or she begins collecting Social Security benefits based on credits earned. However, tribal council members are not allowed to pay into the Social Security program and receive benefits based on their service, which differs from how state and local government legislators are treated under current law.

The Tribal Social Security Fairness Act, which also passed the House by unanimous consent in late-July, corrects this by allowing tribal governments to "opt-in" to agreements extending Social Security coverage to their councilmembers. "With this bill, leaders across Indian Country will have long overdue parity with other governmental leaders," stated Tina Danforth, NAFOA President. "Elected tribal leaders will now be able to 'opt-in' to the Social Security program, which many Americans rely on for a safety net," she continued.

In addition to the "opt-in" provision, the bill allows tribal council members to receive Social Security credit for taxes paid prior to the establishment of the agreement, if the taxes were paid timely and in good faith, and were not refunded.

If you have any questions or comments, please contact Ryan Ward at (202) 594-6593 or Ryan@Nafoa.org.

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Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

2121 SW Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

"Response Circles" Funding Request for the Northwest Tribes

This form is to be used when requesting funding for an activity, event, or training that is associated with domestic & sexual violence prevention. The funds may be used for: meeting expenses, materials and supplies for activities, incentives, travel, and training fees. Funds may not be used for wages, food, or promotional clothing items i.e. t-shirts. Page 2 includes opportunities that can be funded. About $11,000 is available for these requests by the Northwest Tribes and will be available until the money runs out. **Requests can be submitted anytime October 1, 2018 to August 15, 2019.**

Date: _____
Tribe: _____
Department: _____
Address: _____
Contact Person: _____ Phone: _____

Briefly describe the activity, event, training that the funds will be used for:
Total Amount For Request ($1,600 max)
*Please be sure your total request includes all your needs including: indirect, travel, lodging, per diem, registration fees, internet, supplies, print materials, incentives, honoraria, stipends, trainer fees and travel, and/or facility costs. ** Funds may not be used for wages, food, or promotional clothing items i.e. t-shirts.

*Depending on the event/training chosen NPAIHB staff may ask you to provide a short evaluation, survey, or post-description of the event/training. Please fax this document to 503-228-8182, Attn: Colbie, or email ccaughlan@npaihb.org. If you have any further questions, please call Colbie Caughlan: (503) 416-3284.

List of Upcoming Opportunities for Domestic & Sexual Violence Prevention

- At your own pace Online Sexual Assault Nurse Examiner's training http://www.forensicnurses.org/?page=40HourSANE

- October 15-16, 2018 – Veterans and Domestic Violence: Improving Safety, Accountability, and Intervention – Jacksonville, FL https://vawnet.org/events/veterans-and-domestic-violence-improving-safety-accountability-and-intervention

- October 23-26, 2018 – Advanced Domestic Violence and Sexual Assault Training – Las Vegas, NV http://nicp.net/event/las-vegas-october-23-26-2018/

- October 24-27, 2018 – International Conference on Forensic Nursing Science and Practice – Reno, NV http://www.forensicnurses.org/?page=AnnualConfer

- November 4-7, 2018 – 4th World Conference of Women's Shelters – Taipei, Taiwan https://fourth.worldshelterconference.org/

- November 14-16, 2018 - Battering Intervention Services Coalition of Michigan's 2018 Conference: Religion, Faith, Spirituality, Science & Research: engaging for Safety and Accountability – Lansing Charter Twp, MI https://vawnet.org/events/bisc-mi-2018-conference-religion-faith-spirituality-science-research-engaging-safety-and

- November 29, 2018 – February 20, 2019 – Sexual Assault Examiner (Pediatric) Online training https://www.tribalforensichealthcare.org/page/onlinePSAE

- December 4-7, 2018 – Advanced Domestic Violence and Sexual Assault Training – Las Vegas, NV http://nicp.net/event/las-vegas-december-4-7-2018/

- December 5-7, 2018 – 16th National Indian Nations Conference to develop and improve strategies and programs that serve the unique needs of crime victims in Indian Country – Coachella Valley, CA http://www.ovcinc.org/

- February 12-15, 2019 – Advanced Domestic Violence and Sexual Assault Training – Las Vegas, NV http://nicp.net/event/las-vegas-nv-february-12-15-2019/

- February 26, 2019 – May 2, 2019 – Sexual Assault Examiner (Pediatric) Online training (registration opens in late 2018) https://www.tribalforensichealthcare.org/page/onlinePSAE

- March 12-14, 2019 – Sexual Assault Demonstration Initiative's Embracing Change & Growth Conference: Strengthening Services for Survivors of Sexual Violence – Chicago, IL https://www.nsvrc.org/embracing-change-growth-conference

- Sexual Assault Response Team (SART) Toolkit – training on your own, check out https://ovc.ncjrs.gov/sartkit/about.html

Websites to find more opportunities & dates

- National Center on Domestic & Sexual Violence - http://www.ncdsv.org/ncd_upcomingtrainings.html

- Sexual Assault Forensic Examinations, Support, Training, Access and Resources (SAFESTAR) - http://www.safestar.net/training/

- International Assoc. of Forensic Nurses - http://www.forensicnurses.org/?page=registerforSANE

- IHS Tribal Forensic Healthcare http://tribalforensichealthcare.site-ym.com
- Idaho Coalition Against Sexual & Domestic Violence - https://idvsa.org/
- Oregon Attorney General's Sexual Assault Task Force - http://oregonsatf.org/calendar/trainings/
- Oregon Coalition Against Domestic & Sexual Violence - https://www.ocadsv.org/
- Washington State Coalition Against Domestic Violence - https://wscadv.org/
- Washington Coalition of Sexual Assault Programs - http://www.wcsap.org/

PORTLAND AREA INDIAN HEALTH SERVICE

FY 2021 BUDGET FORMULATION MEETING

NOVEMBER 15, 2018 8:30 a.m.—4:00 p.m.

Location: Embassy Suites Portland Airport
7900 NE 82nd Ave
Portland, OR
503-460-3000
(no block of rooms reserved first come first serve)

This meeting is for Tribes and Indian Health Service to come together to exchange information and determine the health priorities for the FY 2021 Portland Area Indian Health Service budget submission.

Questions? Call CAPT Ann Arnett (503) 414-5555 or e-mail ann.arnett@ihs.gov

To view the Final FY2020 submission please visit NPAIHB website at

http://www.npaihb.org/policy/#1531246764700-ef18f104-8800

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

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

You're Invited to Attend! NW Native Adolescent Health Alliance Meeting

Your choice: Virtual Meeting or at the NPAIHB Offices, Portland OR

Friday September 21, 2018 at 10:00 - 11:00 AM

Possible Agenda Items:

- Firearm Safety Module input and draft
- Healthy Native Youth website - Responding to Concerning Posts
- Response Circle updates – domestic and sexual violence prevention project
    - October is Domestic Violence Prevention Month
- Youth opportunities
    - Social Marketing Bootcamps
    - Ambassadors
    - Youth delegates
- Changes and updates to the Adolescent Health Tribal Action Plan

What is the Alliance?

The *NW Native Adolescent Health Alliance* is an inclusive, multi-functional group that meets quarterly in OR, WA, and ID to discuss cross-cutting planning and prevention strategies targeting AI/AN teens and young adults (addressing tobacco, substance abuse, STD/HIV, teen pregnancy, and suicide topics). Our goal is to support regional action planning, resource development, and sharing.

Who Should Attend?

All interested parties are invited to attend, including tribal health and prevention staff, IHS, State Health Department personnel, MSPI funding recipients, and University and Community partners from ID, OR, and WA. Please email Celena McCray at cmccray@npaihb.org if you will be attending in person.

How Do I Attend Virtually?

Join from PC, Mac, iOS or Android: https://echo.zoom.us/j/428512819. If you have any questions about this software, please contact Celena McCray, cmccray@npaihb.org, *prior* to the date of the meeting to find out how to use Zoom. You will need to download the Zoom app for your phone if you want to be part of the meeting via a tablet or cell phone.

More Information?

Check out the **Adolescent Health Tribal Action Plan** here! Project Red Talon and THRIVE developed the plan in partnership with NW tribal health advocates, hoping it will be used by the NW Tribes and partnering agencies to guide program planning, and foster a coordinated response to adolescent health and well-being in our tribal communities.

Funding for this meeting was made possible (in part) by grant number SM61780 from SAMHSA. The views expressed in written conference materials or publication and by speakers and moderators do not necessarily reflect the views, opinions, or policies of CMHS, SAMHSA, or HHS; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid Innovation Accelerator Program (IAP)

Linking & Merging Data Sources

National Webinar Series

September 28, 2016

3:30pm-5:00pm EDT

IAP Medicaid Innovation Accelerator Program

Logistics

- Please mute your line & do not put the line on hold
- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in “full screen” mode
  - Please also exit out of “full screen” mode to participate in polling questions
- Moderated Q&A will be held periodically throughout the webinar
  - Questions submitted via the chat box will be prioritized
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience

Purpose & Learning Objectives

1. States will learn about the **benefits of linking** Medicaid SUD data with various other data sources including other state agency sources

2. States will discuss **different strategies for linking** data from 3 case studies & through peer-to-peer discussions

3. States will explore how data can be used to **meet substance use disorder goals & monitor performance**

Agenda

- Benefits of Linking / Merging Data
- State Experience: Connecticut
  - *Discussion Break*
- State Experience: Washington
  - *Discussion Break*
- State Experience: Oregon
  - *Discussion Break*
- Wrap Up & Resources

Speaker (1/3)

- **Minakshi Tikoo, PhD**
- University of Connecticut
  - Director, Business Intelligence & Shared Analytics
  - Health and Human Services Health Information Technology Coordinator
  - Professor, School of Nursing

University of Connecticut
School of Nursing

Speaker (2/3)

- **David Mancuso, PhD**
- Director, Division of Research and Data Analysis, Washington State Department of Social and Health Services

Speaker (3/3)

- **Jon Collins, PhD**
- Director, Office of Health Analytics, Oregon Health Authority

Facilitator

- **Suzanne Fields, MSW**
- Senior Advisor for Health Care Policy & Financing, University of Maryland

UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

Introduction: Benefits of Linking / Merging Data

Suzanne Fields, MSW

Senior Advisor, Health Care Policy & Financing, University of Maryland

Barriers to Merging Data Sources

Resources

- Staffing
- Time
- Political Support
- Funding

Technical Complexity

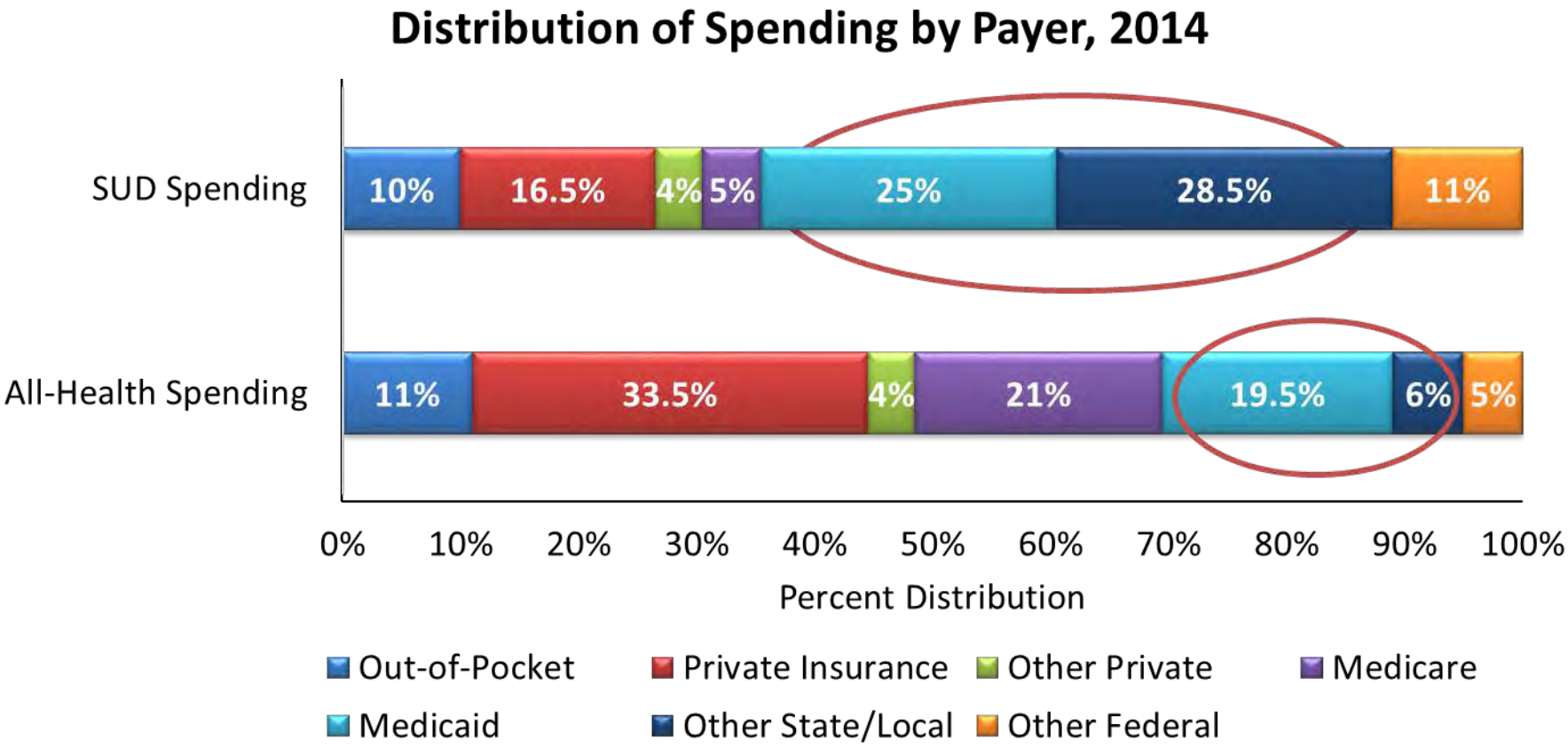
- Linking claims & encounter records
- Varying quality of data sources

Confidentiality

- Working within the confines of 42 CFR Part II

Describing the utility of linked data is key to overcoming these barriers

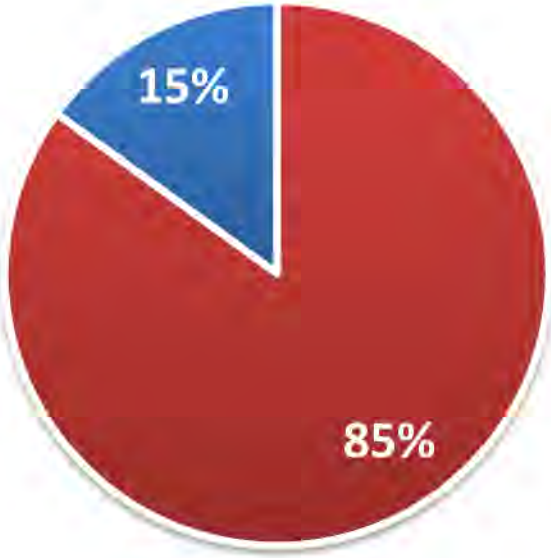
State & Local Payers Fund a Large Portion of SUD Treatment



Source: SAMHSA. (2014). Projections of national expenditures for treatment of mental and substance use disorders, 2010-2020. HHS Publication No. SMA-14-4883. Rockville, MD: SAMHSA.

Much of SUD Treatment Costs Are Paid to Specialty Clinics & Providers

Distribution of SUD Treatment Spending, by Specialty and Non-Specialty Providers, 2014



- **Specialty Providers**
  (Psychiatric hospitals/units, psychiatrists, psychologists, social workers, MH/SUD outpatient or residential treatment)
- **Non-Specialty Providers**
  (General hospitals & outpatient clinics, PCPs)

Source: SAMHSA. (2014). Projections of national expenditures for treatment of mental and substance use disorders, 2010-2020. HHS Publication No. SMA-14-4883. Rockville, MD: SAMHSA.

Utility of Linked Data: Example Policy Questions

- What are the service utilization trends for SUD patients?
- Are patients being reimbursed under Other/State & local payments that are enrolled in Medicaid?
- Is there a disproportionate share of uninsured patients being treated in SUD specialty provider sector? Are they eligible for Medicaid?
- What are the outcomes from providing SUD treatment under Medicaid?
- What is the return on investment from providing SUD treatment under Medicaid?

Treatment Episode Data Set (TEDS)

- Client-level data
  - Demographic, substance abuse, socioeconomic characteristics
  - Reported at endpoints of treatment
  - Collected in state administrative data systems
- Two data sets
  - Admissions records
  - Discharge records
- Treatment programs receiving any public funds are requested to provide TEDS data on publicly & privately funded clients
- Mandatory key fields
  - Client identifier, client transaction type, type of service/setting, admission & discharge dates, date of last contact, state provider identifier, state code, reporting date

National Outcome Measures (NOMs)

- Required to be reported as part of TEDS
- Provides outcomes measures on 10 domains for all state/federal block grant & formula grant programs

Reduced Morbidity

- Outcome: Abstinence from alcohol/drug use
- Measure: Absolute percent change of clients not using between admission & discharge

Retention

- Length of stay, successfully completing treatment plan

Employment

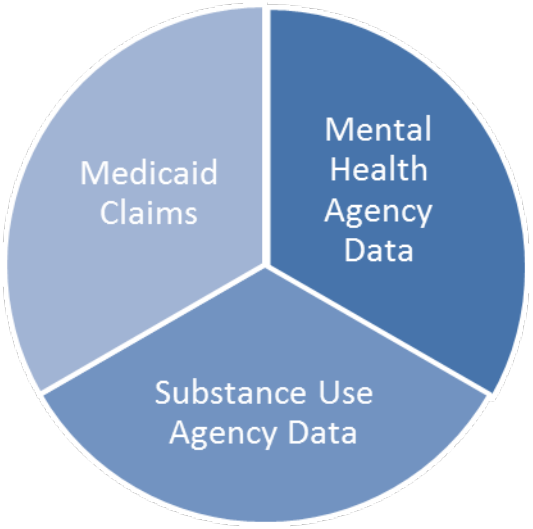
- Increased/retained employment

Crime & Criminal Justice

- Decreased arrests

Case Study: Tracking Outcomes Post Detox

- Integrated database built from claims & other client-level data
  - Data from Medicaid programs, mental health & substance abuse agencies



Source: Mark, T.L., Vandivort-Warren, R. & Montejano, L.B. (2006). Factors affecting detoxification readmission: Analysis of public sector data from three states. *Journal of Substance Abuse Treatment*. 31:439-445.

- Data included for all clients receiving services from state mental health/substance abuse agencies in DE, OK, WA
- Analyzed rate of detox readmissions, factors associated with readmissions

Case Study: Tracking Outcomes Post Detox Cont'd

Index Detox

Readmission Events:

- 25% of clients receiving follow-up
- 28% of clients without follow-up

Readmission for Second Detox

- **73% of sample did not receive follow-up care**
- **Clients receiving follow-up treatment experienced longer time to readmission**

Source: Mark, T.L., Vandivort-Warren, R. & Montejano, L.B. (2006). Factors affecting detoxification readmission: Analysis of public sector data from three states. *Journal of Substance Abuse Treatment*. 31:439-445.

Polling Question (1/5)

- Has your state begun linking/merging different data sources?
  - Yes, we have an operational system
  - Yes, we are building a system
  - No, but we are discussing the process
  - No, this is not a priority for us

University of Connecticut
School of Nursing

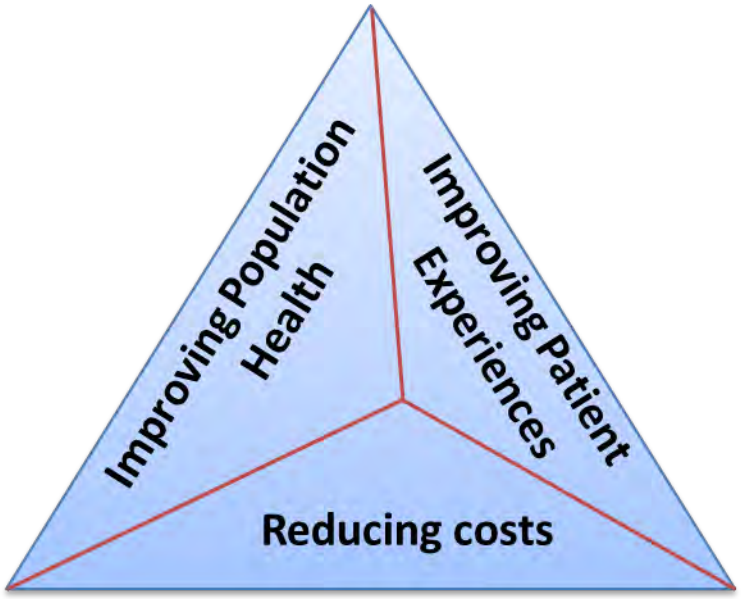
State Experience: Connecticut

Minakshi Tikoo, PhD
Health Information Technology Coordinator
Director, Business Intelligence & Shared Analytics
Health and Human Services

IAP Medicaid Innovation Accelerator Program

Motivation to Link Data

- The "Magic Mantra"– the Triple Aim
  - Requires increased sophistication in the use of data to simultaneously address the Triple Aim



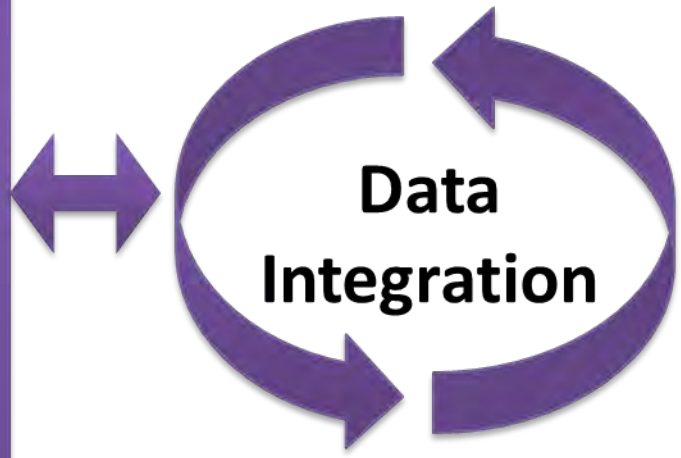
Challenges to Big Data Linkage

- Expensive to build warehouses to combine data
- Data are constantly changing requiring constant updates to data warehouse
- Wealth of data from state agencies
  - Not accounted for in a systematic manner
  - No or limited documentation
  - Need inventory & management process
- Quality of data limits analytics
- Work with small data before getting into big data

Data Integration: the Conceptual Model

Individuals
Data Sources

- Generic Information
- Primary Care
- Pharmacy
- Hospitals
- Specialty Care
- Laboratories
- Allied Health Care Settings
- HIEs
- PHRs



Education on data uses

Increased use & access to info across care settings

OUTCOMES

Seamlessly connected:
Effective, efficient, timely, equitable, safe, person-centered

Electronic copy of health information:
Diagnostic test results, problem & medication lists, medication allergies

Data Integration Using Distributed Data Networks

- Purpose
  - Improve ease of locating data & running analyses
  - Enables you to analyze data across data silos without aggregation
- Zato Health Interoperability Platform
  - Secure federated analysis across data silos
- Cooperative computing 'at the Edge' with Cross-Network Information Fusion
  - Processing of indexes in **parallel** across data silos

Advantages to Distributed Data Networks

Traditional Approach	Cross-organizational Data Interoperability Approach
Centralized processing	Decentralized processing
Standardized application for 1 organization	Diverse applications among many organizations
Data warehouses & data lakes	Health information sharing environments
Centralized privacy protection	Decentralized privacy protection
Centralized security	De-centralized security
Not available	Indexes are reusable, performance data are verifiable
Not available	Pricing model with multiple returns on investment
Not available	Decentralized analysis
Not available	Applications are freely distributed

Next Steps for Connecticut

Developing a system that answers all of our questions:

Population

- How many people do we serve within an agency?
- Number of unique people & families served

Outcomes

- Who is getting better? Who is getting worse?
- How? Why?
- Are there geographic variations?

Costs

- What are the costs?
- Are we buying the right services?
- Can we predict what needs to be in our service mix?

Next Steps for Connecticut Cont'd

Data Types & Sources	Data Integrator / Warehouse	Outcomes
• Claims • Patient-level clinical data • eCQMS • Patient & provider satisfaction data • Participating org-level data • Community-level pop-based data • Other secondary data	Create a continuous quality improvement cycle with iterative feedback loops	Performance Measurement domains Data use for operations & evaluation • Quality improvement • Monitoring & management • Value-based purchasing • Policy development
Data	Information	Knowledge

Challenges

- Agencies do not want to share data
  - Data quality is questionable
  - Fear of looking bad
- Iterative learning process
  - Must acknowledge problems to find solutions
  - Logically connected, slow, build-up
- Support for continued systems development
  - Leadership & vision
  - Retaining talented workforce

Polling Question (2/5)

- If your state is currently linking data, which databases are you integrating? Select all that apply.
  - Medicaid claims
  - Mental health agency
  - Substance use agency
  - Department of Corrections
  - Department of Housing
  - Other
  - Not sure

Discussion and Questions (1/3)

State Experience Linking Data: Washington

David Mancuso, PhD,

Director, Division of Research and Data Analysis,

Washington State Department of Social and Health Services

Motivation to Integrate Data

- High Costs & Complex Needs
  - Program costs are often driven by a small proportion of clients with multiple risk factors & service needs
  - High-cost clients often have significant social support needs
  - Persons dually eligible for Medicare & Medicaid comprise a disproportionate share of high-risk, high-cost Medicaid beneficiaries
- Increased emphasis on quality/outcome measurement & performance-based payment structures
- States need analytic capability beyond traditional siloed data warehousing, business intelligence applications

Assessing Capacity for Integrated Data Analytics

Support

- Build support among agency data owners
  - Connect analytic investments to agency business needs
  - Ensure agency subject matter experts inform analytics strategies
  - Invest in agency staff expertise & capabilities
- Leverage opportunities for external support to maintain & extend capabilities

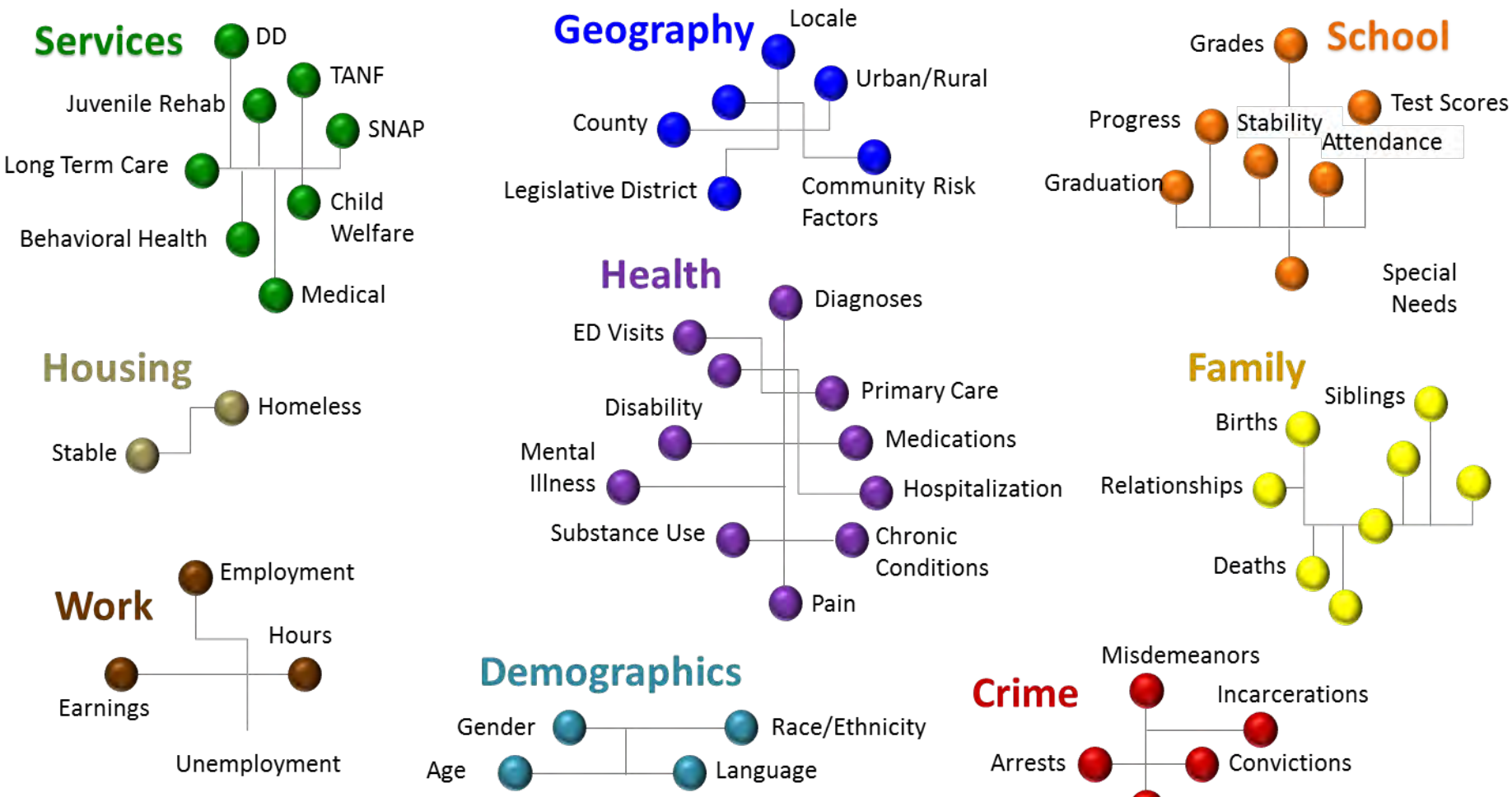
Staffing

- Advanced degrees in quantitative social & health science disciplines
- Analytical programming skills focused on complex data transformation & massive-scale data processing
- Interest in public policy

Expectations

- Implementation timelines
- Scale of potential cost savings
- Resources required to maintain analytical environment in production
- Impact on state agency subject matter expert resources

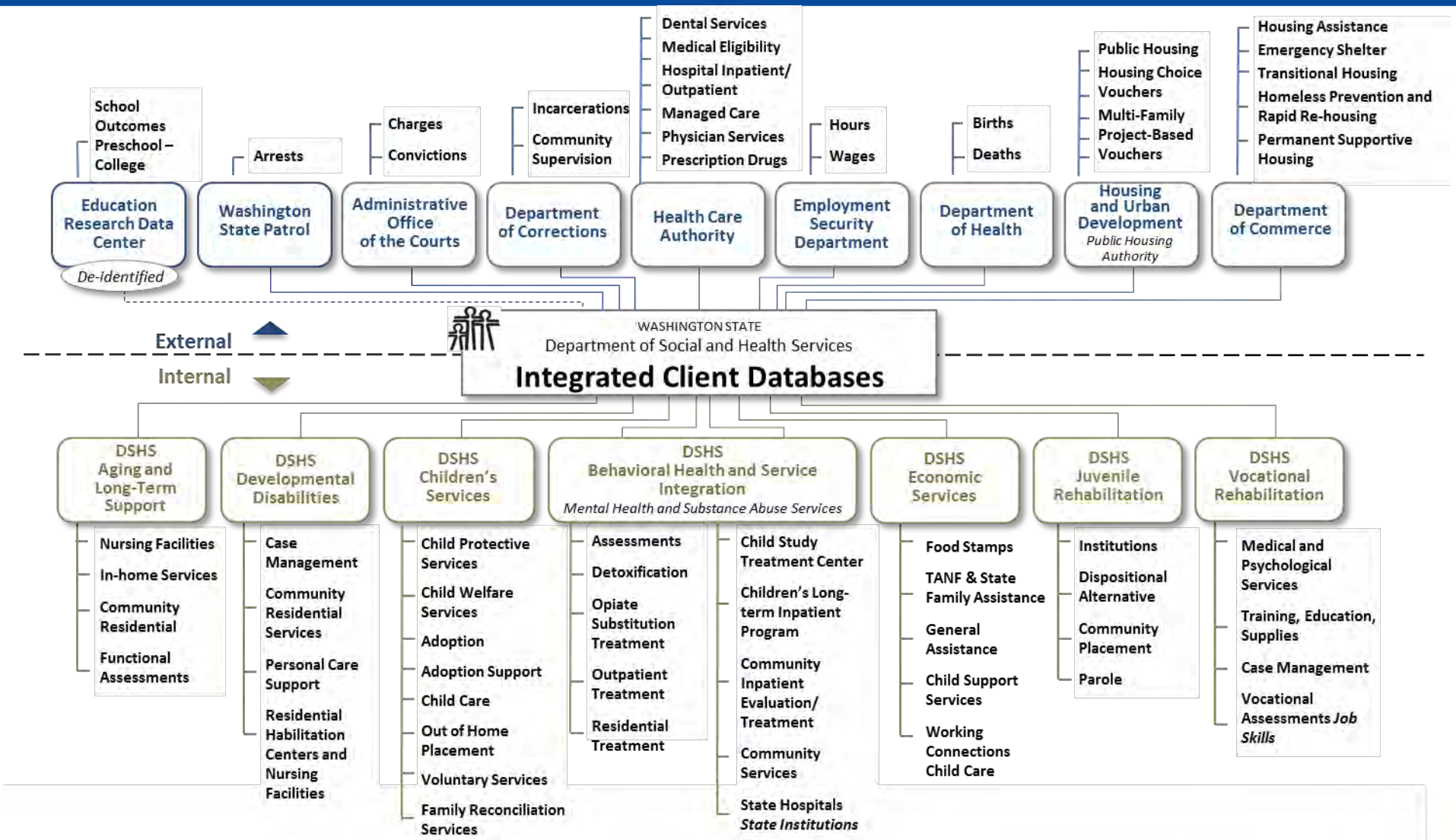
Creating Analytically Meaningful Measurement Concepts



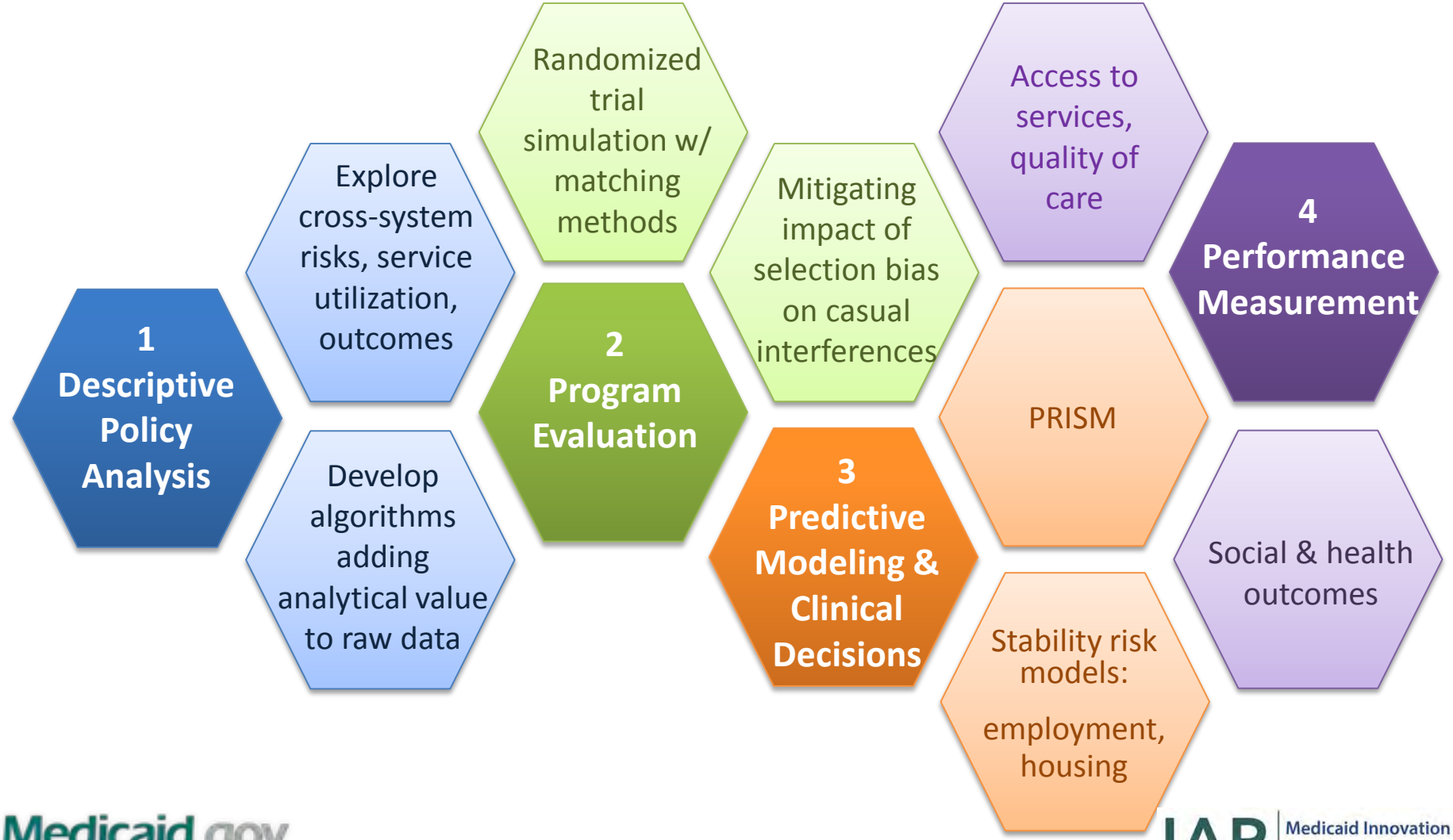
Medicaid.gov
Keeping America Healthy

IAP Medicaid Innovation Accelerator Program

Big Picture:
Integration Across Multiple Databases



Utility of Integrated Administrative Data



Descriptive Policy Analysis

Designed to describe client experiences in a given policy environment

- As opposed to making causal inferences about program effectiveness or impact of policy changes on client outcomes

May require **development of new analytical concepts** with broader applicability as risk factors or outcome measures in future impact analyses

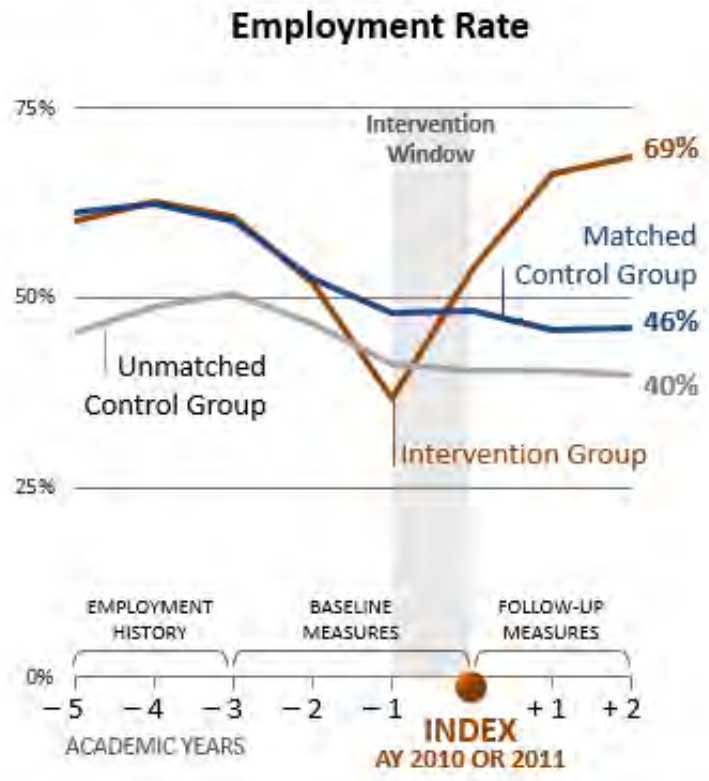
- For example, creating behavioral health risk indicators or housing stability metrics

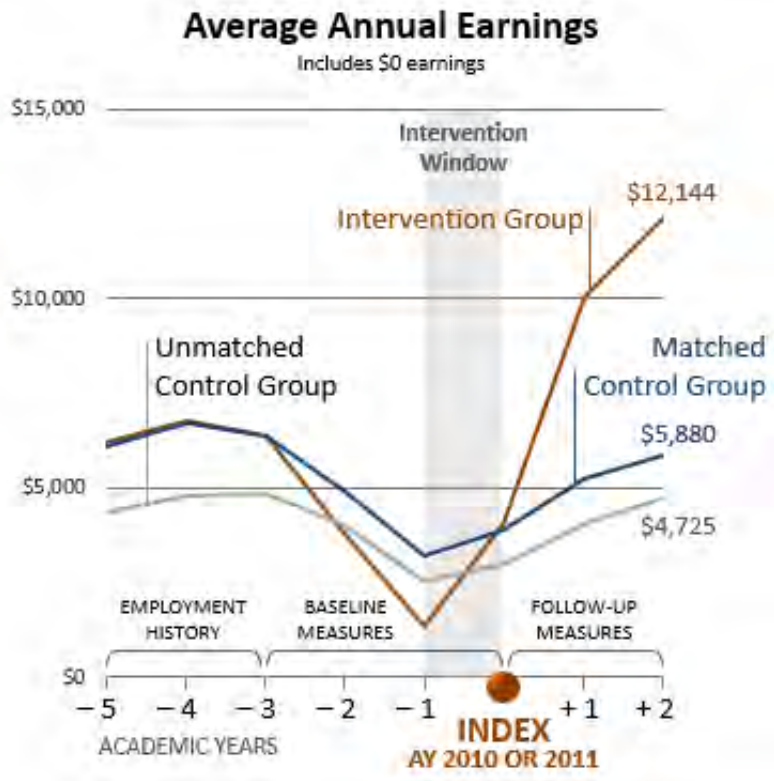
First stage of analysis when exploring newly available areas of data integration

- For example, describing education outcomes for youth receiving different types of social & health services

Program Evaluation

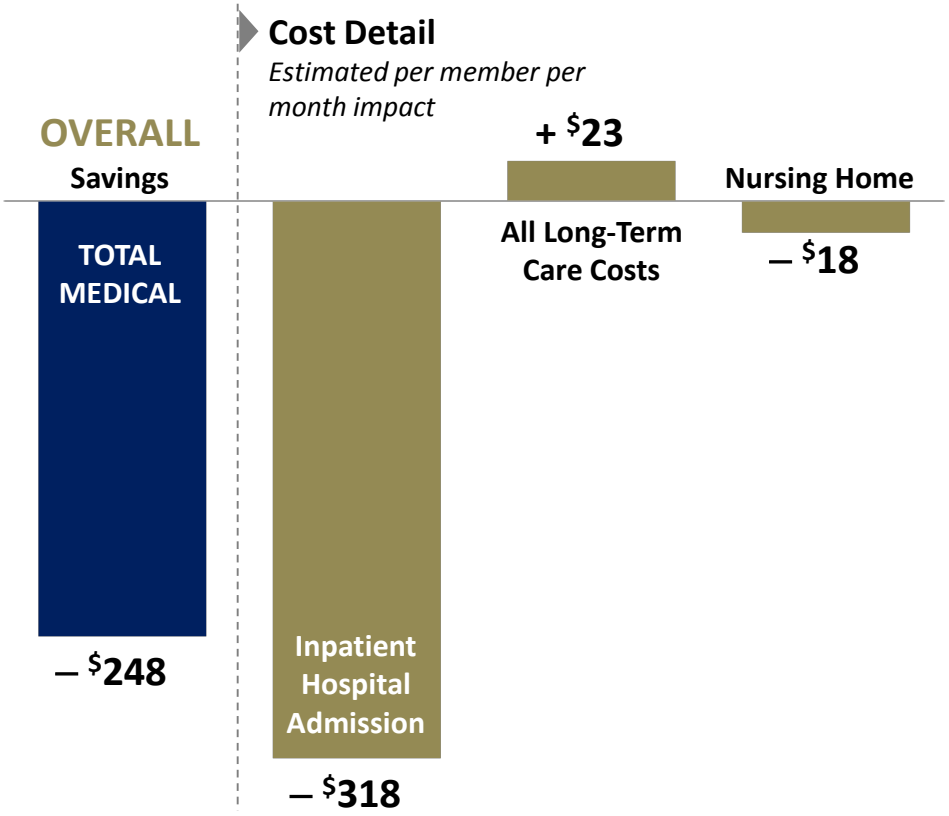
Randomized Trial Simulations Using Matching





Program Evaluation: Care Coordination

- Care Coordination Program for WA Medicaid enrollees reduced inpatient hospital costs
  - Statistically significant reduction in hospital costs
  - Promising reduction in overall Medicaid medical costs



Program Evaluation Cont'd

Considerations

- Randomized evaluation designs are rarely available, so primarily use matching-based "quasi-experimental" approaches
- A pre/post design without a comparison group is rarely adequate, especially if the intervention group is targeted based on extreme baseline behavior
- Fundamental challenge to building a credible evaluation is identifying a valid comparison group
- Matching approach is extremely intuitive, but does not fully address the fundamental issue of selection bias
- Critical to understand the process that "selects" clients into the intervention under study, & to use this knowledge to define a credible comparison group

Predictive Modeling & Clinical Decision Support: PRISM Example

- Rapid-cycle predictive modeling & data integration delivered in a clinical decision support web application
- Data sources
  - Medical, mental health, LTSS services from multiple IT systems
  - Medicare data for duals
  - Housing status
- Data are refreshed weekly for the entire Medicaid population
- Dynamic alignment of patients to health plans & care coordination organizations, with global patient look-up capability for providers

Selected PRISM Uses

- **Triaging high-risk populations through predictive modeling** to more efficiently allocate scarce care management resources
- **Informing care planning & care coordination for clinically & socially complex persons** through integrated & intuitive display of risk factors, service utilization & treating providers
- **A source of regularly updated client & provider contact information** to support outreach, engagement & coordination efforts
- **Identification of child health risk indicators** including mental health crises, substance abuse, excessive ED use, & nutrition problems
- **Medical evidence gathering for determining eligibility for disability programs**

Predictive Modeling

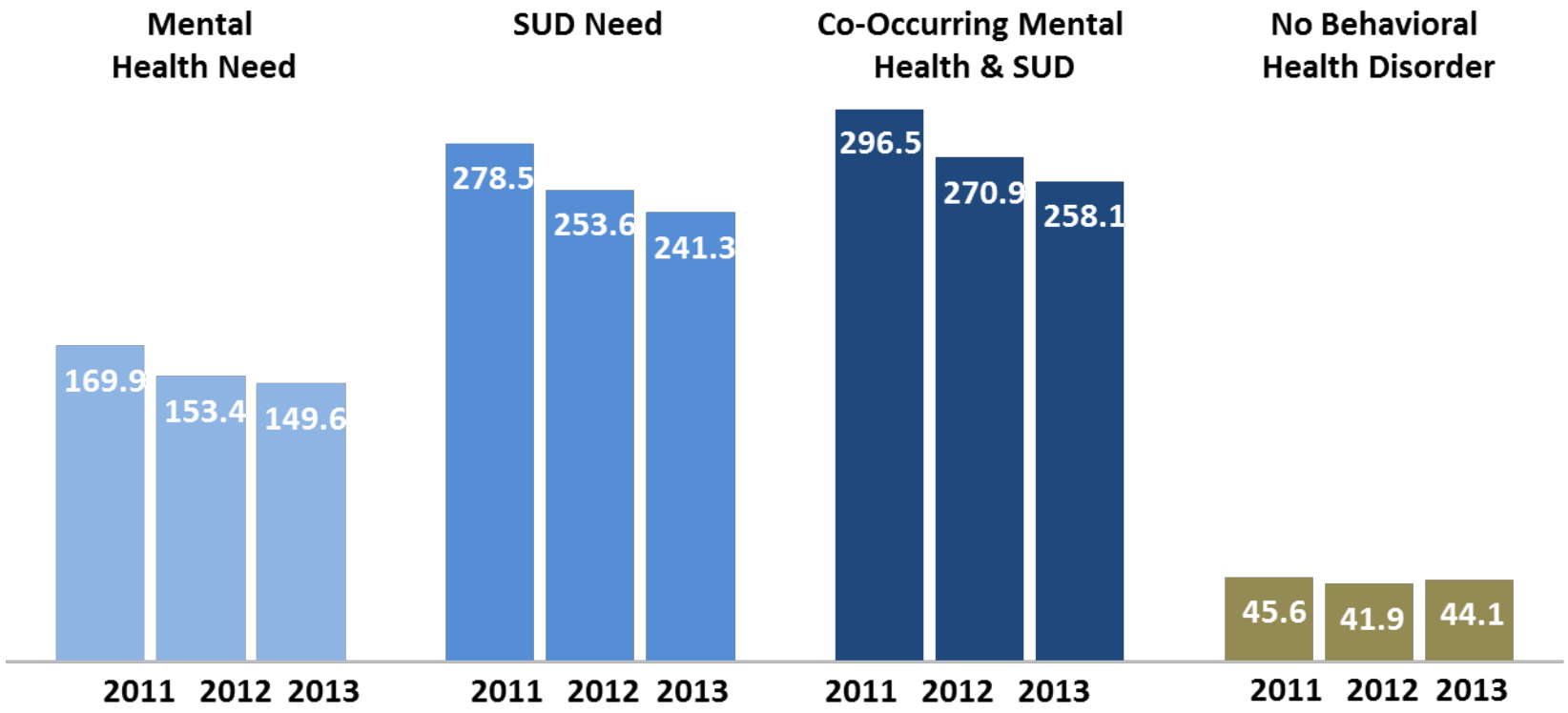
Considerations

- Is the risk model sufficiently predictive to be actionable?
- Are the identified risk factors actionable?
- Improving risk scoring transparency to the end user may be more important than maximizing predictive accuracy
- Invest in staff readiness to use data in decision-making
- Incorporate user feedback in designing information display
- Recognize potential limitations in the timeliness & completeness of available administrative data

Performance Measurement: Outpatient Emergency Department Visits

ED utilization among SSI clients is driven by behavioral health risk

AGES 18-64 • Visits per 1,000 Member Months



SOURCE: DSHS Research and Data Analysis Division, *Managed Medical Care for Persons with Disabilities and Behavioral Health Needs: Preliminary Findings from Washington State*, JANUARY 2015.

Performance Measurement

Considerations

- Outcome over process
- Objective over subjective
- Using administrative data may minimize cost & promote comparability across accountable entities
- Use of national standard where feasible
- Case-mix adjustment reduces incentives for accountable entities to avoid serving high-risk clients
- Performance measurement algorithms require ongoing updating & refinement

Data Integration Challenges: Keys to Success

Trust	Evolve	Governance	Expertise
Building & **maintaining trust** among data owners	**Maintaining** an analytical data **infrastructure** in a **constantly evolving** policy, program & IT **system** environment	Establishing **effective governance** structures	Data are plentiful – **analytic skills informed by policy & program expertise** are scarce

Polling Question (3/5)

- What are the biggest challenges your state faces regarding data integration? Select all that apply.
  - Resources (money, time, staff)
  - Leadership buy-in
  - Quantitative expertise
  - Privacy concerns
  - Competing priorities
  - Other challenges

Discussion and Questions (2/3)

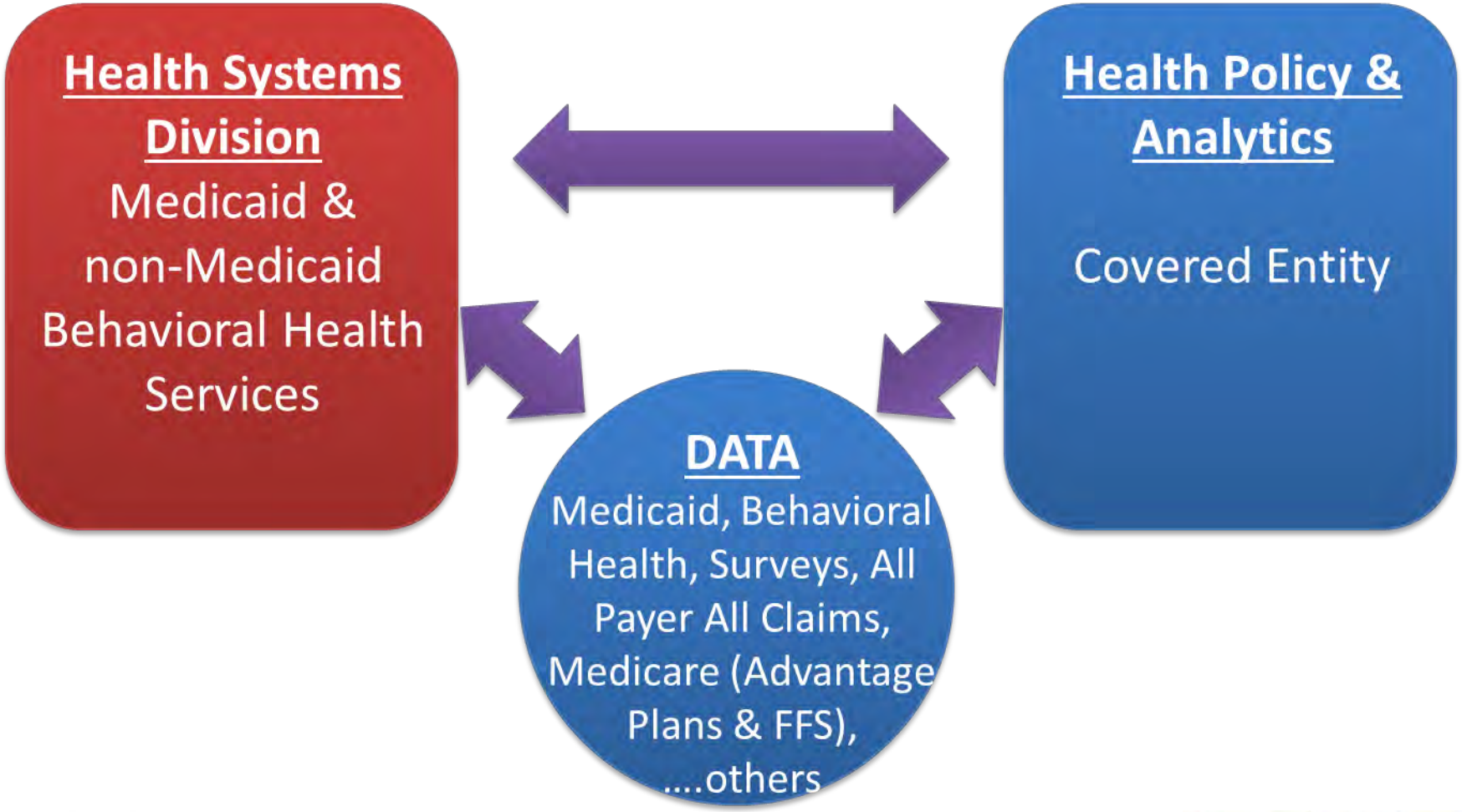
State Experience Linking Data: Oregon

Jon Collins, PhD,

Director, Office of Health Analytics,

Oregon Health Authority

Oregon Health Authority (simplified)



Overview: Measures & Outcomes Tracking System (MOTS)

- MOTS is a comprehensive electronic data system used by behavioral health service providers in Oregon to:
  - Improve care
  - Control costs
  - Share information
- MOTS replaced the Client Process Monitoring System (CPMS)
  - CPMS was a 30 year-old system designed & maintained on a mainframe system
  - It no longer met the business needs of the organization
  - Did a good job of reporting TEDS

The Vision (1/2)

TEDS Episode Data

Profile Data in Measures & Outcomes Tracking System (MOTS)

Medicaid Service Data

Medicaid Management Information Systems (MMIS)

Non-Medicaid Service Data

MOTS

Details of Linking Data: Client Profile Data

- Agency or facility
- Name, date of birth, Medicaid ID
- Treatment status
- Race/ethnicity
- Gender
- Marital status
- Veteran status
- Employment
- Living arrangement
- Counties of residence & responsibility

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Details of Linking Data: Behavioral Health Data

- Service history
  - Admission date, state, zip code
  - Referral information
  - Diagnosis, treatment plan
  - Peer delivered service
  - Intensity of service needed
- Legal
  - Legal status
  - Driving under the influence & arrest history
  - OR Driver License & State Police ID Numbers
- Income & payment source, health insurance
- Interpreter needs
- Pregnancy status
- Number of dependents
- Tobacco & substance use history
- Academic attendance & improvement

Details of Linking Data: Substance Use Disorders Data

- Substance problems
- Age of first use, frequency of use
- Route of administration
- Positive alcohol/drug tests, self-help programs
- Driving under the influence treatment completion date
- Medication assisted treatment
- Assessed & current level of care based on ASAM
- Children living in residential treatment with parents

Details of Linking Data: Non-Medicaid Services Data

- Date of service
- Procedure code
- Place of service
- Number of units & billed charges
- Diagnosis
- Mirrors Medicaid claims

The Vision (2/2)

TEDS Episode Data

Profile Data in MOTS updated every 90 days of active service

Linked via dates of service & Medicaid ID

Linked via dates of service & MOTS ID

Medicaid Service Data

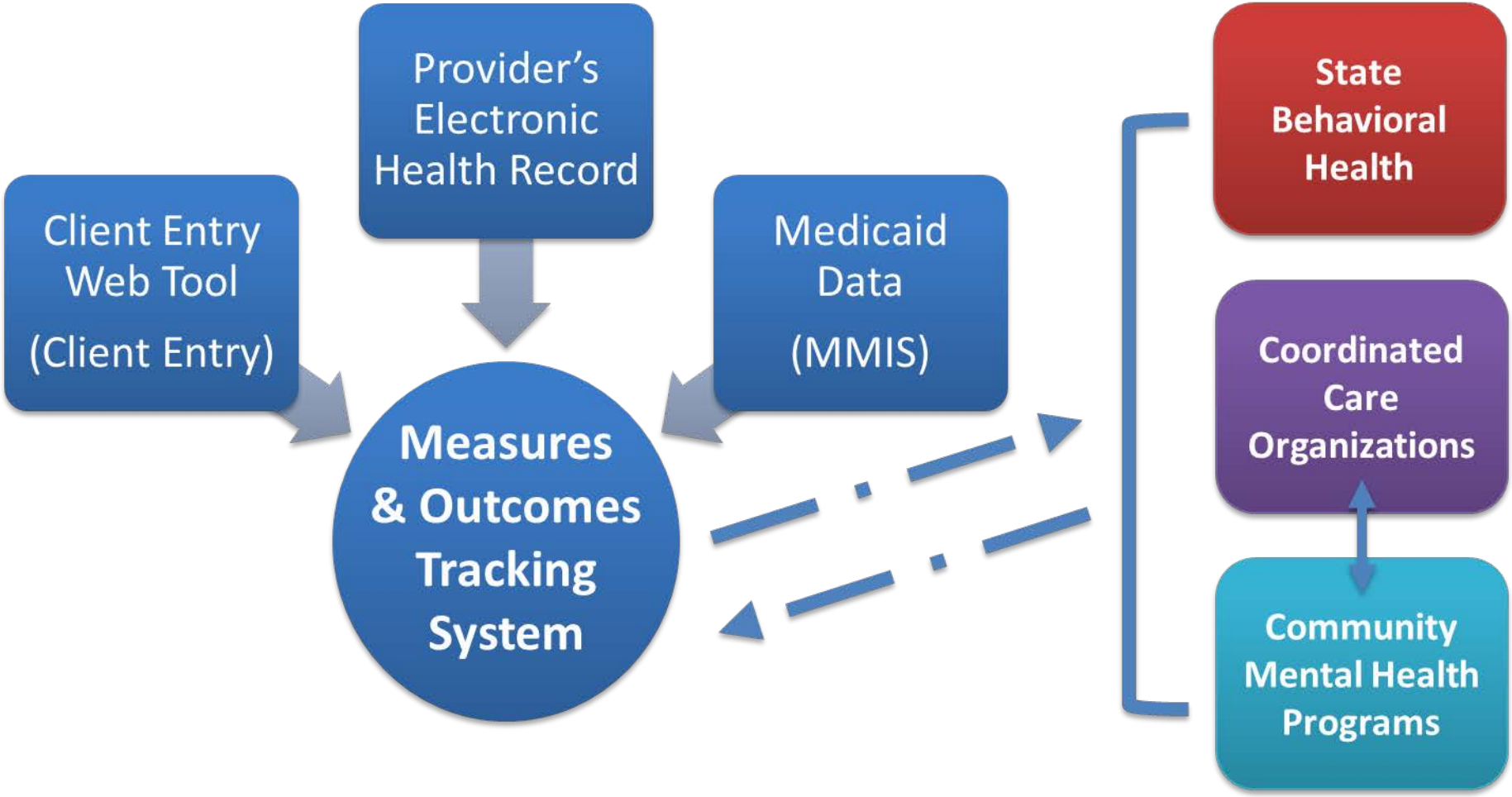
MMIS

Converted to episodes of active service via business rules & linked via common Medicaid ID

Non-Medicaid Service Data

MOTS

Communication Between Data & Payers



Analyzing Outcomes with MOTS

- Using data from MOTS, state behavioral health can track & analyze outcomes
  - Employment improvement
  - Education improvement
  - Stable housing
  - Criminal justice involvement
  - Access to & volume of services
- Equally important, the data can be shared back with Medicaid & non-Medicaid providers
- TEDS data or claims data could not do this alone

Challenges & Lessons Learned (1/3)

- Does it really work that easily?
  - No, not really
  - Challenges
    - Matching up episodes of active treatment & profile data
    - Quality of data input
- 42 CFR Part II
  - The Oregon Health Authority operates with a consolidated Office of Health Analytics
    - A covered entity integrating data across all funding sources & healthcare areas associated with OHA
    - Any data shared back out of the organization is protected & managed by all the regular rules associated with HIPAA & 42 CFR Part II

Challenges & Lessons Learned (2/3)

- Working with providers to switch to the new system
  - Challenges
    - Providers were not initially on-board with the change
    - Providers were not required to report non-Medicaid services under the old system
    - Providers needed to amend their data collections processes, including EHRs
  - Strategies to overcome challenges
    - Working with providers to teach them how to submit complete data
    - Reminding providers that the goal of MOTS is to generate data that is also useful to providers
    - MOTS is a work-in-progress but holds a lot of promise

Challenges & Lessons Learned (3/3)

- Speed of government vs speed of technology?
  - Original platform needs to be updated to keep up with technology standards
    - Our development didn't keep up with these changes
  - Turnover among leadership
    - Turnover in government leadership can often be faster than technology
    - Must keep current leadership informed & onboard

Polling Question (4/5)

- If your state is currently using an integrated database, which kinds of stakeholders receive data from the system? Select all that apply.
  - Providers
  - Criminal justice agencies
  - Social services agencies
  - Health services agencies
  - It does not directly provide data to stakeholders
  - We are not using integrated databases
  - Not sure

Polling Question (5/5)

- If your state is using an integrated database, do you check data for completion?
  - Yes, we have a benchmark data level
  - Yes, we use a standard form to ensure completeness
  - Yes, some other method
  - No / not sure
  - We are not integrating data at this time

Discussion and Questions (3/3)

Webinar Summary: Key Take Away Points

- States need to evolve their analytic capabilities beyond siloed warehousing in order to meet goals of Triple Aim
  - Enhanced data analytics can help resolve questions about cost, outcomes, and population health
- Develop analytic plans around your state's context
  - Variety of data sources can be used
  - Variety of ways to integrate data exist
  - Identify measurement concepts that are meaningful to your needs/questions
- Collaboration with other agencies may be helpful to accessing data, solving problems, & sustaining buy-in

Resources

- Visit the Integrating State Administrative Records to Manage Substance Abuse Treatment System Performance page by SAMHSA here: http://www.air.org/sites/default/files/downloads/report/TAP29_06-07_0.pdf
- Visit the Linking Client Data Records from Substance Abuse, Mental Health and Medicaid State Agencies, National Council for Behavioral Health CBH by SAMHSA here: http://the-link-king.com/SAMHSAtechnicalmonograph.pdf

Contacts

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  - 360-902-7557
- Minakshi Tikoo, PhD
  - University of Connecticut
  - minakshi.tikoo@unconn.edu
  - 860-424-5209
- Jon Collins, PhD
  - Oregon Health Authority
  - jon.c.collins@state.or.us
  - 503-945-6429

Thank You!

Thank you for joining us for this National Dissemination Webinar!

Please complete the evaluation form following this presentation.

Health Data Literacy & Applications for Tribal Health Workshop

October 10th-11th, 2018

Purpose:

The Northwest Portland Area Indian Health Board (NPAIHB) is excited to present the Health Data Literacy & Applications for Tribal Health Workshop! This training provides an excellent opportunity to gain (or refresh) skills in finding, understanding, presenting and applying health data.

Audience:

This will be a very practical skill building session for grant writers, data analysts, health professionals, tribal leaders, policy makers, community planners and students.

Topics:

- Health statistics 101
- Where to find public health data for AI/AN communities
- Best practices for presenting data effectively
- How to get started with collecting and mapping data using Open Source Geographic Information System (GIS) software.
- Putting data to use for community development and health programs

Registration:

Register online at https://www.surveymonkey.com/r/HDLOCT2018 by **September 26th**.

Location:

Yellowhawk Tribal Health Center
46314 Ti'mine Way
Pendleton, OR 97801

Questions?

Contact Sujata Joshi at sjoshi@npaihb.org or (503) 416-3261

Travel Scholarships:

There is no registration fee for this workshop, and travel scholarships (per diem not included) are available for those who are members of or are working with Northwest Tribes (apply during registration). Travel scholarships are limited, so register as soon as you can!

Sponsored by NPAIHB's IDEA-NW and WEAVE-NW Projects.

Thursday, September 27th, 2018
Kiana Lodge
Suquamish, Washington

2018 NW Tribal Food Sovereignty Coalition Gathering-

A celebration of traditional foods, medicine and culture

Click Here To Register

Coalition members, traditional food champions, tribal staff and members are all welcome to attend and take action to improve food systems in your community

Travel will be reimbursed - including hotel, mileage/rental, and flight

Please reserve your room by September 3rd (Limit 2 rooms per tribe)

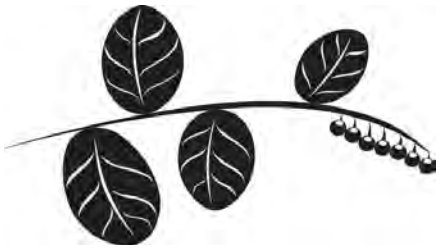
Clearwater Casino Resort
15347 NE Suquamish Way
Suquamish, WA 98392

Click Here To Book Online

Group ID: 14164

For Questions, Please Contact:
Nora Frank-Buckner
WEAVE-NW Project Coordinator
nfrank@npaihb.org
503.416.3253

2018 NW Tribal Food Sovereignty Coalition Gathering Conference Agenda
Kiana Lodge, Suquamish WA



September 27th

8:30	Registration, coffee, tea, breakfast
9:00	Opening blessing, icebreaker, intro from WEAVE and coalition
9:30	Keynote presentation on community health
10:00	All Group Panel Discussion
11:00	Traditional Foods Meet and Greet
12:00	Lunch
1:00-	Breakout session (3-4 sessions)
2:00-2:30	Break
2:30	Breakout session (3-4 sessions)
3:30	All group gathering – All group report back Start Native Chopped Cookoff
4:00	Visit clam bake, salmon and wild game cooked over fire
5:00	Dinner
6:00	Closing

SAVE THE DATE

9th Annual
THRIVE Conference
June 24-28, 2019

*Build protective factors and increase your skills and self-esteem!

*Connect with other Native youth!

*Learn about healthy behaviors!

*Strengthen your nation through culture, prevention, connections, and empowerment!

Who: For American Indian and Alaska Native Youth 13-19 years old

Where: To be determined in Portland, Oregon

What: This conference is made up of four to five interactive workshop tracks!

#WeNeedYouHere

Registration (FREE) will open the first week in April!

Contact Information:
Northwest Portland Area Indian Health Board - THRIVE Project
Celena McCray, Project Coordinator
Ph: 503-416-3270
Email: cmccray@npahib.org
Website: http://www.npaihb.org/thrive/

Director, Dental Therapy Education Program
Swinomish Indian Tribal Community – La Conner, Washington

Located in La Conner, WA, the Swinomish Indian Tribal Community values collaboration with fellow tribal and non-tribal governments. Swinomish partnerships spread throughout Washington State, the Pacific Northwest region and the nation. As a tribal community, Swinomish is proud and honored to play leadership roles through partnerships with the Association of Washington Tribes, the Affiliated Tribes of Northwest Indians, the National Congress of American Indians and other institutions advocating for the rights of Native people. Swinomish Indian Tribal Community ancestors committed to protecting a way of life passed down from generation to generation. The 11 elected members of the Swinomish Senate continue that commitment by strengthening their government and, as a sovereign nation, they engage in local, state and interstate commerce, manage natural resources and exercise power over homelands and waters.

The Dental Therapy Education Program was developed to work with tribal communities to diminish health disparities and increase access to oral health care through training and employment of Dental Therapists. The Swinomish Indian Tribal Community has played a national leadership role in establishing the legal and policy groundwork to allow the training and practice of Dental Health Aide Therapists in Washington State and is honored to launch the first training program in the continental United States in partnership with the Northwest Portland Area Indian Health Board (NPAIHB), Skagit Valley College (SVC) and the Seattle Indian Health Board (SIHB). In preparation for a 2020 educational program launch, the Swinomish Indian Tribal Community is accepting applications for the Director of the Dental Therapy Education Program which will be administered by Skagit Valley College and will have instructional sites in Mount Vernon, the Swinomish Indian Tribal Community, and the Seattle Indian Health Board. Skagit Valley College educational programs are designed to meet community needs and create a campus climate that promotes innovative teaching, quality scholarship, a diverse learning environment, equitable access, and educational achievement for all students.

The Director, Dental Therapy Education Program will be responsible for overall program development and management of the associate degree in dental therapy at the Mount Vernon campus and Swinomish Indian Tribal Community clinical site, and Seattle Indian Health Board practicum site. This position is responsible for articulating the need for and benefits of Dental Health Aide Therapists in tribal communities in national and local forums and for promoting the program to multiple stakeholders. The Director will lead the effort to obtain local and regional accreditation from the Commission on Dental Accreditation (CODA) and Community Health Aide Certification Board.

The Director is an employee of the Swinomish Indian Tribal Community and reports to the Programs Administrator and the Skagit Valley College Workforce Dean and works closely with the Dental Director at Swinomish Dental Clinic to assure program quality with a focus on student learning outcomes and student success, adherence to accreditation standards, achievement of enrollment and retention targets and priorities established through the strategic planning process. The Director will direct faculty and staff to achieve program outcomes. The Director will also work with the Dental Therapy Education Advisory Committee (DTE Advisory Committee) to disseminate information and gather input on continuous improvement of the program.

Duties and Responsibilities:

Program and Curriculum Development:

- In consultation with DTE Advisory Committee, SVC leadership, NPAIHB, and Swinomish, develop program goals and an implementation work plan for new Dental Therapy education program;
- In collaboration with DTE Advisory Committee, the Alaska Dental Therapy Education Program (ADTEP), curriculum developer, CODA specialist and program faculty, develop curriculum for Dental Therapy Education Program at Skagit Valley College;
- In collaboration with a CODA specialist, integrate actions/steps/policies necessary to achieve CODA Accreditation into overall program planning;
- In partnership with Swinomish dental team, develop academic partnership for clinical education of Dental Therapy students;
- In collaboration with SIHB dental team, develop academic partnership for clinical rotations for Dental Therapy students;
- Guide program from planning phase to implementation phase.

Program Leadership and Administration:

- Create an inclusive and supportive working environment that values the contributions of all members of the team;
- Provide effective administration and management of the instructional programs within dental therapy, working closely with department chairs and collaborating with tribal partners, faculty and staff to include: curriculum development, evaluation and revision; faculty recruitment, assignments and supervision; faculty professional development and evaluation; assessing, planning and operating program facilities; input into budget preparation and fiscal administration; coordination, evaluation and participation in determining admission criteria and procedures as well as student promotion and retention criteria.
- Serve as primary liaison with the Commission on Dental Accreditation and Community Health Aide Certification Board and serve as administrator to support department chairs or faculty to assure that all standards are being met;
- Recruit, retain, supervise, evaluate and support full-time and part-time faculty, classified staff, and other unit employees;
- Develop and promote inclusive policies, practices, and programs that reflect a commitment to multicultural understanding, social justice, and work place equity;
- Collaborate with faculty to foster a positive learning environment, including the adoption of teaching methods that support successful learning appropriate to a diverse student population;
- Collaborate with faculty and other unit administrators to develop programs, procedures, and practices to improve student transition, progression and completion;
- Work collaboratively with department chairs and other unit administrators to develop and implement annual and quarterly course schedules that are responsive to student needs;
- Create and provide professional development opportunities for faculty;
- Administer union contracts, work with multiple unions, and constructively approach and solve issues that arise within a unionized workplace environment;

- Ensure compliance with applicable federal, Swinomish, state and college rules, procedures, laws and regulations;
- Advise students and respond to concerns related to instruction.

Budget Management and Planning:

- Contribute to and provide instructional leadership for college initiatives and strategic planning working closely with department chairs for dental therapy and collaborating with faculty and staff;
- Oversee planning and manage budget for instructional programs;
- Develop and implement a Strategic Enrollment Management (SEM) plan for dental therapy and advance the college's overall SEM goals;
- Work with the department chair to establish efficient class schedules that meet enrollment targets, and monitor enrollment and part-time faculty budgets.
- Collaborate with others on campus to bring additional resources—including grants, contracts and partnerships—to expand and improve instructional initiatives;
- Advise on fees, coding, and related functions.

Assessment Activities:

- Conduct ongoing evaluation of instructional programs within dental therapy; identify emergent needs; use data to support and inform decision-making;
- Review and analyze enrollment data, student progression, and completion;
- Collaborate with faculty to conduct ongoing curriculum development, assessment, and revision to reflect innovative pedagogy and advances in dental therapy;
- Collaborate with NPAIHB to produce reports for grant funding and other purposes;
- Create periodic reports that meet college, accreditation, and other stakeholder interest.

Communication Activities:

- Collaborate with dental therapy faculty and staff to be responsive to accreditation requirements, applicable Swinomish, State or Federal laws or regulations, or major initiatives occurring nationally or locally;
- Represent the college to internal and external organizations; represent the college at statewide meetings and other meetings related to the position responsibilities;
- Develop, support, and maintain collaborations and partnerships; maintain communications across the campus including bringing outside initiatives to campus;
- Assist in content management of website, schedule, and catalogs as these pertain to dental therapy.

Committee Assignments and Meetings:

- Serve as the college's liaison for Dental Therapy to the State Board for Community and Technical Colleges, and other official health science agencies and associations;
- Serve as liaison and work closely with Northwest Career and Technical Academy on program articulation for career pathways related to health science;
- Schedule and work with advisory committees in program development and recommended program improvements;
- Collaborate with NPAIHB, Swinomish, SIHB, and other outside partners;
- Serve on Instructional Leadership Team.

Other:

- Demonstrate and model professional conduct expected in the industry as well as through upholding the mission, values and goals of Swinomish Indian Tribal Community and Skagit Valley College;
- Promote Health Education programs, recruit students, and provide service to traditional and under-represented populations;
- Promote student success and ensure sensitivity to student needs and concerns regarding instructional matters;
- Work closely with advising and related support services;
- Provide and facilitate clear communication with program partners and within the College;

SKILLS AND ABILITIES

The successful candidate will demonstrate skills and abilities to:

- Work in partnership with tribes with cultural competency, curiosity and willingness to engage in the community;
- Make definitive decisions and implement set plans and processes;
- Apply knowledge of current theories, research, and high-quality practice in dental education;
- Offer creative innovative ideas to develop programming, curricula, and pedagogy—including, for example, integrative learning, service-learning, online learning, etc.—that incorporate program and general education learning outcomes;
- Promote an equitable work and learning environment and express appropriate awareness of the history of marginalized groups;
- Adhere to applicable federal, state, Swinomish, local and college regulations, policies, processes, procedures, and deadlines;
- Resolve conflicts and address faculty, staff and student concerns in a fair, equitable manner;
- Act and behave according to principles of integrity, respect, open and honest communication, and collaboration.
- Have an understanding of a comprehensive multi-campus community college;
- The successful candidate will be creative, energetic, and able to make significant contributions to the continuous improvement of a high-quality faculty and institution, and possess demonstrated leadership potential.

QUALIFICATIONS:

MINIMUM QUALIFICATIONS

- Licensed dentist (DDS/DMD) or a licensed dental therapist possessing a master's or higher degree;
- Graduate of a program accredited by the Commission on Dental Accreditation;
- Background in education and professional experience necessary to understand and fulfill the educational program's mission and goals;
- Experience working with Tribal Communities;
- Demonstrated commitment to equity and inclusion;

DESIRED QUALIFICATIONS

- Progressively successful administrative experience in education or healthcare with an emphasis on collaboration.
- Dental practice experience in a Native community;
- Experience teaching adults;

RECRUITMENT PROCESS

- Native American hiring preferences under Swinomish Tribal Code 14-01.120 will be in effect during the selection of candidates.
- Applicants must pass a background check and a drug test.

Phone (360) 466-3163
Fax (360) 466-5309

Swinomish Indian Tribal Community

A Federally Recognized Indian Tribe Organized Pursuant to 25 U.S.C. § 476
11404 Moorage Way
LaConner, Washington 98257-0817

APPLICATION FOR EMPLOYMENT

Position Title:	Date:

Name:	Street:	Apt:
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
E-Mail:	Social Security Number:	May we contact you at work: ____Yes ____No

POLICIES AND INSTRUCTIONS:

1. The Tribe uses Native American preference in hiring.
2. The Tribe strives for a drug-free environment. Drug/alcohol screening at time of hire is mandatory in sensitive and hazardous positions where required by the job announcement/description or positions working with Tribal Youth.
3. Read the job announcement and position description carefully.
4. Complete all information on the application. **Do not write, "see Resume"** on the application.
5. Read the information in the signature area carefully, then sign and date the application.
6. Return the signed and completed application to the Personnel Office at the above address**. Applications must be received in the Personnel Office by 5:00pm on the closing date**

PERSONAL DATA

Does Swinomish Tribal Community currently employ you? _____Yes _____No

Have you ever been employed by the Swinomish Tribal Community ____Yes ____No

If so, What Position? _____ Dates: _____

Do you claim Native American Preference? _____Yes _____No

If so, Tribal affiliation: _____ Enrollment number: _____

Do you claim Veteran's Preference? _____Yes _____No

If "yes" attach copy of DD Form 214.

Do you have a valid Washington State Driver's license? _____Yes _____No

Have you been convicted of a crime within the last ten (10) years? ____Yes ____No

If "yes", please explain, including date(s) and court(s).

_____

_____

_____

Can you perform the essential functions of the job with or without reasonable accommodation? _____Yes _____No

Are you legally able to work in this country? _____Yes _____No
(Proof of status will be required if hired)

EDUCATION AND TRAINING

Type of School	School Name and Location	Major Subject	Years Completed	Graduate? Y/N Degree & type
High School				
College (Undergrad)				
College (Graduate)				
Business/ Vocational				
Trade/ Other				
Military				

SKILLS AND ABILITIES

Computer Operation (Specify proficiency level, low, medium, or high and software used)

_____

Equipment Operation (Specify equipment and proficiency level – low, medium or high):

_____

Other Skills and abilities:

Previous Employment: Please list 10 years with the most recent employment first

EMPLOYER:_____Employed From:_____to_____

Address:_____City:_____State:_____

Job Title: _____Duties:_____

Reason for Leaving_____

EMPLOYER:_____ Employed From:_____To:_____

Address:_____City:_____State:_____

Job Title:_____ Duties:_____

Reason for Leaving_____

EMPLOYER:_____Employed From:_____To:_____

Address:_____City:_____State:_____

Job Title:_____ Duties:_____

Reason for Leaving:_____

EMPLOYER:_____Employed From:_____To:_____

Address:_____City:_____ State:_____

Job Title:_____ Duties:_____

Reason for Leaving:_____

EMPLOYER:_____Employed From:_____ To:_____

Address:_____ City:_____State:_____

Job Title:_____ Duties:_____

Reason for Leaving:_____

EMPLOYER:_____ Employed From:_____ To:_____

Address:_____ City:_____ State:_____

Job Title:_____ Duties:_____

Reason for Leaving:_____

Workshops or On-The-Job Training

Location of Training	Training Course	# Of Hours	Certificate of Completion

Additional Information

Please include any additional information that is relevant to this position, including second languages, special qualifications, accreditation, etc.

REFERENCES

Please list three (3) non-relatives whom you have known for at least one year

Name	Title/Relationship	Current Address	Current Telephone

Signature and Affirmation

This application and any attachments become official records of the Swinomish Tribal Community and cannot be returned. Please make a copy for your records before submitting. The Tribe has a confidentiality policy regarding the hiring process.

I hereby certify that the information on this application is true, correct and complete to the best of my knowledge and belief. I authorize investigation of information given in this application. I understand misrepresentation or omission of facts is cause for rejection of my application or disciplinary action, including dismissal, if hired. I understand that if I am hired, my employment is subject to the Swinomish Tribal Community Policy and Procedures Manual, and I consent to a comprehensive background investigation to include a criminal history background check, if employment is offered and accepted.

Applicant Signature:	Date:

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
JOB POSTING – CLOSING DATE: 9/21/18

Job Title: General Office Assistant
Reports To: Administrative Officer
Salary: $12.00-14.00/hr
Department: Administration
FLSAStatus: Non-Exempt (hourly)
Classification: Regular, On-call
Location: Portland, Oregon

Job Summary: The Office Assistant will provide administrative and general support on scheduled short-term assignments or when the NPAIHB needs administrative support with short notice due to employee absence. This position will work on an as needed basis during regular office hours. The tasks may include staff support tasks at conferences and training sessions held off-site.

When working at the front desk, the Office Assistant has primary responsibility to answer a multi-line telephone system, routing callers and visitors in a courteous and professional manner, and to provide clerical support for NPAIHB staff. The Office Assistant must ensure the smooth functioning of the reception area, serve as the first contact to the general public and be the first representative of the Board to all visitors. He or she must be courteous, personable, self-motivated, and have the ability to manage multiple tasks and meet deadlines in providing support for unspecified functions of the organization. The Office Assistant will maintain a professional relationship with all NPAIHB project staff while dealing with sensitive personnel and project information. Therefore, the Office Assistant will need to understand the importance and sensitivity of confidentially and maintain it at all times.

Essential Functions:

1. Provide Reception Support
    - Professionally meet and greet visitors, in person, or over the telephone.
    - Ensure that security protocols are followed, including guest sign-in, and verifying maintenance calls.
    - Route telephone calls to proper departments and/or staff members; provide helpful information as needed.
    - Maintain a comfortable and tidy atmosphere for all guests and visitors in the reception area.
    - Receive package deliveries and notify intended recipient

2. Provide Office Functions and Activities Support
    - Provide general clerical assistance to Administrative Officer and specific projects as assigned
    - Provide general project support to NPAIHB projects on ad hoc and impromptu assignments and committees.
    - Perform word processing assignments.
    - Collect, sort and properly distribute all in-coming mail daily.
    - Properly route and notify designated staff of received contracts, checks, and funding announcements/applications/notices.
    - Prepare out-going mail with correct postage and place in out-going mail box.
    - Assist with conference and meeting set up tasks, as assigned
    - Maintain a clean and well-organized office environment and workspace.

Additional Functions:

- Perform other duties and assignments as directed.
- Prepare a daily or weekly report of tasks undertaken ,completed with enough detail to inform other employees when read

Standards of Conduct:

- Consistently exhibit professional behavior and a high degree of integrity and impartiality appropriate to the responsible and confidential nature of the position.
- Consistently display professional work attire during normal business hours.
- Effectively plan, organize workload, and schedule time to meet workload demands.
- Exercise judgment and initiative in performance of duties and responsibilities.
- Work in a cooperative manner with all levels of management and with all NPAIHB staff.
- Treat NPAIHB delegates/alternates and Tribal people with dignity and respect and show consideration by communicating effectively.
- Abide by NPAIHB policies, procedures, and organizational structure.

Qualifications:

- HS Diploma or equivalent
- Experience in a Receptionist or Office Support position preferred.
- Demonstrates the ability to work effectively with American Indian people in a culturally diverse environment.
- Knowledge of MS Outlook and Word
- Ability to carry out responsibilities with a minimal amount of supervision.
- Ability to use office equipment.
- Available to work on-call as needed.

Typical Physical Activity:

Physical Demands: Frequently involves sedentary work: exerting up to 10 pounds of force and/or a negligible amount of force to lift, carry, push, pull or otherwise move objects, including the human body.

Physical Requirements: Constantly requires the ability to receive detailed information through oral communications, and to make fine discrimination in sound. Constantly requires repetitive movement of the wrists, hands and/or fingers. Often requires walking or moving about to accomplish tasks. Occasionally requires standing and/or sitting for sustained periods of time. Occasionally requires ascending or descending stairs or ramps using feet and legs and/or hand and arms. Occasionally requires stooping which entails the use of the lower extremities and back muscles. Infrequently requires crouching.

Typical Environmental Conditions: The worker is frequently subject to inside environmental conditions which provide protection from weather conditions, but not necessarily from temperature changes, and is occasionally subject to outside environmental conditions.

Travel Requirements: No travel is required.

Disclaimer: The individual must perform the essential duties and responsibilities with or without reasonable accommodation efficiently and accurately without causing a significant safety threat to self or others. The above statements are intended to describe the general nature and level of work being performed by employees assigned to this classification. They are not intended to be construed as an exhaustive list of all responsibilities, duties and or skills required of all personnel so classified.

Except as provided by Title 25, U.S.C. § 450e(b), which allows for Indian preference in hiring, the NPAIHB does not discriminate on the basis of race, color, creed, age, sex, national origin, disability, marital status, sexual orientation, religion, politics, membership or non-membership in an employee organization.

Applications can be found online at www.npaihb.org

SEND RESUME AND APPLICATION TO:

Andra Wagner
Human Resources Coordinator
2121 SW Broadway, Suite 300
Portland, Oregon 97201
FAX: (503) 228-8182
Email: awagner@npaihb.org

STANDARD APPLICATION

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD (NPAIHB)

Please note: You are welcome to submit a resume/CV in addition to, but not in place of, this signed form.

1. Name: _____
   FIRST MIDDLE LAST

   Address: _____

   _____
   CITY STATE ZIP

   Primary Phone:_____Alternate Phone: _____

   Email Address: _____

2. Position for which you are applying: _____

3. When will you be available for work? _____

4. If the position requires travel, are you willing to travel (Check One) ☐ NO ☐ SOME ☐ OFTEN

5. Are you at least 18 years of age? ☐ NO ☐ YES

   If you are under 18 years of age, can you provide proof of your eligibility to work? ☐ NO ☐ YES

6. Are you eligible for employment in the United States? (Proof of identity and eligibility is required for employment)

   ☐ NO ☐ YES

7. How did you hear of this job? __referral, __ad Referred by: _____

8. Do you have any relatives who work at NPAIHB? ☐ NO ☐ YES

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9. **Indian Heritage:** This information is essential if you wish consideration under the Indian Preference Act.
   Verification of blood quantum, enrollment number, tribe, and reservation should accompany this application.

   _____
   TRIBE RESERVATION

   _____
   Enrollment Number/Blood Quantum

---

10. Are you able to perform the essential functions listed in the job announcement you are applying for, either with or without reasonable accommodations? ☐ NO ☐ YES
If not, please describe what functions you cannot perform.

11. EDUCATION, beginning with most recent. A**n attached copy of degree or certificates earned is required.**

College or University	From	To	Credits earned	Major/minor	Degree earned	Year
High School attended :					Graduated? Yes/No	Year
GED completion through:					Yes/No	

Other schools or training: vocational, armed forces, trade, etc. For each give the name, location, dates attended, subjects studied, number of classroom hours, certificates or credits earned. If needed, continue on last page of application.						
Name and Location	From	To	Area of study	Credits earned	Certificate earned	Year

12. COMPUTER and other office machine experience, training. Please name the software with which you have experience in the following areas:

TASK	**Name of software**	**Level of expertise 0-5, (5 being master/high)**
Word processing		
Spreadsheet set-up and usage		
Office E-mail system experience		
Data Management		
High-level data analysis		
Photo-text slide presentations		
Preparation of brochures, flyers		
Other (fax, copier, scanner, etc.)		

13. EMPLOYMENT HISTORY, beginning with most recent

May inquiry be made of your current employer regarding your character, qualifications, and record of employment? ☐ NO ☐ YES ☐ With advance notice to applicant

(A "no" will not affect your consideration for employment opportunities)

A.			
From: _____ To: _____ (Date) (Date)		Title of Position:	
Average Hours Per Week:	Place of Employment City: State:	Number and Job Titles of Employees Supervised:	Kind of Business:
Name of Supervisor: Phone Number:		Name and Address of Employer:	
Reason for leaving position:			
Description of duties, responsibilities and accomplishments: Additional space is provided at the end of application.			

B.			
From: _____ To: _____ (Date) (Date)		Title of Position:	
Average Hours Per Week:	Place of Employment City: State:	Number and Job Titles of Employees Supervised:	Kind of Business
Name of Supervisor: Phone Number:		Name and Address of Employer	
Reason for leaving position:			
Description of duties, responsibilities and accomplishments: Additional space provided at the end of application.			

C.			
From: _____ To: _____ (Date) (Date)			Title of Position:
Average Hours Per Week:	Place of Employment City: State:	Number and Job Titles of Employees Supervised:	Kind of Business
Name of Supervisor**:** Phone Number:		Name and Address of Employer	
Reason for leaving position:			
Description of duties, responsibilities and accomplishments: Additional space is provided at the end of application.			

D.			
From: _____ To: _____ (Date) (Date)			Title of Position:
Average Hours Per Week:	Place of Employment City: State:	Number and Job Titles of Employees Supervised:	Kind of Business
Name of Supervisor: Phone Number:		Name and Address of Employer	
Reason for leaving position:			
Description of duties, responsibilities and accomplishments: Additional space provided at the end of application.			

E.			
From: _____ To: _____ (Date) (Date)		Title of Position:	
Average Hours Per Week:	Place of Employment City: State:	Number and Job Titles of Employees Supervised:	Kind of Business
Name of Supervisor: Phone Number		Name and Address of Employer	
Reason for leaving position:			
Description of duties, responsibilities and accomplishments: Additional space provided at the end of application.			

14. **Special qualifications and skills** (relevant publications; public speaking experience; membership in a professional or scientific society, etc.) Use additional pages if needed.

15. **HONORS, AWARDS, AND FELLOWSHIPS RECEIVED:**

16. **REFERENCES:** List 3 persons who are NOT related to you and who have definite knowledge of your qualifications and fitness for the position for which you are applying. Please ensure that telephone numbers are current.

Name	Phone Number	Occupation
1.		
2.		
3.		

YOU <u>MUST SIGN</u> THIS APPLICATION. Read the following three parts carefully before you sign:

- A false statement on any part of this application may be grounds for not hiring me, or firing me after I begin work. I understand that any information I give may be investigated as allowed by law or Presidential order.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD (NPAIHB)

- In consideration of NPAIHB's review of my application for employment, I hereby authorize NPAIHB and its agents to investigate my background as it pertains to employment considerations. This may include, but is not necessarily limited to, investigation of past employers/supervisors, personal references, educational institutions, criminal records/background checks, motor vehicle records and information contained in public records. I consent to the release of information to NPAIHB, by all persons and sources of information and their agents, relative to such investigation. I hereby release all such persons and sources of information and their agents from any liability or damages on account of having furnished information to the NPAIHB, and release the NPAIHB and its agents from any liability or damages on account of having conducted the investigation.
- I certify that, to the best of my knowledge and belief, all of my statements contained in my employment application and any attached documentation are true, correct, complete and made in good faith.

_____ _____

SIGNATURE DATE

Except as provided by Title 25, U.S.C. § 450e(b), which allows for Indian preference in hiring, the NPAIHB does not discriminate on the basis of race, color, national origin, sex, creed, age, disability, marital status, sexual orientation, religion, politics, membership or non-membership in an employee organization.

12. (a) (for continuation of description of duties, responsibilities, etc., as needed)

Please submit your completed form to:

Human Resources Coordinator
Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300
Portland, OR 97201
Or FAX to: 503-228-8182
Or e-mail to: HR@npaihb.org

Due to a scheduling conflict with Legislatives days, AIHC's Biennial Summit has been rescheduled:

Save the Date!
NEW DATES!!!

2018 American Indian Health Commission for Washington State's Tribal and State Leaders Health Summit

This Summit is scheduled for

November 7th and 8th, 2018

At:

The Suquamish Clearwater Resort and Casino, Suquamish Washington, of the Suquamish Tribe of Indians.

The American Indian Health Commission (AIHC) is committed to advocating for improving the health of all Tribal people. The two-day Summit is a unique and strategically significant event for tribes in Washington State. We bring together Tribal leaders, state legislators, Tribal and urban Indian health organization staff members, state agency representatives, Federal Region 10 representatives and the Portland Area Indian Health Service to discuss Tribal legislative and programmatic health priorities. Over the years the Summit has become a vitally important forum for strategic Tribal – State planning and collaboration in Washington.

The work of the summit will be to produce actionable and accountable plans for work to be done by the State, Tribes, the AIHC and other partners throughout the next two years to improve the health of American Indians and Alaskan Natives in our State.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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

2121 SW Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

September 19, 2018

Re: Support for Expectant and Parenting Teens, Women, Fathers and their Families in Washington State

cc: Washington Tribes

Dear Colleagues,

The Northwest Portland Area Indian Health Board (NPAIHB) is pleased to announce it has received funding from the State of Washington Department of Health (AH-SP1-18-001) to improve healthy futures for AI/AN expectant and parenting teens, women, fathers and their families. Our mutual goal is to create a seamless network of linkages for expectant and parenting teens in Washington, connecting them to culturally-appropriate services, programs, resources, and referrals.

Through this partnership, the NPAIHB is offering financial and programmatic support to WA tribes to establish or expand programs and interventions that serve AI/AN expectant and parenting teens and their families.

The NPAIHB plans to provide 3 mini-grant awards of $10,000. The anticipated funding period is November 2018 – June 2019. Funds may be used to support the following activities at the school, clinic, or community-level:

- Staff FTE and training;
- The implementation of community-selected interventions (e.g. Family Spirit, GRADS, etc.);
- Teen parent case management and referral services;
- Federally-approved indirect rates

Please share this announcement with staff in your community who work with expectant and parenting teens. Those interested in partnering or learning more are invited to fill out this contact sheet:
https://www.surveymonkey.com/r/TeenParentProject

If you have any questions, please contact the *WA DOH Parenting Teens* project coordinator, Celena McCray, at cmccray@npaihb.org or 503-416-3270. For all NW tribes, please feel free to reach out to me as a resource on this topic.

Respectfully,

Celena McCray

Celena J. McCray, MPH (c)
Project Coordinator - WA DOH Parenting Teens & THRIVE
Northwest Portland Area Indian Health Board