NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

NPAIHB Health Recommendations for 2021 Presidential Transition

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization established under the Indian Self-Determination and Education Assistance Act (ISDEAA) that advocates on behalf of the 43 federally-recognized Tribes in Idaho, Oregon and Washington on specific health care issues. NPAIHB's delegates, appointed by each tribe, ensure that NPAIHB's mission and vision guide the work of the organization.

NPAIHB's mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives (AI/ANs) by supporting member tribes in the delivery of culturally appropriate, high quality health care. NPAIHB's vision is "wellness for the seventh generation."

With consideration of our mission and vision, we respectfully request the following:

ACTIONS IN FIRST 100 DAYS

General Requests

1. **Confirm the continuation of the Department of Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC) and other agency-level Tribal Advisory Committees.**

2. **Create a division of tribal affairs office in each HHS operating division.**

3. **In FY 2022, provide direct funding to tribal nations by creating tribal "set asides" for key federal health programs through inter-agency agreements.**

4. **Expand self-governance at the HHS and create funding mechanisms for noncompetitive baseline funding for all tribal nations.**

5. **Extend any deadlines for Provider Relief Funds and create flexibility on how any remaining funds can be used.**

Indian Health Service

6. **Begin work to determine amount needed to fully fund the Indian Health Service.** In FY 2020, IHS was funded at just over $6 billion, an inadequate amount for a seriously underfunded health system. The National Tribal Budget Formulation Workgroup has not had the opportunity to work closely with an actuary to comprehensively analyze and determine full funding for IHS. Tribes request a commitment from the new administration to begin work on determining this amount, with the Workgroup. Prior recommendations of the Workgroup for annual funding are available at: https://www.nihb.org/legislative/budget_formulation.php.

COVID-19 Vaccine

7. **Hold all agencies accountable to conduct meaningful tribal consultation with tribes on all COVID-19 vaccine policies, plans or other documents being released that impact AI/AN people.** The United States' unique legal and political relationship with federally-recognized tribes is recognized in the United States Constitution,

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treaties, federal statutes, executive orders, and judicial decisions. This relationship and trust responsibility extends to HHS and its agencies, and includes the requirement to conduct tribal consultation.[1] Meaningful tribal consultation is not only required, but critical to the government-to-government relationship between the United States and tribes .

8. **HHS must ensure tribes have access to all three options to receive COVID-19 vaccine: federal, state, and local.** Access to all three options means that there should be no limitations or restrictions to the vaccine. Tribes were forced to select one option for the vaccine – the state or IHS. Tribes have also been told that it will be difficult to change their decision once submitted. This limitation does not honor tribal sovereignty and IHS/Tribal clinics must have access to all options, opportunities, to receive the vaccine.

9. **Honor tribes' authority to determine COVID-19 Vaccine Service Populations and Priority Populations.** As sovereign nations, tribes have the authority to determine their service populations for COVID-19 vaccine administration. That is, to whom the tribe will administer COVID-19 vaccine. The federal government, including the IHS, state or local jurisdictions do not have this authority. A tribe's service population can be different from the tribe's IHS User Population and may include non-AI/AN individuals. Moreover, tribes have the sovereign authority to determine priority groups when there are not enough resources to provide mass dispensing of the vaccine to 100% of the tribal nation's service population.

10. **Tribal Governments Must Have the Ability to Choose Vaccine Product.** Tribes must have the ability to determine which vaccine or vaccines it chooses to receive and dispense to its service population. Tribes must also be informed of any vaccines that have been tested on American Indians, and whether they have proven to be effective or ineffective, to assist Tribes in their decision making. Policy must clearly support that federal, state, and local jurisdictions do not possess authority over tribal nations' determination regarding which vaccine to receive and dispense to its service population.

11. **Ensure that tribes have the resources needed to receive and/or store the vaccine.** The various vaccines have different storage requirements. Consideration must also be given to Tribes in rural areas that have frequent power losses. Generators must be provided to these tribes to ensure that any storage requirements can be maintained.

12. **HHS must enforce tribes' authority over COVID-19 vaccine management and dispensing.** Federal law prohibits state and local health jurisdictions from interfering with tribal government regulatory authority which includes a tribe's authority to determine service populations, priority groups, and dispensing strategies.

13. **HHS and IHS must provide funding and infrastructure support to tribes for vaccine reporting.** IHS is an under-resourced recognized jurisdiction for receipt of the vaccine, as it lacks the infrastructure and reporting mechanisms in place at the state level. IHS data reporting for COVID-19 vaccinations has complications involving data flow, permissions, data governance, agreements between entities, and necessary disclosures. A recent GAO report[2] found that of the $65 million allocated to IHS EHR systems, only $0.2m was obligated as of September 30, 2020. IHS current reporting mechanisms require an updated RPMS EHR, which many I/T/U sites have struggled to implement due to costs associated with new hardware. In the absence of an upgraded RPMS EHR, the CDC's VAMS portal has been identified as an alternate reporting mechanism. Rolling out a new system, setting it up, and training users to document in it in the midst of a public health

[1] U.S. Department of Health and Human Services, Tribal Consultation Policy, 2010, https://www.hhs.gov/sites/default/files/iea/tribal/tribalconsultation/hhs-consultation-policy.pdf (last visited October 7, 2020).
[2] https://www.gao.gov/reports/GAO-21-191/

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emergency is challenging. IHS also does not have a viable solution for electronic Employee Health Records, which are required by statute to be stored separately. This is causing complications for documenting the vaccinations of one of the highest priority groups, healthcare workers. Any available CARE Act, or new COVID-19, funds should be allocated immediately to all I/T/U sites.

U.S. Department of Health and Human Services

1. **Protect the Affordable Care Act and fully implement the Indian Health Care Improvement Act to ensure tribes and tribal members continue to obtain the benefits of these laws.** The Patient Protection and Affordable Care Act (ACA) has provided an incredible opportunity for increased access to health insurance for tribal members in our area. Increased access has improved the health outcomes of many AI/AN, while the increase of third-party revenue to IHS and tribal facilities (I/T) has expanded programs and services at I/Ts. There are also several important Indian-specific provisions in the ACA that are critical to the Indian health system. Section 2901(b) ensures that IHS, tribal and urban Indian programs (I/T/Us) are the payers of last resort; Section 2901(c) simplifies eligibility determinations for AI/AN enrolling in CHIP when seeking services from Indian providers; Section 2902 authorizes I/T/Us reimbursement for Medicare Part B services; and Title IX, Section 9021 ensures that health benefits provided by a tribe to tribal members are not counted as taxable income. Specifically:

    a. Ensure Tribal Epidemiology Centers are funded to fulfill their role as a Public Health Authority, as outlined in the IHCIA for activities such as technical assistance, capacity building, evaluation, public health surveillance, etc.
    b. Support tribal elders by funding long term care facilities, skilled nursing facilities, adult-day health centers, and hospice homes. Tribal elders are living longer, many with functional disabilities, and we anticipate that long term care facilities will be a critical need in the near future.
    c. Fund behavioral health initiatives, including sections 702, 704, 705, 709, 710, 711,712, 714, 715, 723 & 724 so IHS/tribal facilities can provide inpatient treatment, training for mental health techs, expansion of tele-mental health as well as demonstration grants.

2. **Support programs for our youth**. Good health can provide adolescents with a strong foundation for adult health. Some adolescents' unsafe choices or vulnerable situations can have serious life-threating consequences. Alternatively, when young people are supported in making positive choices, the benefits to the individual and community are significant, because many life-long patterns are established during adolescence. For these reasons, we believe that addressing the health and wellbeing of Native young people is imperative. Initiatives that provide safe environments for AI/AN adolescents, including safe schools, wellness centers, clinics, homes, and other social service programs are critical, so that AI/AN adolescents have secure places to live, learn, and play. Also, support initiatives for AI/AN adolescents and young adults to take an active role in their own health and wellbeing specific to leadership training, career coaching, Youth Delegates and Youth Councils, mentorship and internship opportunities, community service, and other positive extracurricular activities.

3. **Invest in Maternal Child Heath (MCH) programs that address tribal priorities.** Healthy mothers and babies need a continuum of support that extends across families, communities, health care and social services systems. Support and fund MCH initiatives that address heath through community-based research projects, data surveillance, technical assistance, and creation of tribal action plans to improve maternal, child and infant health**.**

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Centers for Disease Control and Prevention (CDC)

1. **Support Tribal Public Health Infrastructure**. While many tribal health programs have some public health and medical care infrastructure; it is often underfunded and may lack the capacity to respond effectively to health, natural, and manmade disasters. Too often population density is often a primary consideration in the allocation of emergency preparedness resources, it is important to recognize that public health emergencies and disasters can and do occur on Indian reservations and in rural areas in proximity to tribes, and the impact of these emergencies can be felt on everyone regardless of geography. Far reaching impacts of natural disasters, agricultural blight, and infectious diseases are just a few examples of the interconnectedness of our reservation, rural and urban citizens.
2. **CDC/ASPR must develop a procedure for how Tribes can directly access the Strategic National Stockpile from the federal government including federal contact information**. The 2009 H1N1 influenza pandemic, and now COVID-19, have demonstrated the critical need for clear federal guidance to states, local jurisdictions, and tribal governments regarding the distribution of medical countermeasures (MCM) to tribes. In addition, we request that CDC:
    a. Recognize, in all policy, that each tribal nation has the sovereign authority to provide for the welfare of its people and, therefore, has the authority to choose to receive MCM directly from the federal government, the state in which they are located, or a local jurisdiction; choose among various options to dispense MCM; determine the population it chooses to serve; and establish priority groups when there are not enough resources to provide mass dispensing to 100% of the tribal nation's service population.
    b. Support policies that set forth or clarify that state and local jurisdictions do not possess legal authority over tribal nations directly dispensing MCM to their service populations.
3. **Recognize SDPI as a grandfathered CDC DPRP eligible program, with no additional eligibility or reporting requirements.** The Special Diabetes Program for Indians (SDPI) is an evidence-based and community-based program that precedes CDC's DPRP, having been in operation across the country for the past 17 years. The SDPI program has had positive health outcomes for AI/AN participating in the program because it provides culturally appropriate diabetes prevention services. IHS/Tribal SDPI programs should not be required to meet the health outcomes in the CDC DPRP and should be grandfathered into the program without additional program requirements.
4. **Support Good Health and Wellness in Indian Country (GHWIC).** GHWIC initiative supports efforts by tribal organizations and AI/AN communities to implement holistic and culturally adapted approaches to prevent and control commercial tobacco use and exposure to second hand smoke; prevent obesity through increasing breastfeeding , availability of healthy foods, physical activity; and , reducing incidence of type 2 diabetes and prevalence of heart disease and stroke..

Centers for Medicare and Medicaid Services (CMS)

1. **Protect Medicaid Funding and preserve 100% FMAP.** The Medicaid program provides critical health coverage for AI/AN people and has also become a very important source of financing for health care for Indian health programs in our area and across Indian country. Because the IHS budget has not received adequate increases to maintain current services, Medicaid has provided additional revenue for Indian health providers. The increased coverage and revenue associated with Medicaid Expansion has had a very positive impact on IHS/tribal health programs. The 100% Federal Medical Assistance Percentage (FMAP) to IHS/tribal facilities

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for services received through IHS and tribal facilities is a critical component to the Medicaid system and honors the federal trust responsibility.

2. **Honor the government-to-government relationship with tribes and conduct meaningful consultation with tribes prior to issuing policies that have an impact on AI/AN people for demonstration projects.** For example**,** Section 1115 of the Social Security Act (SSA) allows a state to apply to the Centers for Medicare and Medicaid Services (CMS) for a waiver of Medicaid requirements of the SSA for experimental, pilot, or demonstration projects. States can use section 1115 waivers to test health care services that promote the objectives of Medicaid and Children's Health Insurance Program (CHIP). In addition, states can also apply for a Section 1915(b) waiver to provide services through managed care delivery systems or otherwise limit choice of providers; or apply for a Section 1915(c) home and community-based services waiver to provide long-term care services in home and community settings rather than institutional settings. These waivers influence policy-making and alter the delivery of health care services provided to AI/ANs nationwide.

3. **Protect fee-for-service structure because tribes and AI/AN should have an option to receive care at I/T and not be subject to managed care or any value-based payment (VPB) models.** VBP models are being adopted by states to reform healthcare delivery and payments under Medicaid. These models are based on demonstrating population health improvement over a range of specific quality metrics. This approach discriminates against the I/T/U system as the population it serves faces high health disparities, this approach also fails to recognize the positive impact that whole-person, culturally competent care has in the lives of the AI/AN people the I/T/U system serves. Portland Area Tribes are interested in learning more about VBP models, including metrics, expected outcomes, incentives and penalties to ensure tribes can maximize collection revenue. However, the IHS encounter rate must be protected and not impacted by VBP models.

4. **Reimburse Medicare services for American Indians/Alaska Natives at full OMB Encounter Rate.** Medicare only reimburses the IHS for 80 percent of the IHS OMB rate published annually in the Federal Register. IHS is required to waive the collection of deductibles and coinsurance from Indian Medicare enrollees so it does not receive the full OMB rate. The OMB encounter rate is a cost based rate established using IHS cost reports. IHS is only receiving 80 percent of its costs – not 80 percent of its reasonable charges.

5. **Permanently expand flexible telehealth waivers under CMS.** Telehealth services has provided an additional way to take care of our people during the COVID-19 pandemic and, if extended, would provide an option for AI/AN to access services after the pandemic. Many AI/AN live in rural areas and often do not have transportation to get to their health care provider. Telehealth provides an opportunity for IHS/Tribal health programs to increase health care provider shortages because a provider would not have to be based within an IHS/Tribal health care facility to provide telehealth services to AI/AN. For these, reasons, we request that CMS:
    a. Expand the locations that qualify as "originating sites" from which telehealth services can be received
    b. Telehealth modalities include communications via smart phones and similar devices using platforms like FaceTime, Skype, or Zoom, and these modalities should become permanent
    c. Ensure that all telehealth services be reimbursable by Medicare and Medicaid at the Office of Management and Budget (OMB) Encounter Rate
    d. Amend CMS regulations and allow direct physician supervision be provided remotely of non-physician providers
    e. Make telephone consultations reimbursable at the OMB Encounter Rate when lack of access to broadband or internet makes using other modalities impossible.

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Health Resources Services Administration (HRSA)

1. **Establish HRSA Tribal Advisory Committee (TAC) in FY 2021.** HRSA had committed to establishing a TAC which was not realized due to Tribes' active response to the pandemic and limited time. Later this year, HRSA should explore tribes' interest and timing to establish the TAC.

2. **Reduce the administrative and reporting burden of Provider Relief Funds by streamlining reporting requirements and allowing tribal attestation for 3rd party insurance reimbursement reporting.** Tribes in the Portland Area appreciate the changes HRSA made to the targeted allocation of funds, thereby allowing tribal health providers to receive payment based on a percentage of total 3rd party insurance reimbursements received.

3. **Modify Health Professional Shortage Area scoring so that clinics in the I/T/U system are recognized as the source for culturally competent care for AI/AN people.** Culturally competent care is critical for the health and wellbeing of AI/AN people. The ratio of available providers to the given population should not apply to AI/AN people seeking care in an I/T/U clinic because the general provider population is not equipped to provide holistic, culturally competent care to our people. I/T/U clinics should be given a score of "10" for all ratio calculations. The travel time to nearest source of care metric should not apply to AI/AN people seeking care in an I/T/U clinic because the general provider population is not equipped to provide holistic, culturally competent care to our people. I/T/U clinics should be given a score of "5" for all calculations.

Indian Health Service (IHS)

1. **Work with Congress to provide advance appropriations for IHS.** Government shutdowns and continuing resolutions are harmful to our people and the IHS system. Continuing resolutions (CRs) have occurred every year since FY 1998 except for one year (FY 2006). CRs result in administrative challenges to IHS/tribal facilities which impact patients' access to care and the quality of care. However, the worst scenario for tribes is a government shutdown. The 35-day partial government shutdown in 2018-2019 reduced AI/AN access to care and caused financial harm to IHS employees. This must be prevented in the future through advance appropriations. In addition, advance appropriations would allow IHS/Tribal clinics the opportunity to plan with two years of funding, reducing the stress and burden related to appropriations every year.
2. **Support continued funding for Community Health Aide Program expansion in FY 2022**. Portland Area Tribes have taken the lead in the lower 48 on the expansion of the Community Health Aide Program which includes all disciplines and all levels of Tribal Community Health Provider, (BHA/Ps, CHA/Ps and DHA/Ts). There are 13 Dental Health Aid Therapists working within our Portland Area. There are two BHAs from our Area in the Alaska BHA education program who are working in their tribal communities and will graduate June 2021 and 10 more students that are beginning their education in the Alaska BHA education program this year. IHS Headquarters and Areas, like Portland, will continue to need increased funding for CHAP expansion, especially to build and sustain local education programs for our future providers. We also request continued meaningful consultation with Areas in all stages of CHAP to ensure a unified CHAP throughout the US.
3. **Support continued funding for the Community Health Representative (CHR) program.** CHAP expansion should not impact any funding for the CHR program. The CHR programs provides critical services to many of our tribal communities.
4. **Support permanent authorization of SDPI funding at $200 million per year with medical inflation increases every year**. Portland Area Tribes also request support for the option to receive SDPI funding through tribal shares (ISDEAA Title I and Title V contracts).

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5. **Conduct tribal consultation in each IHS Area related to IT modernization or replacement of RPMS.** COVID-19 reinforces the facts that we already know about the RPMS software system. RPMS is inadequate and needs to be replaced. In addition to tribal consultation, IHS must also: (1) provide ample transition period, training, and technical assistance to IHS and tribal facilities once a decision is made; (2) consider the various EHR systems that tribal facilities use and ensure the system is streamlined and aligned with other systems to ensure coordinated care with no gaps in patient care; and (3) consider that many tribal facilities have purchased commercial off the shelf systems and are using tribal resources for upgrades, technical support and maintenance.
6. **Ensure that all AI/AN patients with HCV at I/T/U facilities have access to treatment to fulfill obligations to tribes and AI/AN people**. The AI/AN HCV-related mortality rate in Idaho, Oregon and Washington is over three times that of non-Hispanic whites and this disparity has persisted over time, demonstrating the need for enhanced and expanded access to HCV curative therapies. Lack of drug access to costly new medications (that reduce liver-related deaths, prevalence of hepatocellular carcinoma and decompensated cirrhosis and liver transplants) is the single most important barrier to a scale-up of HCV treatment and liver disease prevention. These HCV drugs are on the IHS formulary, but no funding has been appropriated to IHS for these drugs, so clinicians must spend considerable time mounting often unsuccessful attempts to get third-party payers such as private insurers, Medicaid, and patient-assistance programs to pay for them.
7. **Support increased funding for the IHS Scholarship Program and Loan Repayment Program**. Both IHS and tribally operated facilities have difficulty with recruitment and retention of qualified medical providers. The IHS Scholarship Program and Loan Repayment Program provide incentives for providers to work for IHS/Tribal facilities.
8. **Improve collaboration between IHS and the Veteran's Administration (VA).** Currently, the VA has 16 reimbursement agreements with tribal health programs in the Northwest (1 in ID, 6 in OR, and 9 in WA) and the program is growing. While the VA reimbursement agreements have improved relations between the VA and tribal health programs and the VA and AI/AN veterans, there is still need for improvement. IHS and VA must streamline and improve the process for establishing reimbursement agreements between the VA and tribal health programs, and must ensure that smaller tribes are included in opportunities to enter into agreements. IHS and VA must also work together to get purchased and referred care reimbursed by the VA. Specialty care for veterans is currently paid for by IHS.
9. **Evaluate current Health Care Facility Construction Priority System as to equitable access for all Tribes**. Many tribes and tribal organizations in the Portland Area have had to assume substantial debt to build or renovate clinics for AI/AN people to receive IHS-funded health care because of the long waitlist that will take decades to fulfill. For this reason, NPAIHB does not support appropriations for IHS Health Care Facilities Construction and asks this administration to either restructure, or develop a parallel system, that would allow tribes in all areas to have access to health care facility construction dollars. Until a change is made, support a significant funding increase for the small ambulatory grants program and joint venture projects.
10. **Support funding for area regional referral specialty centers.** As a result of Master Planning activities in 2005, three regional referral specialty centers were proposed to fill unmet needs within the Portland Area. The Portland Area Office, in consultation with the Portland Area Facilities Advisory committee, a local Tribal advisory group, are ready to move forward on the first center. The Program of Requirements and Program Justification Document were finalized in April 2016. The current IHS Healthcare Facilities Construction Priority System does not provide a mechanism for funding these centers. The Portland Area Facilities Advisory Committee recommends that the first center be constructed as a demonstration project under IHCIA, Sec. 143. Indian Health Care Delivery Demonstration Projects {25 U.S.C. § 1637}, for Tribes to test alternative health care models and means.

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11. **Increase support for AI/AN youth inpatient and outpatient mental health and substance use services**. While there are two Youth Regional Treatment Facilities in the Portland Area, the Healing Lodge of the Seven Nations in Spokane and NARA Northwest in Portland, more are needed with expanded services to address youth mental health needs and/or substance use care needs. Also needed are aftercare and transitional living support for both substance use and mental health services.
12. **Support funding for the IHS Behavioral Health Program for Indians at $150 million.** The program must have an option for tribes to receive funding through tribal shares (ISDEAA Title I and Title V contracts and compacts) and non-competitive funding for direct service tribes. The program must also allow for tribes to address all behavioral health and substance use issues with inclusion of prevention services, and cultural and traditional healing practices as evidence-based practices. Area Health Boards/Tribal Epidemiology Centers should be funded to provide support to Tribes for data collection and evaluation.
13. **Strengthen partnerships for integrated care between behavioral health and medical care teams.** There has never been a more important time to work together to improve behavioral health services for American Indian and Alaska Native people. Tribal health programs are struggling to meet the needs in the communities they serve, and the IHS must provide administrative relief and much needed financial support, especially for smaller tribes, to help ameliorate the impact of COVID-19 on the mental health well-being of our people.

National Institutes of Health (NIH)

1. **Support health research opportunities for conducting research and research career enrichment and development that meets the needs prioritized by tribes and tribal organizations.** Fund programs such as the Native American Centers for Health to reduce health disparities in AI/AN populations, supporting community control and prioritization of research and building research capacity and infrastructure.

2. **Prioritize tribally-led research.** Invest in the development of research partnerships that promote tribal leadership in research and build a cadre of AI/AN researchers and scientists.

3. **Ensure that tribes and tribal organizations have meaningful input into the development of NIH policies, programs and priorities.** Adhere to HHS consultation policy and enhance communication and collaboration with tribes. Utilize bodies like the NIH Technical Advisory Committee to assure that NIH officials, institutes, divisions and centers exchange views, share information and seek advice from tribal leader.

Office of the Assistant Secretary for Health (OASH)

1. **Ensure that Indian Country is included in Ending the HIV Epidemic funds and funded at $25 million dollars**. In FY 2020, IHS received no under the Consolidated Appropriations Act of 2020 for *Ending the HIV Epidemic* – despite the fact that other programs were funded. It is anticipated that IHS will not receive funding in FY 2021 either.
2. **Create a funding mechanism for IHS to receive Minority AIDS Initiative (MAI) funding for distribution via the Office of Infectious Disease and HIV/AIDS Policy**. This should not replace the Secretary's Minority HIV/AIDS funds that IHS receives. The Minority AIDS Initiative (MAI) allocates resources to CDC, HRSA, NIH, SAMHSA, and OMH. IHS does not receive direct MAI dollars. Excluding IHS from MAI dollars has far reaching and harmful impacts on IHS's ability to provide HIV/AIDS and HCV prevention, treatment, and outreach efforts.

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Substance Abuse Mental Health Services Administration (SAMHSA)

1. **Simplify and streamline funding opportunities for Tribes.** There are significant gaps in crisis services programs in our Area, and tribal communities have not always been able to support the levels of mental health care that AI/AN people in our Area need. We request that SAMHSA:
    a. Modify and streamline the application and reporting requirements to make SAMHSA funding more accessible for tribes
    b. SAMHSA funding be made flexible to meet the unique needs of AI/AN communities
    c. Work with Congress and/or the IHS so that inter-agency transfer of funds between SAMHSA and IHS is possible so that tribes can receive funds through existing funding agreements based on contracts and compacts

2. **Provide resources to improve and expand tele-behavioral health**. We anticipate an increase in demand for behavioral health services within our tribal communities as the COVID-19 pandemic persists, and view tele-behavioral health as a necessary part of caring for our people.

3. **Support AI/AN youth-focused prevention, treatment, recovery services**. NPAIHB is particularly concerned about our AI/AN adolescents and young adults. Suicide is the second leading cause of death for AI/AN adolescents and young adults. AI/AN suicide mortality in this age group (10-29) is 2-3 greater than that for non-Hispanic whites.

4. **Set aside funding for AI/AN Youth Regional Treatment Centers (YRTC) that provide aftercare and transitional living for both substance use and/or mental health; and support initiatives that increase the number of AI/AN youth substance use and mental health facilities.** While there are two Youth Regional Treatment Facilities in the Portland Area, the Healing Lodge of the Seven Nations in Spokane and NARA Northwest in Portland, more are needed with expanded services to address youth mental health needs and/or substance use.

5. **Continue SAMHSA TOR non-competitive funding for tribes, directly to tribes and in parity with states, for longer terms with the flexibility to address co-occurring mental health issues with funding for prevention, cultural and traditional healing practices as evidence-based practices; and fund technical assistance for TOR grantees at regional level through Area Health Boards/Tribal Epidemiology Centers**. The increased HHS opioid funding has provided an opportunity to address opioids and co-occurring substance use in AI/AN communities. For example, the Substance Abuse Mental Health Services Administration's (SAMHSA) Tribal Opioid Response (TOR) funding has provided 42 of the 43 tribes in the Portland Area with funding to address the opioid epidemic in their communities.

6. **Fully fund implementation of the SAMHSA National Tribal Behavioral Health Agenda to improve the behavioral health of AI/AN with specific emphasis on AI/AN youth.** Incorporate recommendations found in the National Tribal Behavioral Health Agenda that address suicide prevention for youth, adults, families, and communities utilizing protocols, data collection, reporting, community outreach, and discharge (PR1.5, PR1.6, PR1.7).

7. **Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/ANs with Substance Use Disorder (SUD).**

For more information, please contact Laura Platero, Executive Director, Northwest Portland Area Indian Health Board, via email at lplatero@npaihb.org or by phone at (503) 407-4082.