Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

April 2019

Health News & Notes

A Publication of the Northwest Portland Area Indian Health Board

Policy

Tobacco Policy

Ryan Ann Sealy, (Chickasaw) BS
Tobacco Prevention
Project Specialist

Jenine Dankovchik
Biostatistician &
Program Evaluation Specialist
WEAVE-NW Project

Introduction

Traditional tobacco is grown and prepared for ceremony in keeping with the tribe's customs to aid in healing. Post colonization commercial tobacco has been mass produced and includes as many as 4,000 harmful additives, 70 of which are known carcinogens. While not all Northwest Tribes traditionally use tobacco the culture varies across the region, some uses of tobacco may include medicine, smudging, ceremony, prayers, offerings and gifting.

The burden of commercial tobacco use within the Northwest tribes has led to devastating health consequences. Nearly one third of adult AI/ANs in the region are current smokers, which is a higher prevalence than the general population[1]. Long-term commercial tobacco use leads to lung cancer, cardiovascular disease and stroke, and puts the user at a 30-40% increased risk of developing diabetes[2].

Among AI/AN communities in the Northwest, cardiovascular disease and cancer are the leading causes of death, and lung cancer is the form of cancer most likely to result in death. Mortality rates for cardiovascular disease and lung cancer are statistically significantly higher for AI/AN in the region than for non-Hispanic whites. Diabetes is the fifth leading cause of death for AI/AN in Idaho and Oregon, and the fourth leading cause of death for AI/AN in Washington[3].

Northwest tribes have and are continuing with successful tobacco cessation programs. However, with the use of electronic nicotine delivery systems (ENDS) there has been an increase in youth and young adult use as well as duel use of commercial tobacco

continues on page 15

IN THIS ISSUE:

Chairman's Notes

Andrew Joseph, Jr.,
Colville Tribal Council
NPAIHB Chair

Greetings!
The President released his FY 2020 budget for the Indian Health Service on March 11th. I was disappointed to see that the President only recommended a less than 2% increase above FY 2019 enacted level for services and facilities. This will not get us to full funding! The National Tribal Budget Formulation Workgroup recommended a 36% increase for FY 2020. The President also again recommended no funding for Health Education and Tribal Management Grants, a $39 million cut to the Community Health Representatives program, and other cuts to urban health programs, Indian Health Professions, and Self-Governance. I will be advocating against these cuts when I hit the Hill later this month and requesting full funding phased in over 12 years.

On March 6th, I testified before the House Interior, Environment and Related Agencies Appropriations Subcommittee for FY 2020 Indian Health Service funding. I was able to make several of the requests in NPAIHB's Legislative and Policy Requests. Besides the request for full funding I made specific funding requests for Purchased and Referred Care, Mental Health and Substance Use, Small Ambulatory Program, Joint Venture, Special Diabetes Program for Indians and new requests for funding for Long Term Care, IT/EHR Modernization, Community Health Aide Program and Hepatitis C.

In Washington, I also wanted to share that I testified on two bills. I testified on Senate Bill 5415, the Indian Health Improvement Act which will create the forum and funding mechanism to improve the health of AI/ANs in Washington State. I also testified before the Washington Senate Health and Long Term Care Committee on Senate Bill 5569 which will allow eligible tribal facilities to access higher encounter rates though federal funding. This will improve the care for our elders and keep our people home.

Thank you for your support at the last QBM in re-electing me as your Chair. I am honored to do this work on behalf of NPAIHB and our Northwest tribes.

Way límˈlímx (Thank you)
Yəx̌ʷyəx̌ʷúɬxn (Badger)

Andrew C. Joseph Jr.
HHS Chair
Colville Tribal Council
NPAIHB Chair
NIHB Member

Indian Health Update

Geoff Strommer
Hobbs, Straus, Dean & Walker, LLP

This article provides health legislative and funding updates, as well as litigation updates on the national opioid litigation, the Affordable Care Act, the Indian Child Welfare Act, and the ongoing dispute over the processing of Catastrophic Health Emergency Fund (CHEF) program claims.

Status of FY 2019 IHS Appropriations

On February 15, 2019, the President signed an omnibus appropriations bill, H. J. Res. 31, as Public Law 116-6. The Act funds the Indian Health Service (IHS) and many other federal agencies through the remainder of the fiscal year. The IHS had been funded at FY 2018 levels for the first four and one half months of FY 2019.

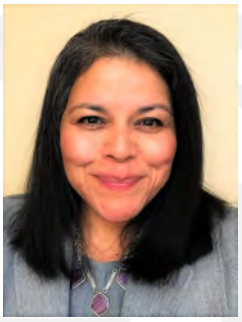
The Act provides $266 million for IHS over the FY 2018 enacted levels. Much of the increase is for staffing of new facilities ($115 million) and an increase ($104 million) in the estimate for Contract Support Costs (CSC). Funding for the Facilities account is flat.

Highlights include:

- Rejection of the large budget cuts proposed by the Administration, *maintaining FY 2018 enacted increases*.
- Rejection of the Administration's proposed deletion of all funding for the Community Health Representatives, Health Education, and the Tribal Management programs.
- Rejection of the Administration's proposal to change the Special Diabetes Program for Indians from one which is funded on a mandatory basis to a discretionary basis ($150 million annual funding).
- $36 million for supplemental funding for operations and maintenance of village built and tribally leased clinics, which compares to $11 million in FY 2018.
- $115 million for staffing packages for newly constructed facilities.
- CSC is maintained as a separate appropriations account with an indefinite amount—"such sums as may be necessary"—which is estimated at $822,227,000, a $104 million increase over the FY 2018 estimate.

continues on page 17

President's FY 2020 IHS Budget Request to Congress



Laura Platero
Government Affairs/Policy Director

On March 11, 2019, the President released his recommendations to Congress for the Indian Health Service (IHS) budget for FY 2020. Details on his request are provided in the IHS Congressional Justification (CJ) released on March 25, 2019. In our preliminary analysis of the President's FY 2020 IHS budget request compared to the FY 2019 enacted level (President's request and CJ use the 2019 annualized continuing resolution level), we have determined that the budget proposes a less than 2% overall increase for services and facilities (+$82.6 Million). Below is a short summary of the increases and cuts, and a few of the President's requests:

- Clinical Services (+$232 million): Recommends funding for Electronic Health Records transition line item (+$25 million), Ending Hepatitis C and HIV/AIDS (+$25.0 million), expansion of Community Health Aide Program (CHAP) (+$20 million), expansion of Recruitment and Retention Program (+$8 million), and Quality and Oversight (+$2 million).
- Preventative Health (-$56.5 million): Proposes elimination of Health Education funding (-$20.6 million) and cuts Community Health Representatives funding (-$39 million) as a phase out and transition to CHAP.
- Other Services (-$17.2 million): Proposes reduction of funding for Urban Health (-$2.5 million), Indian Health Professions (-$13.7 million), and Self-Governance (-$1 million).
- Contract Support Costs (+32.8 million): Required to be fully funded as an indefinite appropriation.
- Facilities (-$75.8 million): Reduces Health Care Facilities Construction (-$77.7 million) and Facilities and Environmental Support (-$647 thousand).

The President's request is only a proposal, and Congress will have the final say in what funding IHS receives in FY 2020. For NPAIHB's FY 2020 IHS Budget Analysis and Recommendations, please email Laura Platero at lplatero@npaihb.org.

2nd Annual Act of Kindness

2nd Annual Act of Kindness

NPAIHB Employees Remember Haruka Weiser through Volunteering at the Oregon Food Bank

On April 3rd, 19 Health Board employees participated in a Wellness Volunteer Activity at the Oregon Food Bank. April 3rd is a heavy day for IHS Medical Epidemiologist, Dr. Tom Weiser, who lost his daughter, Haruka on this day three years ago. Last year staff began this annual Act of Kindness activity as a tribute to Haruka, when her family requested friends and family to perform small random acts of kindness on April 3rd. Dr Weiser remarked, "It made it so much more bearable to have this activity to look forward to and then to actually be there with all the energy and goodwill, I can think of no better way to not just endure a sad day, but to actually transform it."

Employees volunteered at both the North Portland location and the Beaverton location, repacking bulk food into bags to be distributed to individuals who utilize the food bank for their meals. Volunteers donned hairnets, aprons, and gloves and joined in assembly line fashion where food was scooped up, placed in bags, weighed, sealed, and boxed. For fresh fruits and vegetable bagging, staff surrounded large field containers where produce was sorted and placed into mesh bags to be distributed throughout Oregon and SW Washington to families in need. In just 2.5 hours, volunteers packed 44,685 lbs of apples, onions, parsnips, and rice creating the equivalent of 37,238 meals for NW families on April 3rd.

Dr. Weiser hopes that this event will inspire others to find an act of kindness to do today or tomorrow or to share a thought or prayer for others in need.

HRSA Shortage Designation Modernization Project

Sarah Sullivan, MPH
Health Policy Analyst
NPAIHB

Health Resources & Services Administration (HRSA) is the primary federal agency under the U.S. Department of Health and Human Services (HHS) for improving health care to people who are geographically isolated, economically or medically vulnerable. HRSA shortage designations are used to target resources to geographic areas, populations, and facilities with too few primary care, dental and mental health providers and services. Through the National Health Service Corps (NHSC) and other scholarship and loan repayment programs, HRSA increases access to providers and services through financial incentives. Previous years, the NHSC loan repayment program has been able to fund eligible applicants at facilities with HPSA scores from 17-26 and some applicants at 16. Portland Area IHS/Tribal clinics (I/T) rely on eligibility for HRSA loan repayment for recruitment efforts.

The HRSA Shortage Designation Modernization Project was initiated to streamline the shortage designation process based on transparency, accountability, and parity. The Project is updating existing Health Professional Shortage Area (Auto-HPSA) designations in Summer 2019 by using national, standardized data sets, facility-specific data and data provided by state Primary Care Offices (PCOs). All Indian Health Service (IHS) and tribally run clinics are deemed eligible for the Auto-HPSA designation.

HRSA has been providing reports that preview the new projected Auto-HPSA score for each clinic for the 2020 National Health Service Corp application cycle. New preview scores are based on data from the 2016 American Community Survey/Census Bureau; Centers for Disease Control and Prevention (CDC); ESRI Geographic Information System Mapping; HRSA Uniform Data System; and the HRSA Shortage Designation Management System. The preview scores are subject to change, however no changes to the Auto-HPSA scores have happened at this time.

Northwest Portland Area Indian Health Board staff have been notified by our Portland Area I/T of concerns related to their preview scores that have decreased dramatically from previous years. Since becoming aware of the issue, NPAIHB has been consistently advocating to both HRSA and IHS for more information and assistance to our I/T clinics to update their scores.

Here is some information to assist you:

- Clinics will be able to update their HPSA score in the online portal after the national rollout in Summer 2019.
- Clinics should make sure contact information is correct in the HRSA BHW Portal/BMISS system. Clinics should also assist the PCOs with provider data, the PCOs for our Area are listed below:
  - Idaho: Maria Garcia (MGarcia@hrsa.gov)
  - Oregon: Matthew Feist (MFeist@hrsa.gov)
  - Washington: Laura Burns (LBurns@hrsa.gov)
- Clinics should submit facility-specific data as well as supplemental data to increase their scores in replacement of the American Community Survey data.
  - Facility-specific data:
    - Zip codes in which the facility's patients reside;
    - Percent of patients with known income at or below 100% Federal Poverty Level; and
    - Out of total unduplicated patient population, count of individuals younger than 18 or 65 and older, divided by the count of adults 18-64.
  - Supplemental data:
    - Less than 50% of the population has access to fluoridated water;
    - Alcohol misuse rate is in the worst quartile for the nation, region or state; and/or

continues on next page

HRSA Shortage Designation Modernization Project

continued from previous page

  - Substance misuse rate is in the worst quartile for the nation, region or state.
- Clinics can request a briefing or review of your scores and questions or concerns can be sent to sdmp@hrsa.gov.

Please let us know if you are concerned with your preview score and/or keep us apprised of your progress in updating your score. We are here to assist you and advocate to HRSA about your concerns prior to the 2020 National Health Service Corp application cycle.

Ending the HIV Epidemic

Jessica Leston, MPH
HIV/STI/HCV Clinical Programs Director

While rates of new HIV diagnoses are not elevated in AI/AN compared to some other race/ethnicities, there are notable concerns: 1) new HIV diagnoses among AI/AN increased by 70% from 2011 to 2016; 2) AI/AN patients have had the lowest survival rates of any race/ethnicity after an AIDS diagnosis; and 3) both male and female AI/AN had the highest percent of estimated diagnoses of HIV infection attributed to injection drug use (IDU). In addition, most of Indian Country is rural, where barriers to HIV education can exacerbate stigma, and reaching specialists for HIV is more problematic than in an urban setting.

A new national initiative, Ending the HIV Epidemic: A Plan for America (Figure 1) was recently announced by Health and Human Services. This is a national plan to reduce new HIV infections by 75% within 5 years and 90% within 10 years. The plan uses scientific advances to reduce HIV infections, as well as partnerships to implement interventions.

Figure 1. EtHE Strategies: Diagnose, Treat, Protect, and Respond

Ending the HIV Epidemic

Diagnose all individuals with HIV as early as possible after infection. Approximately 165,000 Americans are living with HIV but don't know they have it. Early detection is critical and can lead to quicker results in treatment and prevent transmission to others. Using the latest diagnostics and advanced automation systems, we will make HIV testing simple, accessible and routine. And we will diagnose infection early and connect patients immediately to care.

Treat the infection rapidly and effectively after diagnosis, achieving sustained viral suppression. Eighty-seven percent of annual new infections are transmitted by those not receiving HIV care and treatment. But individuals with HIV who take medication as prescribed and stay virally suppressed can live long, healthy lives and have effectively no risk of sexually transmitting HIV to a partner. We will establish and expand programs to follow up with individuals no longer receiving care—and provide the resources needed to re-engage them in HIV effective care and treatment. The Ryan White HIV/AIDS Program has achieved a viral suppression rate of nearly 86 percent. We aim to leverage the program's comprehensive system of care and treatment to increase viral suppression around the country to 90 percent.

Protect individuals at risk for HIV using proven prevention approaches. Of the estimated 1 million Americans at substantial risk for HIV and who could benefit from PrEP, fewer than 10 percent are actually using this medication. Increasing PrEP use among high-risk groups could prevent almost 50,000 HIV infections by 2020.

Respond rapidly to detect and respond to growing HIV clusters and prevent new HIV infections. New laboratory methods and epidemiological techniques allow us to see where HIV may be spreading most rapidly,

continues on next page

Ending the HIV Epidemic

continued from previous page

thereby allowing CDC and other partners to quickly develop and implement strategies to stop ongoing transmission. We will work with impacted communities to ensure they have the technology, personnel and prevention resources to follow up on all HIV cases and to intervene to stop chains of transmission, and to get those impacted into appropriate care and treatment.

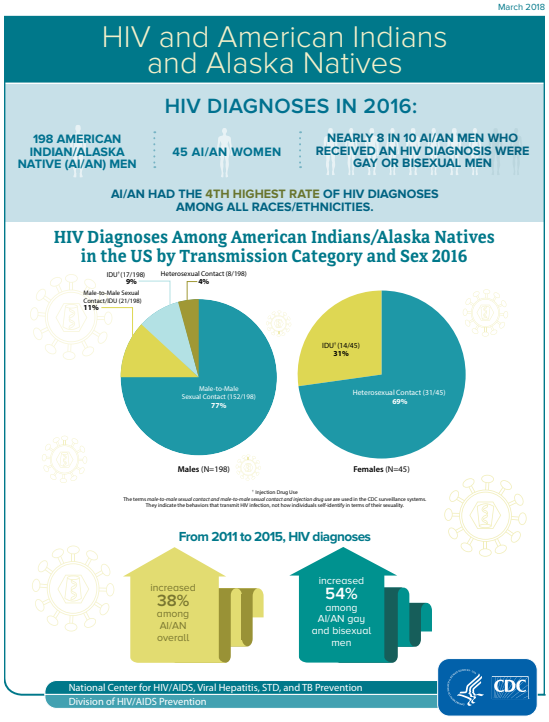
One pillar of the plan is diagnosis. Testing for HIV is inexpensive, reliable, and non-invasive. Early detection of an HIV infection, through screening and targeted testing are the first step in linking patients to treatment.

The next pillar is treatment. Advances in antiretroviral treatment make HIV possible to manage largely like other chronic diseases. With treatment, HIV virus can be kept at such low levels that the patient achieves 'viral suppression', whereby the virus is undetectable in laboratory blood tests. Viral suppression is a key element in treatment-as-prevention: if a patient has undetectable levels of virus, the infection is not sexually transmitted, a principle known as **U**ndetectable = **U**ntransmittable.

Linking patients into HIV care and achieving viral suppression will help the patient have a full life expectancy as non-HIV infected persons, prevent new HIV infections from occurring, and greatly decrease the stigma associated with an HIV diagnosis and seeking care.

Finally, another key element of this plan is to protect persons from HIV infection with pre-exposure prophylaxis (PrEP) medication. To be effective, the patient must take a pill each day, and have a medical visit each 3 months to ensure the medication is working as planned and there are no side effects. However, if taken correctly, PrEP can reduce the risk of contracting HIV from someone by up to 97 percent. An estimated one million Americans could benefit from PrEP, but less than 10 percent are receiving it.

These interventions have their foundation in science, but the response to the epidemic is not just a biomedical one. The program must do more than use science to chase down virus, it must help the communities and people we serve. The EtHE plan emphasizes partnerships that will be necessary to make this plan a reality to educate public health agencies, medical workers, community members, and patients who can benefit from these interventions. Importantly, the medical interventions available should also serve to reduce stigma, which in turn can help this plan to become a reality. Doctors will be more open to discuss HIV risks and consider PrEP. Tribal and state health departments can prioritize the availability of these HIV interventions. Treating HIV as a chronic disease rather than an incurable one will reduce the stigma that HIV patients have in sharing their diagnosis with friends and family, and reduce the stigma of seeking lifesaving care, which we know now can also break the chain of transmission for good.



As work on EtHE begins, we must ensure that the Administration's new National Plan for HIV Elimination is inclusive of tribes and AI/AN as to eligibility, geography, as well as culturally specific education, prevention programs, and linkage to appropriate medical care and ancillary support programs that are critical for adherence to treatment via IHS, tribal, and urban Indian facilities that primarily serve AI/AN communities.

Click on flyer for hyperlink

Dental Therapy Legislation Passes in Idaho

Christina Peters
Native Dental Therapy Initiative Project Director

On Monday, March 25, 2019, Governor Brad Little signed into law a bill that Idaho Tribes hope will begin to close the significant oral health disparity facing tribal communities in Idaho.

The Dental Therapy bill, S. 1129, was sponsored by the Coeur d'Alene Tribe and supported heavily by the Nez Perce Tribe. The new law will authorize the Idaho Board of Dentistry to license dental therapists to practice in tribal communities. The rules associated with the legislation will also define their scope of practice and level of supervision for dental therapists.

Unlike the Washington State law, passed in 2017, which left regulation of DHATs up to the tribes or a federal CHAP board, the Idaho law takes a more hands on approach to licensing this new provider to practice. Under the new law, dental therapists in Idaho must also pass a board exam approved by the Idaho Board of Dentistry to become licensed. Once licensed, they can perform a limited number of routine and preventative procedures under the supervision of a dentist, including preventative care, outreach, fillings and simple extractions.

Access to dental care in Native communities in Idaho is often difficult to obtain, which could partly explain the higher rates of tooth decay they experience. It is often hard to attract and retain dentists in more remote parts of the state and dentists are often backlogged for months, forcing patients to wait for dental care. Dental therapists allow dentists to practice at the top of their scope of practice, opening up more appointment times for patients in the community; thereby improving access to care for everyone. Most importantly, the dental therapy program allows individuals from those communities to become trained and provide care to people they know, in a culturally competent manner.

The Nez Perce Tribe is interested in finding funding to sponsor students from their community to train in Washington or Alaska. On the Coeur d'Alene reservation, Marimn Health has been preparing to offer these services to the community and co-sponsored a student in 2017 who will graduate this June from the Alaska Dental Therapy Education Program at Ilisagvik Tribal College in Alaska. Anna DeGraffenreid, a Coeur d'Alene Tribal citizen, will graduate from the program in June and return to Plummer to serve patients in her home community this summer. "We are very proud of Anna and excited to offer our patients a more personalized level of care—from a member of their own community," said Dr. Taylor Wilkens, Dental Director for Marimn Health. "As a Dental Therapist, Anna will be able to provide culturally competent care. Having her in our department will allow our dentists to concentrate on more complex procedures, which will create a more efficient workflow and allow us to treat more patients."

Community Health Aide Program: History, Policy and Update

Sue Steward (Cow Creek)
CHAP Project Director

The Community Health Aide Program (CHAP) encompasses three disciplines of midlevel providers who wrap communities in the protective arms of modern standards of care married with regional traditional practices. These disciplines are Dental Health Aide Therapists (DHAT), Behavioral Health Aides and Practitioners (BHA/P) and Community Health Aides and Practitioners (CHA/P). The CHAP was born in rural Alaska in the 1950's as a spoke in the hub of limited care provided by IHS in rural villages that were largely only accessible by air or

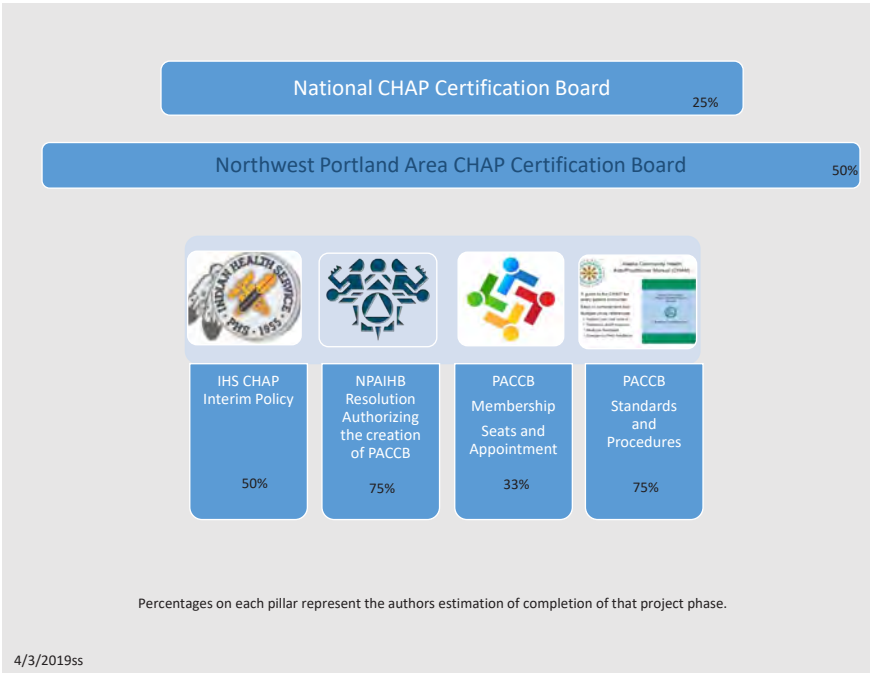
continues on next page

Community Health Aide Program: History, Policy and Update

continued from previous page

water. Physicians enlisted the help of local traditional healers to help bridge the gap in language, culture and trust to address the care needed daily for individual with antibiotic resistant Tuberculosis which physicians were not available to provide.

In 1968 CHAP was officially established under the authority of the Snyder Act, 25 U.S.C. § 13. Federal funding allowed village built clinics to open their doors and volunteers, now called CHAs, to be compensated for some services. CHAP evolved over the years and the ISDEAA 25 U.S.C. P.L. 93-638 assisted Alaska tribes and consortiums to include training and education centers for CHA/P's at hub sites. These hubs employed trainers, referral physicians and other medical staff necessary to support CHAP. In 1992, Congress made CHAP a permanent program in Alaska. CHA/Ps are the backbone of care in Alaska and the Transfer Act, Indian Health Care Improvement Act P.L. 94-437 further solidified CHAP in Alaska with clear expectation of federal responsibility for the care and education of the Indian people through improving the services and facilities of federal Indian health programs. The Transfer Act also contains language that encourages maximum participation of Indians in education programs, thus expanding the authority of the Snyder Act. In 1994, the interim policy (IHS Circular, 94-138) supporting CHAP was approved which also established the regional CHAP Certification Board and the Standards and Procedures for individuals and facilities in Alaska. It was upon these pillars that the Alaska CHAP Certification Board was created in 1998 and still stands strong today. The Certification Standards and Procedures were amended in 2003 to include DHATs and in 2008 to include BHA/Ps, thus completing the wrap around care that Alaska was seeking to provide for all American Indians and Alaska Natives (AI/AN) residing in remote Alaska.



In 2010, when IHCIA was reauthorized under the Patient Protection and Affordable Care Act, it included authorization to establish a national CHAP for the purpose of training and certifying CHA providers to provide health care, health promotion, and disease prevention services outside of Alaska. In January 2018, IHS established a CHAP Tribal Advisory Group (TAG) that has met several times in person and by phone since its formation. Since last summer, the TAG and IHS have been in negotiations on an interim policy to support CHAP and Area CHAP Certification Boards (ACCB) in the 12 Regions with a national Certification Board as the final authority. Many versions of the interim policy have been exchanged between IHS and the TAG. It is anticipated that a Dear Tribal Leader Letter (DTTL) with the interim policy will be disseminated by May of this year. However, there are provisions in the interim policy that IHS and TAG may not agree on prior to the DTLL. For these provisions, CHAP TAG has requested that IHS include footnotes that reference where there is disagreement in the interim policy with "agree to disagree." Permanent, re-occurring funding is needed to support CHAP efforts in education, workforce development and infrastructure outside of Alaska. Surprisingly, the President's budget for 2020 includes an ask of $20 million for CHAP expansion. We are hopeful that it will be funded in FY 2020.

Native Students Together Against Negative Decisions (STAND) Program: its past, present, future

Michelle Singer (Navajo)
Healthy Native Youth Project Manager

The current core research project of the Center for Healthy Communities, funded by the Prevention Research Centers Program at the Centers for Disease Control and Prevention (CDC), represents one more step in the progression of the Native STAND program towards recognition as an evidence-based practice. Over the past 5 years, we have been evaluating the performance of Native STAND in the true-to-life setting to see if it produces a meaningful impact in the hands of tribal communities. This dissemination and implementation research is essential to document how the program is adopted by various groups. Soon we will share the information about lessons learned and outcomes to our participating communities and more broadly to health education professionals.

But have you ever wondered how Native STAND got its start? STAND – "Students Together Against Negative Decisions" – was the brainchild of Dr. Mike Smith of Mercer University School of Medicine in Georgia, who recognized the need for a peer education approach to sex education. The earliest version, used with Appalachian teens, yielded promising results and caught the attention of two STD prevention experts at the Centers for Disease Control and Prevention (CDC), Scott Tulloch and Lori de Ravello. They saw the potential and need to adapt the curriculum to make it culturally relevant to Native youth.

A group of tribal experts was assembled from around the United States. This group modified the curriculum to include traditional knowledge, values, and stories that were broadly representative of the Native experience. The manuals and resources were published on the web by the National Coalition for STD Directors.

Establishing Validity for Native Communities: The Healthy & Empowered Youth (HEY) Project

To ensure that the new Native STAND curriculum was valid and reliable, the program was tested in four Bureau of Indian Education schools by Dr. Smith and Dr. Stephanie Craig Rushing of the Northwest Portland Area Indian Health Board (NPAIHB).

This demonstration project was conducted with high fidelity, meaning that the study units and activities were delivered exactly as described in the manuals. Early results showed positive shifts in knowledge, attitudes and behaviors. In turn, these encouraging findings motivated Nicole Hildebrandt and Dr. Bill Lambert of OHSU's Center for Healthy Communities to apply for Department of Health & Human Services Youth Empowerment Program Grant funding to deliver Native STAND at Fort Hall Jr./Sr. High School in Pocatello, Idaho.

At the time, the Native VOICES curriculum and social media supports like We R Native were being developed by Project Red Talon, led by Dr. Craig Rushing at the NPAIHB, and the team combined the power of Native STAND with youth filmmaking and digital resources. Due to the outstanding efforts of teachers Ben Christiansen and Amanda Rowsell at Fort Hall Jr./Sr. High School, the resulting HEY Project was a great success, and demonstrated the adaptability of Native STAND to the reservation setting.

Expansion of Native STAND

This history brings us to our present day effort which has disseminated Native STAND to 48 tribal communities and organizations located in 15 states, including Alaska. Applying a program evaluation framework designed by Tosha Zaback, the adoption and use of the curriculum has been monitored to document the number of communities and youth reached, the parts of the curriculum that are used and found to be well accepted, and the impact on teens.

Over the past 5 years, with the commitment of our tribal health educators, quantitative and qualitative information has been collected by Michelle Singer, Brittany Morgan, Caitlin Donald, Kavita Rajani, Megan

continues on next page

Native Students Together Against Negative Decisions (STAND) Program: its past, present, future

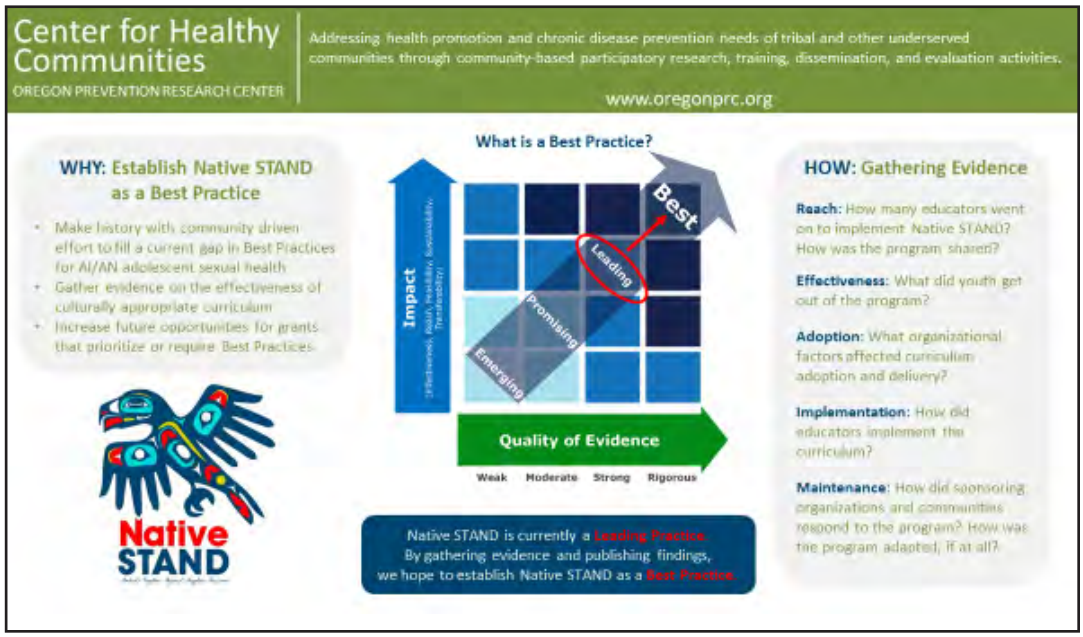
continued from previous page

Skye, and Jennifer Seamans. We are now in the process of cleaning these data and we will report back to each participating community and at conferences. By publishing our findings in peer-reviewed journals, we will establish the evidence needed for Native STAND to receive recognition as a best practice.

Next Steps: Beyond the Center for Healthy Communities – Oregon PRC

The Center for Healthy Communities is proud to be a part of this journey and we are now moving the Native STAND program to its new home as part of the Healthy Native Youth project at the NPAIHB funded by the Indian Health Service HIV/AIDS Program. Now that Native STAND has taken root and is growing throughout Indian Country and in Alaska, it must continue to be supported and improved. This new home at NPAIHB has the advantages of sustainable funding and staffing to allow the program and its outreach to continue.

Our longtime Native STAND core research project manager Michelle Singer has already followed Native STAND from OHSU to NPAIHB, where she and Dr. Stephanie Craig Rushing will update the program to incorporate our new knowledge and experience (www.healthynativeyouth.org). We are excited about this transition, and look forward to watching Michelle and Dr. Craig Rushing prepare the plans for Native STAND 2.0 in coordination and collaboration with many invested stakeholders as the next phase of this program's journey continues! A movement has been started and Native STAND Nation carries on!



Updates in Washington State

Neetha Mony
State Suicide Prevention Plan Program Manager

Camille Goldy
Behavioral health and Suicide Prevention Program Supervisor/ Student Engagement and Support

In 2017, 1,292 Washingtonians died by suicide and about 65 Washingtonians per week are hospitalized for intentional self-inflicted injuries. In response to this preventable issue, last year the state government agencies on the Washington Action Alliance for Suicide Prevention submitted a joint agency suicide prevention decision package. Four pieces of the proposal were included in Governor Inslee's budget and have made progress this session.

Funding proposals

First, the Department of Health (DOH) requested funding to increase the number of Washington-based crisis centers and staff taking National Suicide Prevention Lifeline calls. In 2017, DOH learned that about 60% of Washington -based calls were sent to out-of-state Lifeline call centers, so the Legislature approved $700K for the biennium to improve our in-state answer rate. With the state funding and a one year grant from Vibrant! Emotional Health, at the end of 2018 Washington 's in-state answer rate was 78% in spite of a 40% increase in the number of Washington Lifeline calls (see p. 24 of our 2019 annual report for more information). Currently the 3 crisis centers working with the Lifeline are in Western Washington, so one goal of the funding proposal will be to create a regional network by bringing on 1-2 additional centers in Eastern Washington. Some funding will also go towards continuing a partnership with the Crisis Text Line to promote the keyword "HEAL." The use of this keyword gives the Action Alliance an enhanced data dashboard to learn about crisis trends that can inform future policy requests.

Washington's Health Care Authority (HCA) put forward two funding proposals to improve the continuum of suicide care and community-based suicide prevention strategies. HCA has asked for a clinical suicide prevention specialist who will focus on improving clinical services for suicide assessment, treatment, and management. The HCA suicide prevention specialist would ensure that Washington keeps pace with best practices and current training in providing services such as identifying suicide treatment providers, mobile crisis teams, and crisis center follow-ups after a suicide. Additionally, HCA requested funds for grants to support community-driven priorities and strategies.

State Superintendent of K-12 Education, Chris Reykdal, submitted a funding request to the governor to increase supports for school safety and mental health. The request included the development of regional safety centers at the nine Educational Service Districts as well as regional behavioral health and suicide prevention coordination.

Lastly, the Safer Homes, Suicide Aware program promotes safe storage of medications and firearms to prevent suicide. The proposed budgets from the House and Senate include funding to expand the Safer Homes program to include safer workplaces. Given that this is a long legislative session, the state biennium budget might not be finalized until June 30, so a lot can change over the next few months.

Bills

HB 1216 - Concerning non-firearm measures to increase school safety and student well-being reflected many of the components included in The Office of Superintendent of Public Instruction's (OSPI) Supports for School Safety and Mental Health budget request. The bill includes the regional coordinator role at each of the nine Educational Service Districts to help connect students and their families with community clinical services, and assist schools with suicide prevention, intervention, and postvention needs. With the release of the new 2018 Healthy Youth Survey data, students have reported higher rates of seriously considering suicide and being bullied. Only about half of students

continues on next page

Updates in Washington State

continued from previous page

reported having an adult they could turn to when feeling sad or hopeless or having contact with a counselor at school in the past year. In a press release, Superintendent Reykdal said, "Our students need more support at school. Whether it's increased access to a counselor, multiple pathways to high school graduation, or education about consent – our students are telling us what they need, and we have a responsibility to act on it." OSPI has also proposed the Legislature increase the number of middle school counselors to achieve Comprehensive Supports for All.

Aside from HB 1216, there have been a number of suicide prevention initiatives introduced in Washington during the 2019 legislative session. While many bills have not progressed through session, some bills related to suicide prevention are still pending. Senate Bill 5027 revises the extreme risk protection order act to include youth under age 18. Parents and guardians of youth with an order will be required to secure their firearms. Another bill of interest is SB 5903 which includes recommendations from the Children's Mental Health Workgroup.

Other projects of interest

On March 15, 2018, Governor Jay Inslee signed HB 2671 into law. It called for DOH to create a task force and set up a pilot program to improve behavioral health and prevent suicide in agricultural communities. A preliminary report on the task forces' work was submitted to the governor and the health care committees of the legislature. It identified Washington State University's extension program as a contract partner and Skagit County as the pilot county. The pilot project began on March 1, 2019 and the website will soon be live.

In June 2018, Public Health – Seattle & King County and Washington State Physician and Nursing Leadership released a statement, The Firearm-Related Injury and Death as a Public Health Problem: The Role of the Physicians and Nurses. The work launched the Coalition of Healthcare Professionals to Prevent Firearm Injury and Death is a collaboration of healthcare professional organizations and public health professionals seeking to reduce firearm-related injury and death among their patients and in their communities. The Coalition is co-led by Harborview Injury Prevention and Research Center, DOH, and Public Health – Seattle & King County.

There is a lot of promising work to improve suicide prevention, intervention, treatment, and postvention in Washington and further our state's suicide prevention plan. Learn more about what Washington is doing on DOH's suicide prevention webpage.

Contacts:
Neetha Mony
State Suicide Prevention Plan Program Manager
Washington State Department of Health
Neetha.Mony@doh.wa.gov
360-236-2836

Camille Goldy
Behavioral Health and Suicide Prevention Program Supervisor / Student Engagement and Support
Office of Superintendent of Public Instruction (OSPI)
360-725-6071
camille.goldy@k12.wa.us

Tobacco Policy

continued from cover

products. Among adult e-cigarette users overall, 58.8% also were current cigarette smokers, 29.8% were former cigarette smokers, and 11.4% had never been cigarette smokers[4].

NPAIHB's efforts to address tobacco use

At the Northwest Portland Area Indian Health Board, we are working with Northwest Tribes to decrease all commercial tobacco use. Projects offering technical assistance include WEAVE-NW, Northwest Tribal Cancer Control Project, and We R Native project. As sovereign nations, tribes are well-positioned to approach tobacco control through policy, systems and environmental change. Possible PSE changes are listed in the figure below.

- smoke-free events, tribal buildings, housings and parks
- Reduction in second hand smoke and vape exposure
- Tobacco program and clinical referrals, provisions of nicotine replacement therapy, behavioral health support, and mapping clinic tobacco screening processes
- Age restrictions on tobacco purchasing, tobacco retail restrictions
- Implementation of traditional tobacco use, community education on prevention and intervention
- Community readiness surveys, policy and resolution templates

Northwest Tribes leading the way in tobacco policy

Many Northwest Tribes have taken action through community-based efforts to address commercial tobacco use and improve the health of their population. Some highlights of recent Tribal efforts include:

Coquille – Traditional Tobacco Garden Project: With a goal of reducing or eliminating commercial tobacco use and honoring the cultural sacredness of the tribe's traditional use, the Coquille Cultural Department incorporated a tobacco garden and educational component. The purpose of the traditional tobacco policy is to raise awareness about the harmful impact of commercial tobacco, define the difference between commercial and traditional tobacco, and created protocols for ceremonial use.

Coquille's policy solution built upon the existing momentum in restoring traditional food and medicine practices in which the tobacco garden is also a place of learning and sharing knowledge where the plant is cultivated, harvested, processed, and distributed to tribal member's for cultural use. The access to the traditional tobacco for ceremony protects the health of tribal members by reducing commercial use (seen as a taboo), while ensuring that the sacredness of the plant is maintained.

Klamath – "Ask Me How" referral program: The Klamath Tribal Health & Family Services has a wide range of tools including a cessation program to offer patients who are ready to quit using tobacco; however, the clinic team wanted to maximize options and create a follow up system for patients when referrals were made. To increase cessation success, they created a community-wide "Ask Me How" marketing

[1] BRFSS, via the IDEA-NW state health reports
[2] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2018 Jun 12].
[3] IDEA-NW 2015 cancer fact sheet
[4] https://www.cdc.gov/mmwr/volumes/65/wr/mm6542a7.htm CDC, MMWR
QuickStats: Cigarette Smoking Status* Among Current Adult E-cigarette Users,† by Age Group — National Health Interview Survey,§ United States, 2015

continues on next page

Tobacco Policy

continued from previous page

strategy and a closed loop referral system ensuring patient follow up while simultaneously connected with the resources they needed to quit.

Through the one-month "Ask Me How" campaign, over 900 patients were screen and 303 were referred to cessation programs or provided with tools. Using the closed loop referral system allowed the clinic staff to identify the patients who did not follow through with the referrals to reach out with further support.

Confederated Tribes of the Umatilla Indian Reservation - "21 and Over" tobacco purchasing: Although state law does not apply to the Tribes, Oregon Tobacco 21 law went into effect on 1/1/18, the Tribe put their own 21 and over law into resolution effective 1/22/18. CTUIR casino manages 5 outlets for tobacco sales on the reservation (Arrowhead Travel Plaza, Mission market, and 3 sites within the casino.) Several committees were consulted prior taking it to the board, such as the Law & Order Committee, the Health Commission, and the Economic and Community Development Committee. Work sessions were held to review the Resolution and Amendment to the Criminal code. The Resolution was voted on by the Wildhorse Board increasing the minimum age to purchase tobacco to 21.

Although policy may not be the solution for every situation, in tribal communities there are unwritten cultural beliefs, protocol, and practices that might influence behaviors and can be incorporated into written policies to benefit a community. To support community driven and culturally informed policy development within a tribal context, NPAIHB and the National Indian Child Welfare Association created a Tribal Policy Toolkit that applies tribal knowledge, practice, culture, and sovereignty. The guide is organized to assist tribes with policy development, including community organizing, advocacy, and structuring a work plan at community level to improve the health and well-being of the community. Historically, policies in Indian Country have excluded tribal voices, developed instead by policy makers in top down positions who are not fully informed about Indian County or tribal cultural dynamics. This history of Imposing policies on Tribes without their involvement damaged the concept and value of policy. With tribes now in control of creating their own policy it's time to empower communities to get involved. The Tribal Policy Toolkit will be available Summer 2019 in both print and electronic mediums. Efforts following this release will focus on Toolkit training at a community level and providing technical assistance.

Commercial tobacco has had a devastating effect on the health of native people. Providing opportunities to update and create new tribally-led tobacco policy and an opportunity for some Tribe to return to solely traditional use is the key to decreasing commercial tobacco use and restoring a role that supports health.

Indian Health Update

continued from page 3

- Rejection again of the Administration's proposed language that: 1) would circumvent the *Maniilaq v. Burwell* decision to require full compensation for section 105(l) ISDEAA leases; 2) could be read to deny CSC carryover authority granted by the ISDEAA; and 3) could be used by the IHS to deny CSC for its grant programs.
- $243 million for construction of new health care facilities which includes $15 million for small ambulatory facilities. The Senate Report also notes $6.5 million is for new and replacement quarters and $5 million "for healthcare facilities construction for the Service to enter into contracts with tribes or tribal organizations to carry out demonstration projects as authorized under the Indian Health Care Improvement Act."
- The IHS is directed to work with tribal organizations to submit a report to Congress within 6 months with an assessment of updated facility needs in Alaska and recommendations for alternative financing operations.
- $72 million for the Indian Health Care Improvement Fund.
- $10 million in new funding for opioid grants for a Special Behavioral Health Pilot Program.

IHS Advance Appropriations Initiative

There are significant new developments with regard to the effort to place the IHS budget on an advance appropriations schedule. In 2018 the General Accountability Office (GAO) issued a report regarding IHS advance appropriations issues, and we now provide an update on the recently introduced advance appropriations legislation. The bills differ with regard to what programs would be authorized to receive advance appropriations.

HR 1135, introduced by Rep. Don Young on February 8, is entitled Indian Health Service Advance Appropriations Act of 2019. The bill would provide advance appropriation authority for the IHS Services and Facilities accounts. Among the co-sponsors of the bill are the Chair and Ranking Member of the House Interior Appropriations Subcommittee – Reps Betty McCollum (D-MN) and David Joyce (R-OH), respectively. The legislation was referred to the Natural Resources, Energy and Commerce, and Budget Committees. The Budget Committee is key as they need to include authority for advance appropriations in a Budget Resolution.

S 229, introduced by Senator Tom Udall (D-AZ) on January 25, 2019, is entitled the Indian Programs Advance Appropriations Act. It would authorize advance appropriations for the IHS Services and Contract Support Costs accounts and also in the Bureau of Indian Affairs/Bureau of Indian Education the following accounts: Operation of Indian Programs, Contract Support Costs and the Indian Guaranteed Loan Program. The bill was referred to the Budget Committee. As of this writing, all of the cosponsors are Democrats.

HR 1128, introduced by Representative Betty McCollum (D-MN) on February 8, 2019, is identical to S 229 above. As with HR 1135, cosponsors are from both parties. The legislation was referred to the Natural Resources, Energy and Commerce, and Budget Committees.

The recent government shutdown has created a lot of interest in this initiative and we hope that there will be movement on these bills this session.

SDPI Reauthorization and Funding

Authorization for the Special Diabetes Program for Indians (SDPI) expires on September 30, 2019. This critical program has been credited with reducing incidence rates of diabetes and diabetes-related conditions among AI/AN populations, as well as promoting diabetes prevention and treatment programs across Indian Country. Since its establishment in 1997, however, SDPI has only been extended for periods ranging from one to five years. The resultant uncertainties regarding long-term funding availability and program support create significant challenges for tribal grantees in terms of the recruitment and retention of qualified staff, continuity of services, and program administration. These challenges are

continues on next page

Indian Health Update

continued from previous page

frequently compounded by the lack of adequate funding. SDPI has been level funded at $150 million per year since fiscal year 2004. Additional funding is needed to account for medical inflation and to support program expansion. NCAI and NIHB are advocating that Congress increase the annual appropriation for SDPI to $200 million for fiscal year 2020 to begin to address this unmet need.

On January 18, 2019, Senator Lamar Alexander (R-TN) introduced a healthcare extenders bill that would reauthorize SDPI for an additional five years from 2019–2024. The bill was referred to the Senate Health, Education, Labor, and Pensions (HELP) Committee, where it remains under consideration. Congressman Tom O'Halleran (D-AZ) is expected to introduce a similar bill in the House in April. Hearings on SDPI reauthorization are expected to take place in either late spring or early summer.

To build momentum for SDPI reauthorization, the House and Senate Diabetes Caucuses are circulating sign-on letters of support. The letters underscore the physical and economic toll that diabetes takes on Americans of all backgrounds and ask that Members show their support for continuing to invest in SDPI and the Special Statutory Funding Program for Type 1 Diabetes Research. During previous reauthorization periods, such letters have garnered significant support in both the House and the Senate. In 2016, for example, 75% of the Senate and almost 80% of the House signed on as a symbol of their commitment to renewing the program. The Diabetes Caucuses are seeking an even higher sign-on rate for the current letters with the new Congress. A spreadsheet tracking support for the letters is attached. The names of Senators and Representatives who have already signed on are indicated with yellow highlights. Tribal outreach to the members of their congressional delegation is strongly encouraged.

Village-Built Clinics and Section 105(l) Leasing

In November 2016, a landmark ruling in *Maniilaq Association v. Burwell* held that section 105(l) of the ISDEAA requires IHS to enter into—and fully fund—leases for facilities controlled by tribal providers and used to carry out ISDEAA agreements. That ruling opened the door for organizations to seek full compensation for the operation and maintenance of their clinics.

In FY 2018 (as in FY 2017), 105(l) lease compensation came from an $11 million tribal clinics appropriation, but the popularity of 105(l) leasing has boomed over the past year. In July 2018, IHS issued a letter initiating tribal consultation on how to cover what was then a $13 million shortfall in 105(l) lease funding. IHS proposed to reprogram funding from unallocated inflation increases, which would deny tribes needed program increases to keep pace with the cost of living. In the end, IHS was forced to reprogram $25 million of its $70.4 million inflation increase to cover 105(l) lease compensation—on top of the $5 million allocation from the clinics appropriation.

Congress took note of the agency's dire need. On February 15, 2019, the President signed into law an appropriations act to fund IHS, among many other agencies, for the remainder of FY 2019. The act included a $36 million supplemental tribal clinics appropriation—an increase of $25 million to match the amount IHS had to reprogram in FY 2018. IHS and tribal health care providers are not out of the woods yet, however. With 105(l) leasing expected to continue growing in FY 2019, $36 million will almost certainly not be enough to cover all of the 105(l) lease obligations. In order to avoid reprogramming, which hurts program funding levels, tribes and tribal organizations will need to engage with IHS and the appropriations committees on long-term solutions to what IHS has called the 105(l) funding "dilemma" or "crisis." On March 12, 2019, IHS issued a Dear Tribal Leader Letter initiating tribal consultation and urban confer on short-and long-term options for meeting requirements of ISDEAA 105(l) leases. Comments are due on Friday, April 26, 2019 and may be submitted by email or postal mail to IHS. One solution would be a separate, indefinite appropriation like that for contract support costs (CSC).

continues on next page

Indian Health Update

continued from previous page

Opioid Litigation Update

Over 100 tribes and tribal organizations have now joined approximately 1,000 State and local governmental plaintiffs in litigation against the manufacturers and distributors of prescription opioids for their role in creating the national opioid epidemic. The majority of those cases have been consolidated in "multidistrict litigation" before federal district court Judge Dan A. Polster in Ohio. Although Judge Polster has been clear that he would like to see the parties reach a "global settlement," he has also selected specific "bellwether" (test) cases to move forward with pre-trial motions and, eventually, trial. In December, Judge Polster denied the Defendants' motions to dismiss in the first bellwether cases, which involved city and county plaintiffs, meaning that those cases will be permitted to move forward with almost all of their claims.

Judge Polster has selected two tribal cases as bellwethers (Muscogee (Creek) Nation and Blackfeet Tribe). Indian Country has been eagerly awaiting Judge Polster's ruling on the defendants' motions to dismiss in those cases. On April 1, the magistrate judge released his Report and Recommendation recommending that Judge Polster permit most of the tribal claims to proceed. The magistrate judge's recommendations largely echo those provided in the first bellwether cases, which Judge Polster largely adopted. Although the parties have an opportunity to submit objections to the magistrate's report, and Judge Polster will not issue his final ruling until May at the earliest, it is now expected that Judge Polster will permit the tribal bellwether cases to move forward.

The Report and Recommendation is an important development for tribal plaintiffs in the opioid litigation. Settlement discussions, which are confidential, are ongoing, and surviving the Defendants' motions to dismiss will put tribal plaintiffs in a stronger negotiating position as those discussions move forward.

Affordable Care Act Litigation (*Texas v. United States*)

In December, a federal district court ruling made headlines when the judge held that the individual mandate enacted as part of the Patient Protection and Affordable Care Act (ACA) is unconstitutional. Not only did the district court judge in Texas v. United States rule that the individual mandate can no longer be justified under Congress's taxing power (now that Congress has reduced the tax penalty to $0), but it also held that the entirety of the law must be invalidated along with the individual mandate. The United States, as the defendant in the district court, had agreed with the plaintiffs that the individual mandate is no longer constitutional, but argued that most of the remainder of the law should be left intact.

The district court's ruling has major potential implications for Indian Country. The Indian Health Care Improvement Act (IHCIA) was amended and permanently reauthorized as part of the ACA, and several other provisions of the law provide important new authorities for the Indian health system. Although these provisions are not related to the individual mandate, the district court did not exempt them from its ruling—meaning that the IHCIA and other Indian health provisions of the ACA are at risk of being invalidated if the district court's ruling is upheld on appeal.

On March 25, a coalition of States that intervened in the case in order to defend the ACA filed their opening briefs with the United States Court of Appeals for the Fifth Circuit, arguing that the district court ruling should be overturned. The United States was expected to file its brief on the same day, but instead the Department of Justice filed a two-sentence letter with the court announcing that the United States had changed its position in the litigation. The letter stated that the United States believes the district court's judgment should be affirmed, and that no portion of the judgment should be reversed.

The Department of Justice's letter amounts to an endorsement of the district court's decision invalidating the Indian Health Care Improvement Act along with the remainder of the ACA. The United States' new position places even greater importance on an amicus brief,

continues on next page

Indian Health Update

continued from previous page

filed on April 1 on behalf of 483 federally recognized Tribal Nations individually and as members of amici tribal organizations. That brief argues that the IHCIA and other Indian-specific provisions of the ACA should be preserved regardless of how the court rules with respect to the individual mandate.

The Fifth Circuit likely will not reach a ruling in the case for several months. Indian Country, along with the rest of the Nation, will be watching closely.

Brackeen v. Bernhardt Challenge to the Indian Child Welfare Act

The *Brackeen* case challenging the constitutionality of the Indian Child Welfare Act (ICWA) before the United States Court of Appeals for the Fifth Circuit is fully briefed, and on March 13, 2019, a panel of three judges held oral argument. Now we await the Fifth Circuit's decision.

As we have previously reported, the United States District Court for the Northern District of Texas in *Brackeen v. Zinke* held ICWA violates the United States Constitution—including the equal protection clause, the anti-commandeering clause, and the non-delegation doctrine. Importantly, it held that ICWA is directed at a suspect racial class, finding the principles of *Morton v. Mancari* do not extend to cover ICWA because ICWA applies to children not formally enrolled as tribal members. The case is now on appeal before the Fifth Circuit, and it is currently titled *Brackeen v. Bernhardt*. The decision has major implications not only for ICWA, but for federal Indian law and policy more broadly.

With regard to their equal protection claim, the plaintiffs—which include states and adoptive parents—asserted the equal protection principles of *Morton v. Mancari* apply only to United States actions that are both: (1) directed at tribal members; and (2) deal with tribal self-governance or federal regulation of tribal lands. Meaning, when an action does not do both of these things, it amounts to racial discrimination. The plaintiffs argued ICWA is directed at children who are only racially Native because they are not formally enrolled tribal members. They also argued ICWA is race-based because it does not deal with tribal self-government or tribal lands.

In response to the plaintiffs' argument that an action must relate to tribal self-governance or federal regulation of tribal lands, the defendants—which include the United States and tribes—countered that courts ask only whom an action targets when determining whether a suspect racial class is at issue. They said the subject matter or purpose of the action are only relevant afterwards, when the court is examining whether the action withstands the appropriate level of scrutiny. In the Indian law context, they said, courts have found classifications based on membership in a federally recognized tribe do not target a suspect racial class and have gone on to apply "rational basis review" by asking whether the action is tied rationally to fulfillment of Congress's unique obligation to Indians. Further, they pointed out that no case law limits the equal protection principles of *Morton v. Mancari* to tribal land or self-government.

The defendants, in response to the plaintiffs' argument that ICWA is directed at a racial class because it applies to children who are not formally enrolled tribal members, argued Native people affiliated with a tribe—even when not formally enrolled—have a political status by virtue of their affiliation with a tribal political entity. They said ICWA's eligibility criteria require a child to have a tribal affiliation through the child's own membership or through the child's eligibility for membership and parent's enrollment, and thus ICWA is not directed at Native people lacking political status. They also analogized to federal statutes conferring United States citizenship to children of United States citizens born abroad and said the biological kinship of parent and child is a natural and universal proxy for membership in a political community.

Oral argument for the case lasted approximately one hour and thirty minutes. Much of the discussion during oral argument focused on whether the plaintiffs had standing and whether ICWA constitutes

continues on next page

Indian Health Update

continued from previous page

unconstitutional commandeering. The judges more aggressively questioned the anti-ICWA litigants. Thus, Indian country advocates are hopeful the judges will not rule against ICWA and, if they do, they will do so based only on the Constitution's anti-commandeering clause rather than on the equal protection clause. However, even if the Fifth Circuit rules favorably, the decision may face review by the Supreme Court.

***Redding Rancheria v. Azar:* CHEF and Tribal Self-Insurance**

We previously reported on the federal litigation in *Redding Rancheria v. Azar*, Civ. No. 14-2015 (RMC) (D.D.C. Nov. 7, 2017). The ongoing dispute over the processing of Catastrophic Health Emergency Fund (CHEF) program claims is unfortunately not yet fully resolved between the Redding Rancheria and the IHS.

The litigation initially arose out of the IHS's refusal to pay CHEF claims for individuals covered under the Rancheria's Tribal Self-Insurance Program (TSIP), which the Rancheria implemented to supplement its Purchased/Referred Care (PRC) program. The Rancheria submitted several claims to the IHS—claims provisionally paid for by the TSIP and for which the PRC program later reimbursed the TSIP—for CHEF reimbursement. IHS refused to process the claims and denied CHEF payment based the IHS's position that the TSIP is an alternate resource to PRC under the payer of last resort rule enacted under the Patient Protection and Affordable Care Act, 25 U.S.C. § 1623(b).

In the ensuing lawsuit, the United States District Court for the District of Columbia decided that the IHS cannot treat tribal self-insured health plans as alternate resources to PRC for purposes of CHEF reimbursement. The court remanded the case back to the IHS to process the Rancheria's CHEF claims in accordance with the court's opinion.

Based on a status report filed with the court on February 22, 2019 by the federal government, the IHS has processed ten CHEF claims for the Rancheria and paid eight: IHS approved and paid six claims at the full amounts requested, and approved and paid two other claims at close to the full amount. However, the remaining two claims are still in dispute and the government's status report blames the Rancheria for delay in submitting proof of payment to the providers. The Rancheria filed a "notice of disagreement" with the status report on February 25, 2019, saying the IHS's delay in processing these two remaining claims is based on IHS's "lack of diligence" and cannot be blamed on the Rancheria. For these claims, the Rancheria's TSIP had apparently paid providers electronically rather than by paper check. However, the court previously determined that the IHS could not insist on payment by check to providers, so paying providers electronically should not be a basis for finding improper proof of payment and denial of CHEF reimbursement. We continue to monitor this case.

Tribal Youth Opportunities

Tana Atchley-Culbertson (Modoc/Paiute/Karuk)
I-LEAD Youth Engagement Coordinator

The NPAIHB has some upcoming opportunities for tribal youth who are interested in learning more about health careers to take advantage of. For more information, you can contact the Youth Engagement Coordinator, Tana Atchley Culbertson at tatchley@npaihb.org or (503) 416-3286.

Tribal Youth Delegates

Youth Delegates are the official youth policy body to the Northwest Portland Area Indian Health Board Delegates. Youth Delegates will review NPAIHB programs and policies, and will provide advice about decisions that affect young people. The purpose of the Youth Delegates is to involve youth in all levels of community decision-making.

The program is open to tribal youth from the NPAIHB member tribes who are between the ages of 14-24 and have an interest in health careers. Those interested in

continues on next page

Tribal Youth Opportunities

applying for the second cohort of Tribal Youth Delegates can submit their applications this spring.

On-line applications available via NPAIHB website at http://www.npaihb.org/youth-delegate/ and will be accepted through May 31, 2019.

Youth Internship Stipends
We have teamed up with We Are Healers to support American Indian & Alaska Native youth (age 14-24 years old) interested in pursuing healthcare professions. Selected youth will receive $600 to cover their internship time and/or travel. They will work with a Host Site to provide them with hands-on training in health careers, health promotion strategies, research and evaluation methods, or community-based participatory research.

Online applications are available on the NPAIHB website at http://www.npaihb.org/youth-delegate/#YouthInternshipStipends and will be accepted on a rolling basis until July 1, 2019.

NEW EMPLOYEES

Meena Patil was excited to accept the position of Biostatistician for the Motor Vehicle Injury Data Project. After completing her MPH degree with focus on Epidemiology and Biostatistics from the Oregon Health & Science University she worked for NPAIHB for two years then moved on to work for the Oregon Health Authority's Public Health Division. Meena has more than nine years of experience working with large public health datasets, especially her work focused on surveillance, data analysis, record linkages, and evaluation of the Oregon Cancer Registry data. Over the years she was involved in various cancer control, prevention and intervention efforts of Oregon Public Health Division.

NEW EMPLOYEES

Twenty years ago Meena moved from India to US, she still misses her family, friends and great Indian food. She stays with her husband and two wonderful kids. As both her kids moved to college last year she is trying to fill that spare time with volunteer activities. She enjoys coking, gardening, reading and Yoga. She is very good at cooking Indian dishes.

Dr. Miranda Davis is the Native Dental Therapy Initiative Project Director.

Dr. Davis has been a dentist with the Puyallup Tribe since 2006, where she continues to provide clinical care part-time. In addition to the Puyallup clinic, she has worked in private practice and has volunteered in nine countries. Dr. Davis is passionate about public health, prevention, and expanding access to high quality oral health care. She has special interest in helping patients with dental fears and in providing respectful care. Originally from northern California, Dr. Davis received a DDS from University of the Pacific in San Francisco and an MPH from the University of Washington.

Ya'ateeh (Hello) my name is Corey Begay, I am Navajo from Northern Arizona on the Navajo Nation. I am the newly hired Multi Media Project Specialist working in the Adolescent Health Department alongside a great team.

I graduated from Northern Arizona University with my Bachelor's of Arts degree in Visual Communications, which is basically graphic design with some emphasis on web design. Some other things about who I am is that I'm an artist who likes to paint and be creative with different mediums of art, also that I like to be active, and I'm very outdoorsy. I'm happy to be here at the Northwest Portland Area Indian Health Board.

continues on next page

NEW EMPLOYEES

I am a descendent of the Confederated Tribes of Warm Springs, recent High School graduate and a newly hired TCHP Project Assistant. My name is Savannah Shaw and I am seeking to build my capacity to serve my local Native community and create positive change.

During the summer of 2015 I was an intern at the Northwest Portland Area Indian Health Board (NPAIHB). My tenure at NPAIHB instilled in me a strong desire to work within a Native organization that supports our local tribes. As a new young adult I am eager to utilize my passion and work ethic to further develop my skills to support this work.

As a Warm Springs descendent with strong ties to my family and community, I am fully invested in NPAIHB's values and vision.

Featured Team: Northwest Portland Area Indian Health Board (NPAIHB) - "Road Warriors"

In the 2019 Hood to Coast April Newsletter, the NPAIHB is featured as one of the 350 teams running in the Pacific City race (part of the HTC series).

Teams will have the opportunity to travel the final 78 miles of this epic race course, or the last 54 miles for the walk. This is a one-day, one-van, six-member team relay. Each participant will complete two legs along the 12-leg race course.

Participants will once again experience the beauty of The Original race course with each leg showcasing something special, such as scenic waterways, serene forests, and a sandy finish at the Pacific Ocean near Cape Kiwanda and Haystack Rock.

H2C Pacific City - Road Warriors Team
1. Birdie Wermy (Southern Cheyenne)
2. Lisa Griggs (Blackfeet)
3. Erik Kakuska (Zuni Pueblo)
4. Michelle Singer (Navajo)
5. Renee Rank-Ignacio (Klamath)
6. Chris Harper

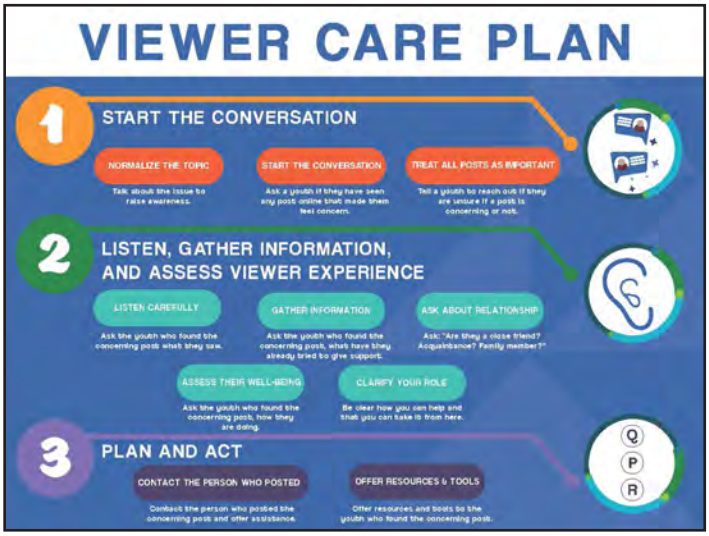
Alternates:
* Nora Frank-Buckner (Nez Perce/Klamath)
* Maggie Tafua-Harper (Southern Paiute)

Upcoming Events

Click on flyer for hyperlink

Upcoming Events

Click on flyer for hyperlink



NW TRIBAL FOOD SOVEREIGNTY COALITION'S 2019 SPRING GATHERING EVENT

SAVE THE DATE

June 4-5, 2019

Skokomish Tribe Community Center

19731 US-101, Skokomish, WA 98584

Questions?
Nora Frank-Buckner, MPH
WEAVE-NW Project Coordinator
nfrank@npaihb.org

Upcoming Events

Click on date for hyperlink

APRIL

April 23-25
National Council of Urban Indian Health
Washington, DC

April 29 - May 2
8th Annual Harm Reducation Summit
Mahnomen, MN

April 30 - May 2
16th Annual Phoenix-Area IHS intedrated Behavioral Health Conference
Glendale, AZ

MAY

May 2 - 3
2019 NW Regional Tribal Diabetes Conference
Portland, OR

May 6 - 9
20th Annual National Tribal Forum on Air Quality
Temecula, CA

May 10
2019 OHA Tribal Meeting
Salem, OR

May 13 - 15
2019 NIHB Natoinal Tribal Public Health Summit
Albuquerque, NM

May 13 - 17
IHS RPMS Third Party Billing and Accounts Receivalbe training
Portland, OR

May 14-16
Portland Area Dental Meeting
Portland, OR

May 15-17
AI/AN National Behavioral Health Conference
Albuquerque, NM

May 21 - 23
Good Health & Wellness in Indian Country
Albuquerque, NM

May 29 - 30
IHS Direct Service Tribes Advisory Quarterly Meeting
Rapid City, SD

JUNE

June 4 - 6
DMS/RPMS Training
Portland, OR

June 4 - 5
NW Tribal Food Sovereignty Coalitions's 2019 Gathering Event
Skokomish, WA

June 10 - 14
2019 IHS Dental Updates Continuing Dental Education Conference
Albuquerque, NM

Upcoming Events

Click on date for hyperlink

JUNE

June 10 - 14
Breastfeeding Peer Counciling Trainng
Fife, WA

June 10 - 14
NW Tribal Public Health Emergency Preparedness
Training & Conference
Portland, OR

June 11 - 13
IHS Partnership Conference
Spokane, WA

June 21
2018 IHS Director's Awards Ceremony
Rockville, MD

June 24 - 28
9th Annual THRIVE Conferece
Portland, OR

June 24 - 27
Mid Year NCAI Conference and Marketplace
Sparks, NV

JULY

July 10
NPAIHB IHS Institutional Review Board Meeting
Portland, OR

July 15 - 18
NPAIHB & CRIHB Joint Quarterly Board Meeting
Lincoln, CA

We welcome all comments and Indian health-related news items.

Address to:
Health News & Notes/ Attn: Lisa Griggs or by e-mail at lgriggs@npaihb.org

2121 SW Broadway, Suite 300, Portland, OR 97201
Phone: (503) 228-4185 FAX: (503) 228-8182

For more information on upcoming events please visit www.npaihb.org

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

2121 SW Broadway • Suite 300 • Portland, OR 97201

Return Service Requested

NON-PROFIT ORG.
U.S. POSTAGE
PAID
PORTLAND, OR
PERMIT NO. 1543

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD JANUARY 2019 RESOLUTIONS

RESOLUTION #19-02-01
State Tribal Youth Suicide Prevention Grant

RESOLUTION #19-02-02
weRnative: *How Can Technology Support AI/AN Adolescent Mental Wellness?*

RESOLUTION #19-02-03
Tribal Youth Delegate Program

RESOLUTION #19-02-04
Establish a Food Sovereignty Sub-Committee

Photo credit: E.Kakuska - Dancing in the Square Powwow 2018