MINUTES

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING

January 19-20, 2021

Via Zoom

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January 19-20, 2021

MINUTES

Summary of Minutes

Issue	Summary	Action	Follow-Up
TUESDAY JANUAY 19, 2021			
Call to Order:	At 8:39AM by Nick Lewis NPAIHB Chairman		
Roll Call:	Greg Abrahamson, there were 27 delegates present, a quorum was established		
Approve Agenda		**MOTION PASSED**	
Review and approve October's Quarterly Board minutes		**MOTION PASSED**	
Election of Officers	1. Vice Chair • Greg Abrahamson, Spokane Tribe nominates Cheryle Kennedy, Grand Ronde. 2nd by Shawna Gavin, Confederated Tribes of Umatilla • **Motion Carried: Cheryle Kennedy elected to Vice-Chair by acclamation** 2. Treasurer • Greg Abrahamson, Spokane Tribe nominates Shawna Gavin, Confederated Tribes of Umatilla. 2nd by Cheryle Kennedy, Grand Ronde • **Motion Carried: Shawna Gavin elected to Treasurer by acclamation** 3. Sergeant-at-Arms • Cheryl Rasar, Swinomish nominates Kim Coombs, Shoalwater Bay. 2nd by Shawna Gavin, Confederated Tribes of Umatilla. • **Motion Carried: Kim Coombs elected to Sergeant-at-Arms by acclamation**		
Chairman's Report, Nick Lewis, NPAIHB Chair	As we gather together today over Zoom, I can't help but think about what we were all doing a year ago. We were together at Tulalip. It was our first big snow storm of 2020, and we were worried about our tribal leaders and our staff driving in the snow. I was also elected to be your Chairman. I was so honored that you gave me a chance to serve. How could we have known that driving in the snow would be the least of our worries in 2020? We have lived under the shadow of the COVID-19 pandemic for over 10		

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months where COVID-19 revealed the disparities and underfunding of our health system. And as hard as it has been, our people have proven to be resilient. We have lost loved ones, too many to this disease, and too many to the other challenges we face. We have been unable to mourn our losses in our traditional ways, and we have found new ways to say goodbye. We have been quarantined, we have been tested, both by this disease and for this disease.

We experienced wildfires and seriously unhealthy air quality. We have yet to know about the long-term impacts of these fires on our communities.

We had social justice come to the forefront with and civil unrest, and it continues with much unknown in the coming days as the administration changes.

We have had to figure out how to use Zoom, remember to mute our phones, how many times have we said "can you hear me?" on a call? The way we work and the way that we serve our communities is forever changed. The thing that will always remain the same is the commitment that you all show to the work and to your communities.

My hands go up to each and every one of you. You haven't quit, you haven't stopped serving, you have persevered, and you have gone above and beyond in your service to our people. I will forever be grateful for how hard you have worked for your tribes this year, and I will be forever grateful for the trust you have placed in me.

At Lummi we say "Es titem sen" – it means "I am doing the best that I can" I want you to know that I am doing the best I can in my work for this Board, just like you are, each and every day. I won't be perfect, and I will make mistakes, but "Es titem sen", we are all doing the best that we can.

As the Portland Area Board Chair, I have continued to:

- Chair the Tuesday, COVID-19 Tribal calls, with IHS and state leadership on those calls alongside our tribal leaders and tribal health directors
- Since the last board meeting, we had two COVID-19 vaccinations approved and distributed across states and throughout Indian Country. The Pfizer vaccine was the first to come out, and from the first shipment Lummi received 300 doses, Umatilla received 300, Yakama received 150, and Upper Skagit received 75. The week it came

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	out, I drove over 800 miles to take the vaccine to our tribes. Right now, tribes are working with the IHS or their States to get vaccines into the arms of our tribal people. We hope that Tribes will have more options under the next administration, and we are remaining vigilant. In order to provide more options, the Lummi Nation and the Nooksack Indian tribe are participating in the Novavax vaccine trial, that just started on January 08. Participating in a clinical trial was a big step to take, but we believe it is the right thing to do to help fight COVID-19. • We held Portland Area IHS Fiscal Year 2023 Budget Formulation Meetings in November. I want you all to know that at the NIHB Annual Meeting in October, Senator Chuck Schumer promised full funding for the Indian Health Service if he becomes the Senate Majority Leader of the 117th Congress – we need to hold him to that promise. • In December I participated in the Tribal Leaders Summit with National Indian Health Board. We are working with all the other Areas, and tribes across the country to get tribal priorities in front of the Biden Administration. • We, as tribal representatives, need to stay focused on what the outgoing Trump administration is doing with rule changes, and actively pursue a different direction with the Biden Administration. We may need to have the Biden Administration reverse some of the things that Trump's administration has done in its last 60 days. • I was a part of the National Indian Health Board's virtual annual meeting in October, as well as actively participating in their weekly Board and Quarterly Board meetings. • I've participated in multiple Biden Transition Team meetings through NIHB and ATNI. We submitted NPAIHB's priorities in December to the Transition Team to get your priorities out in front of the federal government's new leadership. I am hopeful when I look at the Biden Administration's engagement with Indian Country. And I will work to hold our federal trustee accountable to their obligations. • The Board's Executive Committee has been meeting weekly since March. Executive		

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	Committee members share updates on our communities with each other, get admin and finance updates, discuss policy concerns, and get COVID-19 and epi updates. • More than anything, I am here for you. Please ask me any questions you want, and let me know if there is anything you'd like to Board to do. • Before I turn it over to Laura, I'd like to announce the Delegate of the Year. This Year's Delegate of the Year is Greg Abrahamson. Here are some of the things that were said: o "Has been on the Executive committee. Always available to cover for others. Carries himself professionally. Besides being on the Health Board he represents the Direct Service Tribes." o "Greg effectively represents the NPAIHB values and goals through his contact with outside entities. He also quietly and with humor is quick to resolve any conflicts that might arise at any given moment. His dedication to our work is always an encouragement." o "He is a Tribal Leader who I have worked with and does a Great Job representing the NPAIHB Tribes at the National Level as well as he is fun to work with."		
Executive Director Report, Laura Platero	QMB Highlights • Delegate of the Year • Policy Priorities for FY 2021 / Legislative Opportunities • Tribal Advisory Committee Updates • Strategic Plan 2020 to 2025 • Epi / COVID-19 work • Bylaws Update New Position, Deputy Director Sue Steward, Sue Steward is a citizen of the Cow Creek band of Umpqua Tribe of Indians, is		

Summary of Minutes

a current council Board of Directors member and Health Advisory Chair with over 8-years of experience as a tribal leader

Personnel Updates:
Promotions

- Birdie Wermy, Behavioral Health Program Manager
- Danica Brown, Behavioral Health Program Director
- Candice Jimenez, Health Policy Specials

Separations or retirements:

- Corey Begay, Behavioral Health Manager
- Jacqueline Left Hand Bull, Administrative Officer
- Luella Azule, IP& PHT Project Coordinator

New Employees:

- Carrie Sampson, CHAP Director
- Liz Coronado, Health Policy Specialist
- Samantha Wells, Temp. Legislative Field Organizer
- ---, TOR Project Specialist
- Nick Cushman, ECHO Pharmacy Case Manager

Recognitions – 10 years of Service

- Jessica Leston, Clinical Program Director
- David Stephens, ECHO Clinic Director

Special Recognition

- Erik Kakuska, helping with the Health News & Notes

Summary of Minutes

Employee of the Year

- Amy Franco, Grants Management Specialist

Office & Administration

- Office Closed – Only Essential Staff in the Office; Project Staff Intermittently
- Staff to get COVID-19 vaccine
- Revisit Lease -Terms is June 1, 2017 to May 31, 2023
    - Attorney Opinion – July 2020
        - No early termination clause
        - Options: Negotiate termination/buy out or sublease space
    - Last year: Anticipated return to office in Spring or Summer
    - Now: Uncertain return to office; will explore options again

Finance

- Continue implementation of Microix - electronic purchase order system
- FY 2021organizational budget
- Administrative Officer (AO) retired 11/30/20. AO had oversight over Finance and Admin staff; now hiring Finance Director (position still open)
- Annual audit preparation has begun; date TBD

New Awards and Supplements 2020

- In 2020, NPAIHB received nearly 13 million dollars in new awards or supplements
- These new dollars funded projects related to COVID-19 response, Environmental Health, Tribal Elders, Dental Support, Food Sovereignty, Youth Sexual Health, Tribal Opioid Response, and Behavioral Health

Continuations on Existing Grants

Summary of Minutes

	• In 2020, NPAIHB received approximately $5,477,000 in continued funding on existing projects • Projects receiving continuing funding included Public Health Infrastructure and Training, the EpiCenter, THRIVE Area 4 and 2, Response Circles, Opioid-related projects, and NARCH 9 and X • **Motion to approve Executive Director Report by Libby Watanabe, Snoqualmie.** • **2nd by Cheryl Rasar, Swinomish** • **Motion Carries**	**MOTION PASSED**	
Financial Reports & FY 2021 NPAIHB Budget, Eugene Mostofi,	• **Motion to approve Finance Report by Andy Joseph, Jr., Colville Tribe** • **2nd by Cheryle Kennedy, Grand Ronde Tribe** • **Motion Carries** • **Motion to add Sue Steward, Deputy Director to the Board's Bank Accounts and Investment portfolios to replace Jacqueline Left Hand Bull** • **Motion by Cassie Sellards-Reck, Cowlitz.** • **2nd by Shawna Gavin, Confederated Tribes of Umatilla** • ***Motion Carries***	**MOTION PASSED** **MOTION PASSED**	
IHS Area Director Report, Dean Seyler, Portland Area IHS Director	**Indian Health Service Portland Area** **Office of Tribal & Service Unit Operations** **PPPHCEA – HHS Testing Funds Transfer (FY20 closeout)** ❖ Sent week of June 1st, 2020 ❖ Requires a comprehensive Budget, Signed Amendment & Testing plan ❖ Portland Still has 7 Tribes outstanding **Calendar Year Tribes Remaining**		

Summary of Minutes

- 5 – Title I AFA's
- 4 – Title V FA's

Contract Support Costs

- Portland Area Continues to work on prior year reconciliations for prior years to true up payments and ensure all CSC amounts are brought up to current.

Division of Finance

- H.R. 133 – Consolidated Appropriations Act, 2021
  - FY 2021 IHS Budget, $6.2 billion
  - Became law on December 27, 2020
- Funding received by Area to date:
  - Exception Apportionment (Fiscal-Year Tribes Only)
  - CR1 PL 116-159: 10/01/20 – 12/11/20
  - CR2 PL 116-215: 12/12/20 – 12/18/20
  - CR3 PL 116-225: 12/19/20 – 12/20/20
  - CR4 PL 116-226: 12/21/20
  - CR5 PL 116-246: 12/22/20 – 12/28/20
  - 30-day apportionment of FY20 Recurring Base, which runs through 1/27/2021
- On December 27, the President signed the Coronavirus Response and Relief Act, 2021 as part of a broader legislative package.
- The bill includes a total of $1 billion for IHS, Tribal, and Urban Indian health programs.
- The bill includes language stipulating that these funds are provided on a one-time, non-recurring basis, and can only be used for the purposes outlined in the statute.
- These funds are appropriated to the CDC and the Public Health and Social Services Emergency Fund. The bill directs HHS to transfer the funds to the IHS for distribution.

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	❖ The $1 billion in new COVID-19 resources includes two separate appropriations: ❖ $210 million for vaccine-related costs, available through FY 2024, and ❖ $790 million for testing and related costs, available through FY 2022. ❖ The bill provides the IHS a total of $210 million for the following activities: ❖ To plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage, and ❖ To restore, either directly, or through reimbursement, obligations incurred for coronavirus vaccine promotion, preparedness, tracking, and distribution prior to the enactment of this Act. ❖ The bill provides the IHS a total of $790 million for the following activities: ❖ Testing, contact tracing, surveillance, containment, and mitigation to monitor & suppress COVID-19, ❖ Support for workforce, epidemiology, and personal protective equipment needed for administering tests, ❖ Use by employers, elementary and secondary schools, child care facilities, institutions of higher education, long-term care facilities, or other settings, ❖ Scaling up testing by public health, academic, commercial, and hospital laboratories, ❖ Community based testing sites, mobile testing units, health care facilities, and other entities engaged in COVID-19 testing, and ❖ Other activities related to COVID-19 testing, contact tracing, surveillance, containment, and mitigation. ❖ The bill also requires that recipients of these funds update their COVID-19 testing plans required by the Paycheck Protection Program and Health Care Enhancement Act. ❖ It further requires the Secretary to make these plans publicly available. ❖ It also requires the IHS to provide a spend plan on the uses of funds to Congress within 60 days of enactment, and report to Congress on uses of funding, commitments, and obligations, quarterly thereafter.		

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FY19 Catastrophic Health Emergency Fund (CHEF)
Status as of January 11, 2021

- 92 Total Cases
- 41 Total Amendments
- $4,651,630.00 Reimbursed
- $0 Pending Reimbursements
- 100% Total Reimbursed
- **FY19 CHEF Balance: $0**

FY20 Catastrophic Health Emergency Fund (CHEF)
Status as of January 11, 2021

- 54 Total Cases
- 33 Total Amendments
- $1,839,066.00 Reimbursed
- $164,407.33 Pending Reimbursements
- 91% Total Reimbursed
- **FY20 CHEF Balance: $28,195,367**

FY21 Catastrophic Health Emergency Fund (CHEF)
Status as of January 11, 2021

- 1 Total Cases
- 0 Total Amendments
- $0 Reimbursed
- $13,883.16 Pending Reimbursements
- 0% Total Reimbursed
- **FY21 CHEF Balance: $53,000,000**

Summary of Minutes

Division of Health Facilities Engineering

Combined Supportable Space Data Request

- Requesting Space and Deficiency Data Updates
- Packets Sent by Email to Tribal Health Director and Tribal Chair week of January 11th
  - Notify lee.wermy@ihs.gov if you did not receive.
- Response Required to be Eligible for Project M&I (BEMAR) Funding
- Due February 15th

Division of Sanitation Facilities Construction

- In FY20, the Portland Area DSFC initiated a total of 49 new projects and amended 8 previous projects using $18.5M from all funding sources.
- This included $10.6M from IHS and $7.9M in contributions from Tribes, EPA, USDA, and HUD.
- CARES Act funding: Portland Area DSFC received $421,017 in CARES Act funding for special projects to provide Personal Protective Equipment to Tribal operators and to help operate and maintain water and wastewater systems and support public health.
- 8 CARES Act projects were funded, benefitting 10 Tribes.
- In November, the Portland Area DSFC submitted its annual list of identified project needs to SFC Headquarters: 43 reportable projects valued at 59.6M.
- This list will be used to award projects in FY21.
- This represents a significant increase over the FY20 submission, which included 30 projects valued at $26.5M.
- This is the result of our continued partnerships with Tribes to identify needs, as well as changes in the guidance last year that allowed us to report needs that do not yet have a fully scoped project solution.
- We are currently beginning to schedule meetings with Tribes to identify needs for

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	FY22 funding. **Division of Sanitation Facilities Construction** ❖ DSFC Director: CAPT Alex Dailey, 503-414-7780, alexander.dailey@ihs.gov ❖ Western Oregon District Office: LT Derek Hancey, 503-414-7784, derek.hancey@ihs.gov ❖ Yakama Field Office: Samantha Handrock, 509-865-1775, samantha.handrock@ihs.gov ❖ Olympic District Office: CDR Roger Hargrove, 360-792-1235 x113, roger.hargrove@ihs.gov ❖ Port Angeles Field Office: CDR Craig Haugland, 360-452-1196, craig.haugland@ihs.gov ❖ Spokane District Office: CDR Steve Sauer, 509-455-3486, steve.sauer@ihs.gov ❖ Fort Hall Field Office: LT Kevin Remley, 208-238-5473, kevin.remley@ihs.gov		
Review of 2020 Policy Priorities, Candice Jimenez, Health Policy Specialist and Liz Coronado, Health Policy Specialist	***Please see attached PowerPoint***		
Legislative & Policy Update, Veronica Smith, Policy Consultant	***Please see attached PowerPoint***		
Portland Area Tribal Advisory Committee (TAC) Reports, Sue Steward,	***Please see attached PowerPoint***		
Strategic Plan Review, Nora Frank-Buckner, Food Sovereignty Initiatives and Director & Stephanie Craig-	***Please see attached PowerPoint***		

Summary of Minutes

Rushing, Project Director			
	4**:30 PM Recess for the Day**		
WEDNESDAY JANUARY 20, 2021			
Call to Order:	at 8:31AM by Cheryle Kennedy		
Importance of Patient Screenings in a Virtual World, Colbie Caughlan	***Please see attached PowerPoint***		
NPAIHB Washington Youth Sexual Health (WYSH), Celena McCray, WA DOH Parenting Teens Project Coordinator	***Please see attached PowerPoint***		
EpiCenter Update, Victoria Warren-Mears, NWTEC Director	***Please see attached PowerPoint***		
COVID 19 Response, Celeste Davis, Environmental Health Director	***Please see attached PowerPoint***		
2021 Policy Priorities Liz Coronado, Health Policy Specialist, and Candice Jimenez, Health Policy Specialist	***Please see attached PowerPoint***		
Tribal Reports by Burns Paiute Tribe, Twila Teeman	***Please see attached PowerPoint***		
Committee Reports	**Elders Committee – Clarice Charging, NPAIHB staff** (A copy of the report is attached) **Veterans – Debra Jones, Samish Tribe –** (A copy of the report is attached)		

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	Public Health – Andrew Shogren, didgwalic Wellness Center (A copy of the report is attached) **Behavioral Health – Danica Brown, NPAIHB Mental Health Program Manager** (A copy of the report is attached) **Personnel – Cassie Sellards-Reck, Cowlitz** (A copy of the report is attached) **Youth – Cassie Sellards-Reck, Cowlitz –** (A copy of the report is attached) **Legislative Report – Report Sue Steward, NPAIHB Deputy Director** (A copy of the report is attached)		
Resolutions:	21-01-06 Ratification: ***Community Catalyst Funding Opportunity to Support Native Dental Therapy Initiative*** • Motion by Andy Joseph, Jr., Colville • Motion 2nd by Libby Wantabe, Snoqualmie • **Motion Carried** 21-01-07 Ratification: ***Lead Testing in School and Child Care Program Drinking Water Tribal Grant*** • Motion by Cassie Sellards-Reck, Cowlitz • Motion 2nd by Cheryl Rasar, Swinomish • **Motion Carried** 21-02-01 ***Support for Legislation to Amend Lease Compensation Provisions of the Indian Self-Determination and Education Assistance Act*** • Motion by Andy Joseph, Jr., Colville • Motion 2nd by Cheryl Rasar Swinomish	**MOTION PASSED** **MOTION PASSED** **MOTION**	

Summary of Minutes

	• **Motion Carried** 21-02-02 ***Environmental Protection Agency Region 10 General Assistance Program (GAP)*** • Motion by Cheryl Rasar, Swinomish • Motion 2nd by Andy Joseph, Jr., Colville • **Motion Carried** 21-02-03 ***T1-21-007 Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMSHA) Tribal Opioid Response (TOR) Grant*** • Motion by Andy Joseph, Jr., Colville • Motion by Libby Wantabe, Snoqualmie • **Motion Carried** 21-02-04 ***Behavioral Health Aid Training and Support Project*** • Motion by Andy Joseph, Jr., Colville • Motion by 2nd by Cheryl Rasar, Swinomish • **Motion Carried**	**PASSED** **MOTION PASEED** **MOTION PASSED** **MOTION PASSED**	
	Adjourn at 3:35 PM • Motion by Andy Joseph, Jr., Colville • Motion 2nd by Cheryl Rasar, Swinomish • **Meeting Adjourned**	**MOTION PASSED**	

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

JANUARY 2021
QUARTERLY BOARD
Zoom Meeting

January 19-20, 2021

MINUTES

TUESDAY JANUARY 19, 2021

Call to Order: at 8:39 AM and Welcome by Nick Lewis, NPAIHB Chairman

Roll Call: Greg Abrahamson

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

There were 27 delegates present, a quorum was established.

1. Approve Agenda
   - **Motion to approve agenda: Cassie Sellards-Reck, Cowlitz**
   - **Motion 2nd by Cheryle Kennedy, Grand Ronde**
   - **Motion Carried**

2. Future Board Meeting Dates/Sites
   - April 20 – 22, 2021, TBD
   - July 20 – 22, 2021, TBD
   - October 19 – 21, TBD

3. Review and Approve October QBM Minutes

- **Motion by Shawna Gavin, Confederated Tribes of Umatilla**
- **Motion 2nd by Cheryl Rasar, Swinomish**
- **Motion Carried**

4. Election of Officers
   - Vice Chair
     - Greg Abrahamson, Spokane Tribe nominates Cheryle Kennedy, Grand Ronde. 2nd by Shawna Gavin, Confederated Tribes of Umatilla
     - **Motion Carried: Cheryle Kennedy elected to Vice-Chair by acclamation**
   - Treasurer
     - Greg Abrahamson, Spokane Tribe nominates Shawna Gavin, Confederated Tribes of Umatilla. 2nd by Cheryle Kennedy, Grand Ronde
     - **Motion Carried: Shawna Gavin elected to Treasurer by acclamation**
   - Sergeant-at-Arms
     - Cheryl Rasar, Swinomish nominates Kim Coombs, Shoalwater Bay. 2nd by Shawna Gavin, Confederated Tribes of Umatilla.
     - **Motion Carried: Kim Coombs elected to Sergeant-at-Arms by acclamation**

CHAIRMAN'S REPORT, NICK LEWIS:

As we gather together today over Zoom, I can't help but think about what we were all doing a year ago. We were together at Tulalip. It was our first big snow storm of 2020, and we were worried about our tribal leaders and our staff driving in the snow.

I was also elected to be your Chairman. I was so honored that you gave me a chance to serve. How could we have known that driving in the snow would be the least of our worries in 2020? We have lived under the shadow of the COVID-19 pandemic for over 10 months where COVID-19 revealed the disparities and underfunding of our health system. And as hard as it has been, our people have proven to be resilient. We have lost loved ones, too many to this disease, and too many to the other challenges we face. We have been unable to mourn our losses in our traditional ways, and we have found new ways to say goodbye. We have been quarantined, we have been tested, both by this disease and for this disease.

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My hands go up to each and every one of you. You haven't quit, you haven't stopped serving, you have persevered, and you have gone above and beyond in your service to our

people. I will forever be grateful for how hard you have worked for your tribes this year, and I will be forever grateful for the trust you have placed in me.

At Lummi we say "Es titem sen" – it means "I am doing the best that I can" I want you to know that I am doing the best I can in my work for this Board, just like you are, each and every day. I won't be perfect, and I will make mistakes, but "Es titem sen", we are all doing the best that we can.

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- More than anything, I am here for you. Please ask me any questions you want, and let me know if there is anything you'd like to Board to do.
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Executive Director Report, Laura Platero

QMB Highlights

- Delegate of the Year
- Policy Priorities for FY 2021 / Legislative Opportunities
- Tribal Advisory Committee Updates
- Strategic Plan 2020 to 2025
- Epi / COVID-19 work
- Bylaws Update

New Position, Deputy Director
Sue Steward, Sue Steward is a citizen of the Cow Creek band of Umpqua Tribe of Indians, is a current council Board of Directors member and Health Advisory Chair with over 8-years of experience as a tribal leader

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- David Stephens, ECHO Clinic Director

Special Recognition
- Erik Kakuska, helping with the Health News & Notes

Employee of the Year
- Amy Franco, Grants Management Specialist

Office & Administration
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    - No early termination clause
    - Options: Negotiate termination/buy out or sublease space
  - Last year: Anticipated return to office in Spring or Summer
  - Now: Uncertain return to office; will explore options again

Finance
- Continue implementation of Microix - electronic purchase order system
- FY 2021organizational budget
- Administrative Officer (AO) retired 11/30/20. AO had oversight over Finance and Admin staff; now hiring Finance Director (position still open)
- Annual audit preparation has begun; date TBD

New Awards and Supplements 2020
- In 2020, NPAIHB received nearly 13 million dollars in new awards or supplements
- These new dollars funded projects related to COVID-19 response, Environmental Health, Tribal Elders, Dental Support, Food Sovereignty, Youth Sexual Health, Tribal Opioid Response, and Behavioral Health

Continuations on Existing Grants
- In 2020, NPAIHB received approximately $5,477,000 in continued funding on existing projects

- Projects receiving continuing funding included Public Health Infrastructure and Training, the EpiCenter, THRIVE Area 4 and 2, Response Circles, Opioid-related projects, and NARCH 9 and X

- **Motion to approve Executive Director Report by Libby Watanabe, Snoqualmie.**
- **2nd by Cheryl Rasar, Swinomish**
- **Motion Carries**

Financial Report & FY2021 NPAIHB Budget, Eugene Mostofi:
FY2020 budget report – Covers period October 2019 through September 2020 with $30.7 million for the overall organization. The next column shows actual expenses vs total budget that's a difference of about $9.5 million. Those funds will be carried forward to FY2021. You can see our budget has increased from $30 million to $36 million.

FY2021 budget report – Current FY2021 budget is $36 million we continued to grow over the past few years. We've been averaging about $6 million in expenditures over those years. October 202 to this point our expenditures are about $3 million. What remains in this year's budget is about $33 million. This budget has been transferred in to our new Microix system this helps us better manage project budgets.
every cost center has a Project Director and this budget intergrades with our new purchase order system, Microix and that's how we manage this information. This report is available to Manager's to review through the accounting system. I wanted to show that organizationally through November 30th summary by all projects of the spending by individual line items so far $2.9 million in project spending and about $33 hundred thousand includes the indirect expenses

Balance sheet – as of November 30th we have about $9 million in cash compared to last FY where it was $10 million there was about $1 million different in our offset earned revenue, so those two offset each other. But our financial standing is healthy. Investments small increase because of interest earning of about thousand dollars.

We are about six months in this system most of the staff is trained on the Microix system. They are able to track their budges this is going to be a key piece moving forward and a daily basis on managing budgets on a Management level, on Project Director bases, and for the staff that create the POs in the system. You can see if they have money in there or not. There is a process for approval goes to the authorizing Project Director, the Management approval process, then to Certification of accounting funds then it's off to Accounts Payable to also approve it and pay it.

- **Motion to approve Finance Report by Andy Joseph, Jr., Colville Tribe**
- **2nd by Cheryle Kennedy, Grand Ronde Tribe**
- **Motion Carries**

- **Motion to add Sue Steward, Deputy Director to the Board's Bank Accounts and Investment portfolios to replace Jacqueline Left Hand Bull**

- **Motion by Cassie Sellards-Reck, Cowlitz.**
- **2nd by Shawna Gavin, Confederated Tribes of Umatilla**
- ***Motion Carries***

IHS AREA DIRECTOR REPORT, DEAN SEYLER:
Indian Health Service Portland Area
Office of Tribal & Service Unit Operations
PPPHCEA – HHS Testing Funds Transfer (FY20 closeout)

- Sent week of June 1st, 2020
- Requires a comprehensive Budget, Signed Amendment & Testing plan
- Portland Still has 7 Tribes outstanding

Calendar Year Tribes Remaining

- 5 – Title I AFA's
- 4 – Title V FA's

Contract Support Costs

- Portland Area Continues to work on prior year reconciliations for prior years to true up payments and ensure all CSC amounts are brought up to current.

Division of Finance

- H.R. 133 – Consolidated Appropriations Act, 2021
  - FY 2021 IHS Budget, $6.2 billion
  - Became law on December 27, 2020
- Funding received by Area to date:
  - Exception Apportionment (Fiscal-Year Tribes Only)
  - CR1 PL 116-159: 10/01/20 – 12/11/20
  - CR2 PL 116-215: 12/12/20 – 12/18/20
  - CR3 PL 116-225: 12/19/20 – 12/20/20
  - CR4 PL 116-226: 12/21/20
  - CR5 PL 116-246: 12/22/20 – 12/28/20
  - 30-day apportionment of FY20 Recurring Base, which runs through 1/27/2021
- On December 27, the President signed the Coronavirus Response and Relief Act, 2021 as part of a broader legislative package.
- The bill includes a total of $1 billion for IHS, Tribal, and Urban Indian health programs.
- The bill includes language stipulating that these funds are provided on a one-time, non-recurring basis, and can only be used for the purposes outlined in the statute.
- These funds are appropriated to the CDC and the Public Health and Social Services Emergency Fund. The bill directs HHS to transfer the funds to the IHS for distribution.
- The $1 billion in new COVID-19 resources includes two separate appropriations:
- $210 million for vaccine-related costs, available through FY 2024, and
- $790 million for testing and related costs, available through FY 2022.
- The bill provides the IHS a total of $210 million for the following activities:
- To plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage, and

- ❖ To restore, either directly, or through reimbursement, obligations incurred for coronavirus vaccine promotion, preparedness, tracking, and distribution prior to the enactment of this Act.
- ❖ The bill provides the IHS a total of $790 million for the following activities:
- ❖ Testing, contact tracing, surveillance, containment, and mitigation to monitor & suppress COVID-19,
- ❖ Support for workforce, epidemiology, and personal protective equipment needed for administering tests,
- ❖ Use by employers, elementary and secondary schools, child care facilities, institutions of higher education, long-term care facilities, or other settings,
- ❖ Scaling up testing by public health, academic, commercial, and hospital laboratories,
- ❖ Community based testing sites, mobile testing units, health care facilities, and other entities engaged in COVID-19 testing, and
- ❖ Other activities related to COVID-19 testing, contact tracing, surveillance, containment, and mitigation.
- ❖ The bill also requires that recipients of these funds update their COVID-19 testing plans required by the Paycheck Protection Program and Health Care Enhancement Act.
- ❖ It further requires the Secretary to make these plans publicly available.
- ❖ It also requires the IHS to provide a spend plan on the uses of funds to Congress within 60 days of enactment, and report to Congress on uses of funding, commitments, and obligations, quarterly thereafter.

FY19 Catastrophic Health Emergency Fund (CHEF)
Status as of January 11, 2021

- 92 Total Cases
- 41 Total Amendments
- $4,651,630.00 Reimbursed
- $0 Pending Reimbursements
- 100% Total Reimbursed
- **FY19 CHEF Balance: $0**

FY20 Catastrophic Health Emergency Fund (CHEF)
Status as of January 11, 2021

- 54 Total Cases
- 33 Total Amendments
- $1,839,066.00 Reimbursed
- $164,407.33 Pending Reimbursements
- 91% Total Reimbursed
- **FY20 CHEF Balance: $28,195,367**

FY21 Catastrophic Health Emergency Fund (CHEF)
Status as of January 11, 2021

- 1 Total Cases

- 0 Total Amendments
- $0 Reimbursed
- $13,883.16 Pending Reimbursements
- 0% Total Reimbursed
- **FY21 CHEF Balance: $53,000,000**

Division of Health Facilities Engineering

Combined Supportable Space Data Request

- Requesting Space and Deficiency Data Updates
- Packets Sent by Email to Tribal Health Director and Tribal Chair week of January 11th
  - Notify lee.wermy@ihs.gov if you did not receive.
- Response Required to be Eligible for Project M&I (BEMAR) Funding
- Due February 15th

Division of Sanitation Facilities Construction

- In FY20, the Portland Area DSFC initiated a total of 49 new projects and amended 8 previous projects using $18.5M from all funding sources.
- This included $10.6M from IHS and $7.9M in contributions from Tribes, EPA, USDA, and HUD.
- CARES Act funding: Portland Area DSFC received $421,017 in CARES Act funding for special projects to provide Personal Protective Equipment to Tribal operators and to help operate and maintain water and wastewater systems and support public health.
- 8 CARES Act projects were funded, benefitting 10 Tribes.
- In November, the Portland Area DSFC submitted its annual list of identified project needs to SFC Headquarters: 43 reportable projects valued at 59.6M.
- This list will be used to award projects in FY21.
- This represents a significant increase over the FY20 submission, which included 30 projects valued at $26.5M.
- This is the result of our continued partnerships with Tribes to identify needs, as well as changes in the guidance last year that allowed us to report needs that do not yet have a fully scoped project solution.
- We are currently beginning to schedule meetings with Tribes to identify needs for FY22 funding.

Division of Sanitation Facilities Construction

- DSFC Director: CAPT Alex Dailey, 503-414-7780, alexander.dailey@ihs.gov
- Western Oregon District Office: LT Derek Hancey, 503-414-7784, derek.hancey@ihs.gov
- Yakama Field Office: Samantha Handrock, 509-865-1775, samantha.handrock@ihs.gov
- Olympic District Office: CDR Roger Hargrove, 360-792-1235 x113, roger.hargrove@ihs.gov
- Port Angeles Field Office: CDR Craig Haugland, 360-452-1196, craig.haugland@ihs.gov
- Spokane District Office: CDR Steve Sauer, 509-455-3486, steve.sauer@ihs.gov
- Fort Hall Field Office: LT Kevin Remley, 208-238-5473, kevin.remley@ihs.gov

Cassie Sellards-Reck, Cowlitz Tribe - you mentioned special projects and funding, what special projects and funding did IHS do?

Dean Seyler, IHS – there was one if SFC for example continued to work with some tribes who had some water issues that required immediate types of contracts to address the issues for the community that was the primary focus.

Kay Culbertson, Cowlitz Tribe – regarding vaccines and receiving them from Chemewa? We're getting people who are living in Portland and are stating they are not able to receive vaccines through Chemewa. Can you tell us, I'm trying to plan for the impact on that?

Dean Seyler, IHS – General update, I hope Ashley Tuomi is on the call. If you remember we had asked Tribes and our Service Units to identify their user pop. For different age brackets, their health care providers and those numbers are the ones that are used to order the vaccines. So, it is our understanding that Tribes would include Tribal memberships whether they did include those that live off the reservation or not, I don't know. What happen at Chemewa there is an identified amount of user pop. which doesn't include the students because the boarding school is not in operation. Those are the primary focus to get the vaccine to, by all means if we have some extra and that starts rolling out we'll reevaluate and take a look at how we can vaccine more people at that location.

Kay Culbertson, Cowlitz Tribe – okay these are not Cowlitz tribal members we did account for Cowlitz tribal members. What we did not count on is that we would have other people coming up from Oregon Tribes trying to get the vaccine.

Dean Seyler, IHS – I do release that there is a large Urban population in Salem, Portland, and Eugene area and those we have tried to account for they may have visited Chemewa at one time or NARA or may have been another location and they would be accounted for.

Question: Can you give us a more detailed vaccine update?

Dr. Ashley Tuomi, IHS – for the Portland Area and the Tribes that did go with IHS as of today's shipment we have received 72,000 Moderna prime, those are the first shots, and 2,925 Pfizer prime, and we've also received 3,800 Moderna boost, those are the second shots, and 2,925 Pfizer boosts. How the process works for the Area each week for Operation Warp Speed gives Indian Health Services a specific allocation and that is divided up amongst the Areas. Once it gets to the Areas it is divided among the clinics who have chosen to receive their vaccines from Indian Health Services. From the Area allocations there are a couple things that I look at each week; one is inventory the current inventory of the prime dose of the vaccine as well as the percentage received from what Tribes submitted in their pre-planning worksheets from their 1A – 1C group and trying to keep those as equitable as processed throughout the Area. I did send out an email last week to all the Clinic Directors and the vaccine point of contacts that we do have an

opportunity to update our numbers for that pre-planning worksheet. Those are due to me by this Friday. It is quite a lengthy process in order to get those numbers all the way up to Operation Warp Speed so they do need to be done all at once and not changed every week. It is a great opportunity for sites to increase their numbers if they did not initially estimate a high enough number. There is no guarantee that this will impact the number of vaccines IHS will receive it just depends on how the numbers end up. But, it could change the amount the Area is given and once it reaches the Area it could change the amount that's given to each site. So, it is very important that sites take the time look at what they submitted in their pre-planning worksheets and see if there are any data that needs to be updated in terms of their numbers. We are still interested waiting and asking for additional vaccines again IHS is not the one who selects how much we get they are sharing that with CDC and Operation Warp Speed as well of our increased need. I do know from the inventory report that I do get from all of our Tribes that you guys are all rock stars and you are getting these vaccines into the arms of people often within a day or two of receiving the allocation. So, we are trying to figure out how we can get more vaccines I know there are some conversations at the task force level about how we could potentially partner with States, if States have additional vaccines that they can give and trying to figure out what that process would look like to be able to have that collaboration and I'm looking forward to more information in the next couple weeks about that. Also, just closely watching any changes that come with the new Administration we don't have any expectations yet on whether or not the allocation models will change with that but we are closely monitoring that and we'll let all the Area's point of contact know. That's all that I have for my update.

Nate Tyler, Makah Tribe – my question is specific to Operation Warp Speed from what I'm seeing and Governor Inslee here in Washington State came out and said there is no inventory for that second shot, Moderna. What the truth on current inventory Makah Tribe has the Moderna and it's a two-shot process is there inventory for that second shot?

Dr. Ashley Tuomi, IHS – I can clarify that situation a little bit. There was initially we though a stock pile holding back for that second shot. The Administration already decided to start releasing that instead of holding back because the manufactures have said they can produce enough to cover the first and second does. At this time there is no indication there will be a shortage in that second does it's just not being stockpiled in a warehouse currently

Nate Tyler, Makah Tribe – what dose that do with timelines stock piled in a warehouse as far as getting it out to the Tribes that opted in.

Dr. Ashley Tuomi, IHS – there will be no delay in receiving your second does shipments

Greg Abrahamson, Spokane Tribe – Recruiting for some of these jobs that are open for our clinic?

Dean Seyler, IHS – our HR staff have been filling positions at all the Service Units specifically for your location. Those have been advertised and some interviews and some offers made and

what I understand is people have backed off in going to locations. We'll continue to advertise, interview, and make offers. We just need those to show up at their locations.

Andy Joseph, Jr., Colville – I've been looking a post and a lot of our members indifferent Areas. In Colville we're still in Phase II or III because of the lack of Service Providers are service population numbers have never been really accurate because they can only see so many patients per day with the five Providers that we have. Someone needs to track those larger tribes to make sure we get enough for our population.

Dean Seyler, IHS – that is something we do work with our Service units with at our Governing Board meetings such as staffing needs, third party revenue since we're not getting increases for staffing. As far as the vaccine specifically for Colville there was a shipping delay from the company cause Colville and a couple other locations have theirs delayed. We have a couple other Service Units this week and next week who have started giving the second shot of the Moderna. Hopefully more of that will come our way.

Andy Joseph, Jr. Colville – with that I think IHS should send us a double shipment were a week behind to catch us up. As Tribal leaders were getting static from our members that are seeing other Tribal people receive their shots and moving past that first phase. We take the blame for a lot of things as a Tribal leader we can tell them were behind but how do we catch up with the rest of the world.

Lisa Guzman, Yellowhawk - in general were talking about supply and demand and what Andy said I guess would like to know if the Portland Area are being aggressive enough to make our plea to the CDC that we are ready. That we have capacity. That our clinics are having to do daily operational moving around we are finding times to give these vaccinations. I guess this question is for Ashley as well originally, we were requested to turn in our pre-distribution plan basically we were given the number of vaccinations that we needed and we gave that estimations, at that time we were told that we were going to get about 25% of what we were requesting. At this point where were at maybe about a third of what we requested, but we are ready and I know others are ready. I agree with Andy we get questioned on if we are moving quick enough? We all developed our own vaccination plan, rolled out our vaccination plan to our communities, using the CDC guidelines. But this is really about supply and demand of our specific reservation areas are we moving to slow? Ashley, I appreciate that you ask us daily about our reporting numbers at this point we are ready to start another cohort all our vaccinations in our freezers are earmarked and ready to go for our prime and booster we are ready for another shipment now to start calling another group to keep our vaccination clinics going. Because if we have a delay in our vaccination clinics then it messes up our daily operations because we are having to balance seeing our patients on a regular bases then providing vaccination clinics. So, if we have a gap then we have to rotate our staff all over again, we are constantly rotating our staff and it really impacts the clinics operations. How can we be a little bit more aggressive keep the vaccinations coming the data there we now we are utilizing them up like Andy said they want vaccinations so they can catch up. I know it has to do with the Pfizer and the Moderna but were a Pfizer Tribe.

We even had discussion about if the Pfizer's are behind do we need to take a look at the Moderna and separate our vaccinations. I'm just asking with all the Tribes are we being aggressive enough in asking for the vaccinations?

Nick Lewis, NPAIHB Chairman – that's what I wanted to ask about and I'm glad others are speaking up on that. I did talk to Laura and our Executive Committee about some of that frustration our Tribes feeling with what appears to be a slow roll out of the supply. I know we are working on getting a letter out to the powers that be in DC and will be sent out to all the Tribes. I would encourage Tribes to use their sovereignty voice as well to help push. Fast forward today, it causes a lot of anger in our communities when we have to scale back with the limited supply we have on hand. The numbers of 72,000 and just under 3,000 that's not very much overall for the whole Portland Area. Then those Tribes who get large amounts through the State creates frustration we are seeing in our communities, where people are really questioning things, really doubting the work that's taking place because neighboring Tribes are getting a lot more. I know it's a very complex matter I think this is ultimately a failure of the Administration but what they have done is really divided communities. I know most of understand the work it takes and all of us understand it's not easy. From IHS standpoint when we are getting a few doses here and there and we do see Tribes getting thousands and thousands of doses it brings to question should we switch to the State and I'm aware some Tribes maybe having those discussions. I have my own council question things and working with IHS because we have a slow roll out. I understand the supply and things are bare back in DC so to speak. Secretary Azar did say that he believes manufacturing the vaccine can keep up with the demand but I think there is a lot of distrust with the way things have happened and the inconsistencies that we're seeing. Going through IHS or the State it's really frustrating when we're not getting the vaccine we're building up that frustration in our communities it does make it harder to do some of things to fight COVID and protect our people. We do need more help from our IHS Area to get more vaccines to the Area, the States are getting and getting out to the Tribes, again that might be a supply issue. But we need that same advocacy to get as many vaccines thought IHS just as much through the State. So, if there is anything IHS can respond to Tribes that would be greatly appreciated. Also, I encourage Tribes to send their own letters advocating for that as well.

Dean Seyler, IHS – I'll asks Ashely to expand on this. But let me say early last, we I did share with Senior leadership at headquarters on a call that included all the Area Directors of the concerns that you have expressed on the States and how they are pushing our much higher amounts of the doses out to the Tribes who elected the States. Our distribution is based on a formula and what we get IHS wide. After I made that comment Senior leadership asked me to put that in writing and I did about five other Area Director's chimed in and said the same thing was happening with in their Areas. This is not something that is happening within the Portland Area but it's happening Nationwide. There was discussion with the liaison to Operation Warp Speed was going to raise this up to the CDC as a concern with the agency is hearing from the Tribes. I hope to hear more on tomorrow call with Senior leadership what if any action has taken place. Let me ask Ashley if she has any further follow up?

Dr. Ashley Tuomi, IHS – and I did get clarification on the call that the concerns that have been raised should be taken up directly to HHS and not CDC. CDC is aware and they are trying asses but ultimately it is not in their hands either. So, the recommendation is to have your letters go directly to the HHS Secretary they have the most influence. I just want to say I echo your guys frustrations and I thank everyone's for their understanding as we work through this. Just to give a little bit more on data on weekly bases and give some understanding to the situation that we have here in Portland. Today we shipped out, they shipped out 1,500 does of Moderna so those come in 100 doses, we have 19 Tribes in the Portland Area that are working with IHS. With only 1,500 doses there are Tribes that are leaf out on a weekly basis. So, each week trying to figure out how to get these spread out as evenly as possible is difficult so that why I rely on some of that data that each of the Tribes submit. When we get a Pfizer shipment in the Area I'm trying to spread these out we only get the one Pfizer tray and we only get 500 Moderna. So, on those weeks that we elect to get a Pfizer we are only serving six Tribes at that time. So, it really doses severely limit the spread for that week. I am working for instance with Lummi they were one of the Pfizer sites they did get a Moderna this week and looking at supplementing our Pfizer sites with Moderna again to spread out how often the Pfizer shipment happens. But it has defiantly been a struggle we are not even receiving enough vaccine to give every Tribe 100 vaccine for that week. I know the frustration of not knowing and having to wait one week at a time to figure out what your getting is very difficult for planning. Again, I want to say thank you for your guys understanding and help with that. We continue to push this issue every chance we get with our Headquarters staff and I know they are pushing that forward as well.

Nate Tyler, Makah Tribe – the question I was going to ask Ashley pretty much answered it with the slow roll out with IHS. I was going to ask the Makah Tribe went through the State and back to what Inslee was saying the is no Warp Speed, no stockpile, I think we're going to have Makah's due for their second dose within the next week to ten days and if there is no stockpile where dose that put the Makah Tribe? I know I' comparing the State to HIS but can we at the Makah Tribe try to tap into IHS second shot? Is that a no go? I'm just hearing Ashley's report the 19 Tribes sharing 1,500 doses that's kind of troublesome. But, we're in a different predicament on that second dose so I'm just curious on the second shot for sure.

Dr. Ashley Tuomi, IHS - there are no concerns currently with anyone receiving their second dose shipments. The stockpile was discussed to be distributed anyways because the manufactures said they can produce both the prime and the booster that are needed. You should be receiving your second dose shipments just fine. They are not going to stop those allocations to those jurisdictions which include the States or IHS.

Cheryle Kenney, Grand Ronde Tribe – I think all of this is just outrageous. I know that Tribes have been identified being in critical need and that our populations are so vulnerable. The only like it in the United States are the Native Americans and the Tribes because we all live together. Our extended family what we call extend family is right under our roof. As and example we I called in for Roll Call I let the Executive Committee know that my mother is 96 years old and she as a house right behind mine so I go over there every morning to cook for her, we have

grandchildren in our home and nephews and nieces. We're talking about that and this probably applies to most Tribal families we try to take care of one another. I do want to thank Ashley for her outreach Oregon Tribes most of them went with the State not because we really wanted to but because of the situation and the demand and the outlook was in order to participate quickly and make your decision and only choose only one, which all of us had to do. The States rules weren't fully transparent so Tribes then were behind and we're the largest Tribe in Oregon and we have almost 6,000 people and we got 150 doses sound similar to what the rest of you have gotten. We are on call 2-3 times a week and it feels like your beating your head up against a wall. In Oregon they say we get ours directly from manufacture they are shipped to us, I'm not sure if that's true or not. I'm not sure if there are enough vaccine's manufactured to meet the demands. We are really in a hostage situation where we have to believe I guess the powers that be that they are there and they are waiting. I just want to echo all the frustration I've heard here I believe it just outrageous were put in the place of being and there is always a middle man. It's so paternalistic that we have to step back and listen. I wanted to go on record.

Sharon Stanphill, Cow Creek Tribe – my question for Dean is about Indian Health Services Chief Medical Officer has been filled yet? We know that Dr. Lawrence and Dr. Holt are Acting and helping, any information?

Dean Seyler, IHS – I set to interview an applicant on Thursday.

Nick Lewis, NPAIHB Chairman - the machines that were sent out some of the machine HIS had shipped out to collect data one of the frustrations with the machine is that you have to put in a lot of data that's not applicable to us we're not a hospital we are very rural so they are asking about the data taking a lot of time to put that in. This is burdensome to our Public Health team with unnecessary work. Is there anything we can do to address to concerns on that machine? Have you done any training to bypass those?

Dean Seyler, IHS – let me ask Roney Won who's on the call. He's the one who collecting the data for us to send to headquarters.

CAPT Roney Won – Which machines are you talking about the testing machines, I don't know of any reporting machines. If it's the Abbott machine it's just a requirement getting set up. Can you clarify

Dean Seyler, IHS– one last item RAD Weahkee last day is tomorrow at noon he was asked to resign by the Administration.

BREAK

REVIEW OF 2020 POLICY PRIORITIES, CANDICE JIMENEZ, HEALTH POLICY SPECIALIST AND LIZ CORONADO, HEALTH POLICY SPECIALIST

Legislative and Policy Committee

Indian Health Service

- Fully fund the IHS
- Establish a separate and indefinite discretionary appropriation for 105(l) lease funding.
- Provide mandatory funding for IHS
- Amend IHCIA to authorize advance appropriations for IHS.
- For Purchased and Referred Care, move access to care factor from category 3 to category 2 in funding formula.

Health Care Facility Funding

- Request GAO to issue a report on IHS Health Care Facilities Construction Priority System.
- Create equitable health care facilities funding opportunities for all IHS areas.
- Fund Regional Referral Specialty Care Demonstration Project in the Portland Area.
- Increase funding for small ambulatory programs and joint venture projects.

SDPI

- Permanently authorize SDPI at $200 million per year with medical inflation rate increases annually. (NPAIHB Res. No. 19-04-12)
- Create options for tribes to receive SDPI funds through Title I or Title V compacts or contracts.
- Allow areas to reallocate data infrastructure funds to Tribal Epi Centers to assist tribes in managing their SDPI data.

Patient Protection and Affordable Care Act / IHCIA

- Congress must protect ACA and IHCIA.
- Fully fund IHCIA, including long term care, recruitment and retention, and behavioral health.
- Fund Tribal Epi Centers to fulfill their role as a Public Health Authority. (TA, capacity building, evaluation, public health surveillance)

IHS IT Modernization

- For FY 2021, fund $25 million for planning and phased in maintenance of RPMS.
- Conduct tribal consultation in each IHS area on any efforts to modernize or replacement of RPMS.
- Provide ample transition period, training, and TA.
- Consider the many tribal facilities that have purchased commercial off the shelf systems.

Medicaid/CHIP

- Protect 100% FMAP.
- Protect FFS (not subject to managed care or value-based payments).
- Support legislation that:
    - Extends Medicaid eligibility for all AI/AN with household income up to 138% of the federal poverty level.

- Authorizes IHCPs in all states to receive Medicaid reimbursement for health care services delivered to AI/ANs
- Extend full federal funding through 100% FMAP to states for Medicaid services furnished by urban Indian providers
- Removes the limitation on billing by IHCPs for services provided outside the 4 walls of a tribal clinic

Workforce Development

- Establish HRSA TAC in FY 2021.
- Expand Title 38 authorities to ensure that IHS and tribal facilities can be competitive in the current job market.
- Fund IHCIA 112, 132, and 134 for additional resources to address recruitment and training programs.
- Increase funding in FY 2021 for IHS Indian Health Professionals in the amount of $10 million to fund scholarships and support Loan Repayment Program

Elders Committee

Elders and Long-Term Care

- Congress must fund long term care services, assisting living services, hospice care and home/community-based services (*all authorized under IHCIA for AI/AN people*)
- HHS/CMS/IHS must create an encounter rate (*or enhanced rate*) for tribal nursing homes
- Congress must increase funding to IHS or ACL for elder access to no-cost eyeglasses

Behavioral Health Committee

Behavioral Health (Mental Health & Substance Use)

- Increase support for AI/AN youth inpatient and outpatient mental health and substance use services
- Support funding for the IHS Behavioral Health Programs for Indians
- Strengthen partnerships for integrated care between behavioral health and medical care teams
- Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/Ans with Substance Use Disorder (SUD)
- SAMHSA –
    - Accessible funding, tele-behavioral health, youth-focused, National BH agenda

Community Health Aide & Oral Health Committee

Community Health Aide Program Nationalization & Dental Health Aide Therapists

- Support continued funding for Community Health Aide Program (CHAP) expansion in FY 2022
- Support continued funding for the Community Health Representative (CHR) program
- Implement nationalization of CHAP in the Portland IHS Area (NPAIHB/CRIHB Joint Res No. 17-04-09)
- Support tribes to authorize/license/certify CHAP providers

- Creation of permanent series and classification of position descriptions for DHA/Ts and CHA/Ps in federally-operated facilities

Public Health Committee

COVID-19 (Vaccine)

- Hold agencies accountable to conduct ongoing and meaningful tribal consultation on all COVID-19 vaccine policies and plans
    - Ensure access to all 3 options to receive vaccine: federal, state and local
    - Ensure that tribes have resources needed to receive and store vaccine
- Honor tribes' authority to determine service & priority populations
- HHS and IHS must provide funding and infrastructure support to tribes for vaccine reporting.

HCV & HIV Treatment and Funding

- For HCV, ensure that all AI/AN patients with HCV at I/T/U facilities have access to treatment
- Ensure that Indian Country is included in *Ending the HIV Epidemic Funds*
- IHS to support creation of a funding mechanism to receive Minority AIDS Initiative (MAI) funding for distribution via the Office of Infectious Disease and HIV/AIDS Policy
- For State Medicaid Agencies, make HCV treatment a clinical priority and ensure access to medications to all persons with medical need
    - as determined per American Association for the Study of Liver Diseases (AASLD) guidelines (NPAIHB Res No. 18-02-03)
- Ensure Administration's National Plan for HIV Elimination is inclusive of tribes and AI/AN communities

Public Health

- Appropriate funding directly to tribes for tribal public health infrastructure
- Develop Tribal Public Health capacity; equitable access to services & gradual capacity improvement
- Authorize Public Health Emergency Fund established through the Secretary of HHS that tribes can access for tribally-declared public health emergencies
    - analogous to tribal disaster declarations to access FEMA funding
- Fund Tribal EpiCenters to fulfill their role as a Public Health Authority
    - Outlined in IHCIA for activities such as technical assistance, capacity building, evaluation, public health surveillance, etc.
- Provide targeted funding to CDC for tribes to increase asthma treatment programs
    - Education and remediation of environmental triggers associated with poor asthma control and housing-related environmental hazards.
- Ensure equity in funding to address social and economic factors that impact health (SDoH)
    - Support programs like Good Health and Wellness in Indian Country and invest in MCH programs

Veterans Committee

- On Reimbursement agreements:
  - Pass legislation to preserve and strengthen VA reimbursement agreements
  - Ensure reimbursement at the OMB encounter rate & allow VA reimbursement of Purchased and Referred Care (PRC) dollars for specialist care to AI/AN veterans
- Streamline and improve process for establishing reimbursement agreements between the VA and tribal health programs
- Increase outreach & advocacy resources to ensure all AI/AN veterans are eligible for health care benefits available in their community including veterans' care coordination and mental health care needs
- Support and improved interoperability of the EHR for IHS, VA, and DOD
- Pass legislation creating VA Tribal Advisory Committee (NPAIHB Res No 19-04-11)
  - *See* HR 7105 and HR 6237

Youth Committee

- Fund initiatives that provide for AI/AN adolescents & young adults:
  - Fund tribes to invest in safe and secure environments; places to live, learn and play (*Safe schools, wellness centers, clinics, homes, social wraparound/coordinated care programs and services*)
  - Funds IHS Tribal Epi Centers to improve tribal capacity to support adolescent youth
- Prepare AI/AN youth in taking an active role in their own health and wellbeing

2021 Policy Priorities - Development

- Committee instructions
  - Review 2020 Leg & Policy requests and Biden transition priorities
  - Discussion during Committee on any additions/changes to 2021 policy requests
  - Committee leads will compile those changes/additions and return to Liz/Candice

12:35 PM – LUNCH BREAK

12:45 PM – COMMITTEE BREAKOUT ROOMS

2:00 PM BREAK

2:15 PM – LEGISTLATIVE & POLICY UPDATE, VERONICA SMITH, POLICY CONSULTANT

Legislative and Policy Update Agenda

- Dental Therapy Legislative Activities
  - Pam Johnson, NPAIHB Native Dental Therapy Initiative
- FY 2021 Appropriations
- Coronavirus Response and Relief Supplemental Appropriations Act, 2021

- Recent Legislation
- New and Pending Federal Policy Changes
- Litigation
- Upcoming Regional and National Meetings

Oregon Dental Therapy Legislation

- HB 2528 allows Oregon Board of Dentistry to license dental therapists who have completed CODA accredited education program, or an education program approved by a state pilot project and passed an exam. Dental therapists could work in all practice settings under general supervision (off-site) with a signed practice agreement with dentist.
- NPAIHB convenes the Oregon Dental Access Campaign, a broad coalition of dental and health care organizations, educators, community organizations and Tribes. More information and a link to the bill at: odac.nationbuilder.com

Washington Dental Therapy Legislation

- SB 5142 licenses dental therapists statewide, in limited practice settings: FQHCs; hospitals, nursing homes, schools and tribal clinics. Importantly, this allows Urban Indian Programs to hire dental therapists. Private practice settings were removed from this bill in response to lawmaker and opposition concerns. This year's bill also adds additional hours to the preceptorship.
- Tribal dental therapists will still work under the authority of a tribal license, but this bill would offer opportunity for dual licensure. This could allow for patient and community care outside of tribal lands, or care for non IHS-eligible patients.

FY 2021 Appropriations Department of Interior, Indian Health Service

Overall, this is an increase of **$189** million above FY 2020 enacted budget, and $**57m BELOW** the President's budget request. As I'm sure you remember, in 2020 IHS reprogrammed $72 million within the IHS's FY 2019 Services appropriation account to pay for the 105(l) lease cost agreements from multiple budget lines.

FY 2021 Appropriations IHS Clinical Services

Hospitals and Clinics are the only clinical service that took a significant decrease for FY 2021, at $86m. Within these line items there is also $5m for the nationalization of the CHAP program, $2m for DHAT training in ID/OR/WA and AK, $5m for HIV and Hepatitis C, $5m for Alzheimer's, and $5m for the maternal/child health initiative.

FY 2021 Appropriations – IHS Other Services

- $5m increase urbans
- $2m increase for IH professions
- $10m for IHS direct operations

FY 2021 Appropriations – IHS Facilities

Small changes to IHS Facilities budgets with $3m in Sanitation construction

Just under $2m for Facilities/Environmental health and an additional $1m for equipment. This is $149m above the President's budget request and includes a $5m investment in green infrastructure.

Coronavirus Response and Relief Supplemental Appropriations Act, 2021

- Tribal governments have until Dec 31, 2021 to use CARES ACT received
- Unemployment insurance benefits will have addt'l $300/week through Mar 14, 2021
- Provider Relief Fund language changes re expenses and revenue losses

Provider Relief Fund changes

- "Lost revenues attributable to coronavirus" calculated as the difference between the budgeted and actual revenue budget for budgets developed prior to Mar 27, 2020.
- FAQ reverts back to the Jun 2020 guidance.
- "Payment" is defined as a pre-payment, prospective payment or retrospective payment, as determined appropriate by the Secretary

Legislation Impacting American Indian Alaska Native Veterans

- Other provisions of HR 133 Omnibus Appropriations
  - Tribal grant schools now have access to the Federal Employee Health Benefit program
  - Requires states consult with tribes, tribal organizations, urban organizations, and Native Hawaiian health care systems re. youth suicide intervention and prevention strategies
  - H.R. 4029 "Tribal Access to Homeless Assistance Act" makes tribes and tribally designated housing entities eligible for homeless assistance grants

Legislation Impacting American Indian Alaska Native Veterans

- H.R. 6237 Proper and Reimbursed Care for Native Veterans Act
  - Amends Indian Health Care Improvement Act
  - Requires Department of Defense to reimburse for services provided through Purchased/Referred Care

- H.R. 7105 Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020
  - Prohibits the VA from collecting copays from AI/AN Veterans
  - Forms a Tribal Advisory Committee at the Veterans Administration
  - Develops a MOU between the IHS and the VA for homeless veterans' case management services

Legislation Impacting Special Diabetes Program for Indians

- **Special Diabetes Program for Indians**
  - Funded at $150m/year
  - Expires Sep 30, 2023

- **NPAIHB Policy Position**s
  - Permanent reauthorization at $200m/year with medical inflation rate increases (Reso17-03-08, 18-03-06, 19-04-12)
  - Subject to contracting requirements under P.L. 93-638 (Reso 12-03-07)
  - Funding in five-year increments (Reso 12-03-07)
  - Contract support costs
  - Funding allocation for new programs should be made through Tribal consultation (Reso 06-04-08)

Legislation Impacting Urban Indian Organizations

- Health Care Access for Urban Native Veterans
  - Adds UIO's to the list of eligible to receive reimbursement from the Veterans Administration for services provided to AI/AN veterans
- H.R. 6535/S. 3650
  - Extends Federal Tort Claims Act Coverage to UIO's and employees of UIO's

Recent and Upcoming Consultations

- **IHS Consultation Jan 04, 2021 - $790/$210 m Coronavirus Response Funds**
  - $790m distributed as follows
    - $50m – Urban Indian Organizations
    - $190m – Purchase of COVID-19 tests, test kits, testing supplies, therapeutics, and PPE
    - $550m – Program increases to Hospitals/Clinics, PRC, Alcohol and SUDS, MH, CHR, PH Nursing
  - $210m – expect a DTLL in the near future
- **Health IT Modernization, comments due Jan 24, 2021**
  - Four Options: Stabilize RPMS, Renew RPMS, Selective Replacement, Full Replacement
  - Stabilizing RPMS has to happen, IHS recommends full replacement
  - Current Funding: $8m FY 2020, $65m CARES Act, $34.5m FY 2021 appropriations
  - Full cost estimated between $3 – 8 billion over 10 years
  - Parity with the VA system, tribal decision-making in the project, interfacing, COTS

- Section 105(l) leases, FY 2021 appropriations Section 431(a) includes
  - Tribal lease payments to begin no earlier than the date the lease proposal is received
  - Secretaries of the Interior and Health and Human Services directed to hold consultation with tribes and tribal organizations re. the requirements of Section 105(l) leases, consistent and transparent implementation process for the payment of the leases
  - **Consultations will take place in FY 2021**

New and Pending Federal Policy Changes

- **4-Walls Extension moved from Jan 31, 2021 to Oct 31, 2021**
  - IMPACT: More time to make a decision re. Tribal FQHC designation, if necessary (only 9 states have SPA's)
- **HHS Eliminates X-Waiver Requirement for DEA-Registered Physicians for the Administration of Buprenorphine, Jan 14, 2021**
  - IMPACT: Expands access to MAT at tribal clinics
- **Final CMS Interoperability and Prior Authorization Rule, Jan 15, 2021**
  - IMPACT: Requires interoperability/HL7 between insurance companies and providers; 72 hours for urgent prior authorizations (2024)
- **Final SUNSET Rule, Jan 08, 2021**
  - IMPACT: Threatens the stability of specific provision w/in IHS, CMS, CHIP that protect AI/AN people
- **Final Medicare Program Changes to Part B Payment Policies, OUD Coverage, Telehealth, Jan 01, 2021**
  - IMPACT: Finalized expansion of Medicare telehealth services for opioid use disorder and other substance use disorders, added telehealth physical and occupational therapy
- **Proposed Modifications to HIPAA**
  - IMPACT: Allows disclosure of PHI to social service programs, reduces paperwork, gives patients right to inspect PHI in person, improves electronic information sharing, eliminates the requirement to obtain a signature on a Notice of Privacy Practices
- **Final Revisions to Safe Harbors under the Anti-Kickback Statute (AKS), Jan 19, 2021**
  - IMPACT: AKS does not provide safe harbors for I/T/U system, see TTAG priorities

Litigation

340B Contract Pharmacies

- Beginning in Q3 2020, some pharmaceutical manufacturers stopped making discounted drugs available through the 340B program to more than one contract pharmacy
- Sep 28, 2020 NPAIHB Testimony in HRSA Consultation re impact on Northwest tribes without pharmacies, tribes rely on a network of pharmacies if they do not have a pharmacy (Jamestown S'Klallam, TTAG, NIHB letters)
- Dec 11, 2020 American Hospital Association+ sued HHS re 340B
- Dec 30, 2020 HHS Office of General Counsel Advisory Opinion issued, stating that drug manufacturers in the 340B program are required to deliver covered outpatient drugs to contracted pharmacies and to charge no more than the 340B ceiling price for those drugs.
- Jan 13, 2021 Eli Lilly, Sanofi, and AstraZeneca sued HHS over the General Counsel Advisory Opinion

Contract Support Cost (CSC) Claims

- *Sage Memorial,* 2016 court decision finding that IHS owes CSC on health care services funded by third-party revenues.

- In *Swinomish* and *San Carlos Apache* cases, courts ruled in favor of the IHS. *Swinomish* decision currently on appeal in the D.C. Circuit court. Decision expected soon.
- IHS has agreed to pay CSC on most COVID-19 funding

Opioid Litigation

- Over 3,000 plaintiffs, trying to hold opioid manufacturers/distributors accountable for the opioid epidemic
- Judge has identified specific cases to resolve claims and move toward settlement, including the Cherokee Nation's case.
- Some defendants, including Purdue Pharmacy, have filed for bankruptcy
- Movement toward a "global" settlement, Tribal Leadership Committee that HSDW serves on is working toward a "top-line tribal allocation"

Texas vs. United States (Affordable Care Act litigation)

- Case heard by the Supreme Court on Nov 10, 2020
- Appears unlikely that the Court will strike down the entire Affordable Care Act

JUUL Litigation

- 16 Tribes, one tribal school, and one tribal health organization have sued JULL (e-cigarette manufacturer) along with many non-tribal plaintiffs
- Deceptive marketing, targeting tribal youth

Biden Administration Potential Appointments

- Deb Haaland (Pueblo of Laguna) – Secretary of Interior
- Dr. Don Warne, MD (Oglala Lakota) – Surgeon General
- Karina Walters, PhD (Choctaw) – Director, Office of Minority Health
- Mary Smith (Cherokee) – Office of Management/Budget Director or Deputy
- Victor Joseph (Native Village of Tanana)
- Aaron Payment, PhD (Sault Ste. Marie Tribe of Chippewa Indians)
- Terra Branson-Thomas (Muscogee (Creek) Nation)

NPAIHB Policy Resources

- Weekly Legislative and Policy Updates
- Regulations Tracker
- Weekly COVID-19 Call Lists
- 117th Congress Legislation Tracker
- Developing a TAC Call List
- Developing Policy Briefs

PORTLAND AREA TRIBAL ADVISORY COMMITTEE (TAC) REPORTS, SUE STEWARD,

Short updated on Regional and National Committees
Andy Joseph, Jr. nominated for FAAB

January 19-20, 2021

MINUTES

STRATEGIC PLAN REVIEW, NORA FRANK-BUCKNER, FOOD SOVEREIGNTY INITIATIVES AND DIRECTOR & STEPHANIE CRAIG-RUSHING, PROJECT DIRECTOR

Timeline

- **September 2019:** All staff input
- **October:** Share staff-recommended edits to key delegates
- **October:** Brief discussion at October QBM for input from delegates
- **November-December:** incorporated edits/updates and share back to staff and delegates
- **January 2020:** Final plan put on pause at January QBM for involvement of new Executive Director
- …PANDEMIC…
- **January 2021**: Finalize Strategic Plan for Approval

Goals for Update

- Streamline document
- Align with new electronic monthly activity reports (E-MARs)
- Include missing areas not reflected in current strategic plan, including COVID response
- Address major themes from staff and Delegate input collected in 2019
- Reflect vision of the new Executive Director and Executive Committee

Summary: Staff and Delegate Input 2019

Summary of Staff Input

- Improve NPAIHB Activity collection and Reporting (E-MARs)
- Internal & External Communication
- External Project Outreach & Community Engagement
- EpiCenter: Tools, Technologies and Software
- Infrastructure: Workforce Development
- Support Delegates and Leadership

Delegates: What are you Proud of?

- NPAIHB and EpiCenter are a national leader in healthcare
- Proud of how we protect tribal Sovereignty (consultation
- State and federal involvement at Board meetings
- State and National Lobbying and Legislative efforts
- NPAIHB Staff
- Leverage collective knowledge to create change
- Tribes are able to access grants from the Board
- The Board is willing to try new efforts
- The Board partners on health research and promotion
- Data drives money – research and surveillance

What can we work on?

- Make sure new Delegates are supported (for both Adults and Youth Delegates)

- Restructure QBM meeting to condense schedule
- Identify the training needs of Health Directors; offer more trainings and education for Health Directors
- TA workshops via webinar on issues (learning how to lobby, learning how to caucus, practice)
- Increased youth participation across the Board's goals – integrating youth
- Robust Health Director meetings
- Increase: Youth, Veteran focus
- Lobbying – Who do we send to Lobby. They want to see tribal leaders face-to-face
- How do we prepare tribal leaders to lobby and advocate? And get them involved and at the QBM table?
- Give our lobbying packets to other Tribal Leaders.
- Educate them on all aspects of healthcare; its complex
- Passing Resolutions: we never hear how/whether our resolutions are received by NCAI – how can we amplify our voices in those settings? Delegates could attend NCAI.
- Being knowledgeable about our traditional healing practices

5-year Vision

- Expand and support programs addressing: youth, MCH, elders, and veterans
- Tribal support staff need more engagement to support their ideas, training – come to Portland or offer other opportunities for networking
- Develop an Indian Health Leadership Program
- Offer training to Delegates and health Directors. We only get to see the good programs that tribes are doing during site visit… find other ways to highlight and share tribal programs
- Certification board for CHAPS
- CHR & BHA Training
- Acquire larger facilities - clinics
- Demand facilities construction
- State-wide CHSDA?
- Own our own NPAIHB Building
- Bring in heavy hitters – Invite them to a QBM meeting (Group Health) – Make the pitch to support our programs

10-year Vision

- Expand on the CHAP process to grow our staff in a variety of positions; train staff on-site
- IHS Hospital
- Regional Specialty Referral Center
- Scholarship Program for students
- Hard funding for a training center
- Develop a training program for Indian Policy gurus – training the next wave of policy leaders
- Transfer State and DHHS functions to the Board

- Full funding at the federal level
- All Delegate seats filled – representation
- Robust research agenda – Native-led and Native-staffed
- Robust Environmental Health program
- Youth Delegate program thriving
- Adolescent Health programs thriving

2022 – 2025 Discussion: Update Mission Statement Update Vision
Current Draft – Notable Changes

- Up for Consideration:
  - Update the Vision Statement?
  - Broadened the Mission Statement to make it inclusive of all health promotion strategies (beyond just healthcare)
- Added the 5- and 10-year Organizational Goals (a new section, on page 10)
- Will: Add an Executive Summary from NPAIHB's Executive Director and Chairman

Recess for the day at 4:30 PM

January 19-20, 2021

MINUTES

WESDAY JANUARY 20, 2021

Call to Order by Cheryle Kennedy at 8:31AM

Invocation: Nick Lewis, NPAIHB Chairman

IMPORTANCE OF PATIENT SCREENINGS IN A VIRTUAL WORLD, COLBIE CAUGHLAN

Suicide has no single cause; it occurs in response to biological, psychological, interpersonal, environmental, and societal influences that interact with each over time. For that reason, it is imperative to take a multi-level approach that considers the range of risk and protective factors across the individual, relationship, community and societal levels.

Why Screening is Needed

- Increased symptoms of a trauma- and stressor-related disorder (TSRD) related to the pandemic
- Increased substance use because of COVID-19.
- Suicidal ideation was also elevated in the previous 30 days than did adults in the United States in 2018, referring to the previous 12 months (10.7% versus 4.3%).
- Increased anxiety disorder and depressive disorder increased considerably in the United States during April–June of 2020, compared with the same period in 2019.
- Youth Risk Behavior Survey (YRBS) stats indicate disturbing trends in mental illness and suicide-related behaviors
- US high school students have reported significant increases in suicidal ideation and making a suicide plan
- School closures and requirements for social distancing have the potential to generate feelings of isolation and loneliness
- 25.5% of young US adults (ages 18 to 24 years) reported having seriously considered suicide at some point during late May and June 2020.
- Among adults currently being treated for PTSD, 44.8% reported suicidal ideation.

Keys to Selecting a Screener

- Right for defined population
    - Age
    - Diagnose, symptom or disability
- Can be used frequently (not just annually)
- Will identify changes
- Easy, short
- Clinically relevant

Validated Suicide Screeners

- PHQ-9: Patient Health Questionnaire

- PHQ-A: Patient Health Questionnaire- Adolescent
- ASQ: Ask Suicide Screening Questions
- GAD-7: General Anxiety Disorder
- CYW ACE-Q: Adverse Childhood Experiences Questionnaire-Child
- CYW ACE-Q: Adverse Childhood Experiences Questionnaire-Teen

COVID-19 Learning Needs Assessment

- The NPAIHB assessed the needs of thirty-six NW Tribal medical and behavioral health providers in the wake of COVID-19.
- The purpose of the need's assessment was to identify necessary resources, knowledge, and skills to effectively continue activities (suicide, interpersonal violence, substance misuse prevention) during the COVID-19 pandemic.
- The survey was administered from October – November 2020 via survey monkey.

Survey Results

- **Suicide Prevention:**
  - 93% of respondents provide suicide prevention and/or intervention services.
  - 44% reported having highly developed screening specific to suicide.
  - 38% indicated they have a highly developed suicide specific risk assessment when someone presents with suicide.
  - 67% reported developing or enhancing appropriate patient/family education and resources on suicide prevention
  - 42% provide highly developed coordinated care for patients at risk of suicide.
- **Mental Health:**
  - 88% of respondents indicated that they provide mental health services
  - 68% reported having highly developed regular screening specifically for depression and anxiety
  - 58% provide a highly developed risk assessment
  - 74% indicated that they were either developing or enhancing appropriate patient/family education and resources on Mental Health
  - 56% provide highly developed coordinated care for patients at risk for mental health concerns
- **Substance Use/Misuse Prevention, Treatment & Recovery (SUD/OUD):**
  - 73% of respondents provide substance use/misuse medication assisted treatment and recovery prevention and/or intervention services
  - 60% reported having highly developed screening for SUD/OUD, however only 36% reported providing specific screening such as SBIRT.
  - 64% provide a highly developed SUD/OUD assessment when someone is at risk of SUD/OUD

Clients Current Concerns:

1. Mental health care
2. COVID-19 specific resources
3. Health care overall

Potentially negative experiences that clients are reporting:

1. Increase in depression, anxiety, or other mental health concerns
2. Increase in alcohol or drug use
3. Being fired from their job/becoming homeless.

Telehealth Waivers from the Centers for Medicare & Medicaid Services (CMS)
Temporary policy changes during the COVID pandemic:

- Conduct telehealth with patients located in their homes and outside of designated rural areas
- Practice remote care, even across state lines, through telehealth
- Deliver care to both established and new patients through telehealth
- Bill for telehealth services (both video and audio-only) as if they were provided in person

Development of Telehealth Informed Consent Procedures

a) Describe telehealth service delivery and specify technical considerations
b) Explain how service providers operate and the limits of telehealth
c) Delineate client expectations and responsibilities of all parties involved
d) Identify emergency contacts and specify multiple communication options
e) Obtain consent for specific service providers to offer telehealth
f) Telehealth consent procedures should be reviewed by legal counsel to ensure compliance with state and federal regulations

Patient Health Questionnaire (PHQ-9)
PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is a tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.

- Incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self- report
- Rate the frequency of the symptoms which factors into the scoring severity index
- Q.9 screens for the presence and duration of suicide ideation
- Screens and assigns weight to the degree to which depressive problems have affected the patient's level of function

Article: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/
Questionnaire:
https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf

Ask Suicide Screening Questions (ASQ)

- Validated tool for use among both youth and adults
- A set of four screening questions that takes 20 seconds to administer
- Can be administered in multiple settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care)

- Ask Suicide-Screening Questions (ASQ) Toolkit: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml

Generalized Anxiety Disorder-7 (GAD-7)

- Self-administered 7 item instrument that uses some of the DSM-V criteria for GAD (General Anxiety Disorder) to identify probably cases of GAD along with measuring anxiety symptom severity
- Clinicians will still need to use their clinical interviewing skills
- Tool can be used to measure longitudinal changes and track treatment progress
- 2-5 min to complete
- One resource: https://www.mdcalc.com/gad-7-general-anxiety-disorder-7

Suicide Interventions and Therapeutic Frameworks

- Traditional and Cultural Interventions
- Making it Matter with Micro Interventions: Simple Tools To Support Ourselves and Others in Stressful Times (https://training.ursulawhiteside.org/p/micro-interventions/?affcode=346122_682vo98u)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Cognitive Therapy for Suicidal Patients (CT- SP)
- Motivational Interviewing (MI)
- Distress Tolerance Skills
- Problems Solving Treatment in Primary Care (PST-PC)

Cognitive Therapy for Suicidal Patients (CT-SP)
CT-SP is an evidence-based, manualized cognitive-behavioral treatment for adults with suicidal ideation and behaviors that treat problems and boosts happiness by modifying dysfunctional emotions, behaviors, and thoughts.

- Solution orientated
- Encourages patients to challenge distorted cognitions
- Changes destructive patterns of behavior

Motivational Interviewing (MI)
MI is a counseling method that helps people solve ambivalent feeling and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes.

- Used to address addiction and the management of physical health conditions such as diabetes, heart disease and asthma
- Helps people become motivated to change the behaviors that are preventing them from making healthier choices
- Prepares individuals for further, more specific types of therapies

Problems Solving Treatment in Primary Care (PST-PC)

PST-PC is a form of therapy that involves providing patients with tools to identify and solve problems that arise from life stressors, both big and small, to improve overall quality of life and reduce the negative impact of psychological and physical illness.

- Studied in a wide range of settings
- Teaches and empowers patients to solve the here-and-now problems contributing to their depression and helps increase self-efficacy
- Involves six to ten sessions, depending on the patient's needs

NPAIHB WASHINGTON YOUTH SEXUAL HEALTH (WYSH), CELENA MCCRAY, WA DOH PARENTING TEENS PROJECT COORDINATOR

Adolescent Health Updates & Trending Topics

- Ending the HIV Epidemic (EHE) in Indian Country – Project Red Talon
  - Recruit 6-10 partners to improve HIV prevention and care.
  - Develop and disseminate HIV/STI texting and PrEP use campaign
- Teen Pregnancy Prevention (TPP) Innovation and Impact Network
- 2020 Youth Health Tech Survey
  - Native Identity or Cultural pride
  - Mental Health
  - Social Justice and Equality

Adolescent Health Trending Topics

- Native youth are comfortable engaging with conversations around sex, pregnancy, and abortion
  - **More than 1.1K Mentions** around pregnancy, birth control, abortion, rape, sexual assault, and domestic violence from Native youth since March 2020.
- Personal experiences of being a young mom – especially those that were single.
- Native youth advocate for inclusive health resources/education for Trans, Two-Spirit, and Non-Binary youth

Overview of WYSH Project

- Improve access to and experience with sexual health care
- Intervention focused on clinical setting, but network includes stakeholders from all sectors.
- Encourage preventive health screenings for youth
- Improve linkages between prevention programs and health service settings
- Ongoing youth engagement through local and state planning committees.

Recruitment

- 4-6 WA Tribal Health Departments, school-based health programs, local I/T/U clinics, and youth engagement programs who have a bi-directional impact on youth and their access to and experience with sexual healthcare.
- Tribal subcontracts will range from $65,000 - $100,000 per year

- 3-year project
  - July 2020-June 2023

BREAK

EPICENTER UPDATE, VICTORIA WARREN-MEARS, NWTEC DIRECTOR

Overview

- Overview of NWTEC
- Update on Data Sharing with Idaho
- New Data products – WA Public Health Modernization
- Update on Food Security during COVID-19 assessment
- COVID-19 Training and Technical Assistance Report
- COVID-19 Data
- Questions

NWTEC

- Formed in 1996 with first funding 1997 – 25 years of tribally directed activities
  - Tribal leaders had approved the concept and function of a tribal research and epidemiology center prior to this time.
- Guided by the Public Health Committee of the NPAIHB, and report to the NPAIHB Board
- Every action undertaken is a result of tribal resolution from our Board *(tribally driven research and public health agenda)*
- Functions as a departmental designation with oversight of over 55 employees
- NWTEC staff have trained 3 CDC EIS Officers with another who will begin in August and 2 PHAP assignees from CDC.

Update on Idaho Data Sharing

- On January 13, 2021 a data use agreement was signed between the Idaho Department of Health and Welfare and the NWTEC.
- This will allow us to do data linkages quarterly or more often with COVID-19 data.
  - The state will transmit the corrected data to CDC
  - This likely will give Idaho the most accurate AI/AN data in the nation

Public Health Modernization Projects

- NPAIHB is supporting efforts for all three states.
- The NWTEC has funding to:
  - Enhance data for Washington Tribes,
  - Conduct capacity surveys with Oregon Tribes, provide summaries and assist with tribal health improvement plans and implementation (project includes NARA).
  - Conduct assessments to determine ways to improve the state BRFSS to meet the needs of the Oregon Tribes
  - Support work toward Public Health Accreditation for all NW Tribes

NPAIHB WTPHI Project Objectives

- Ensure AI/AN disease surveillance, investigation, and control
  - Produce communicable disease data briefs
  - Train and deploy NPAIHB staff for disease outbreak investigations
- Participate in surveillance and epidemiology committees and task forces with FPHS partners, including DOH, local health jurisdictions, tribal government, and tribal health organizations

WA AI/AN Communicable Disease Data Briefs
To be released January 2021:

- Hepatitis B & C
- HIV/AIDS
- Sexually Transmitted Infections
- Tuberculosis

Summaries of available data to describe disease burden experienced by AI/AN communities in Washington

- Topic Overview
- Data Summaries
- Data Figures
- Resources
- NPAIHB Project Contacts, within the NWTEC staff

WTPHI Data Partners Meeting

February 3, 2021
10:00 AM – 1:00 PM
Topics:

- Intro to NPAIHB WTPHI Project
- WA AI/AN Data Linkage Update
- Communicable Disease Data Review
- Facilitated Discussions
  - Data Access
  - Data Needs

Registration: https://www.surveymonkey.com/r/DataPartnersMtg
For more information, contact Nancy Bennett, NPAIHB:
nbennett@npaihb.org

Food Sovereignty and Food Security Survey

- Received IRB approval
- Finished qualitative interviews with 10 tribal leaders and/or program staff
- Beginning to analyze information to finish adapting the quantitative survey
- Working with AIHC to recruit and receive tribal resolutions
- What's next?

- Launching the quantitative survey by February
- Completing analysis and reporting by end of March
- Still seeking funding for Idaho and Oregon to expand this survey further.

Environmental Public Health Grants
- Two opportunities
- Available to tribes in Idaho, Oregon and Washington
- 7 total awards will be made

Environmental Health Response, Recovery, Mitigation and Other Expense Related to 2018/2019 Declared Disasters
4 Grants Awarded at $50,000 each
- **Project activities will include:**
  - Improve EH data and informatics capacity to strengthen tribal data and data systems for monitoring, diagnosing, investigating, & mitigating EH hazards resulting from disasters.
  - Develop standard templates and forms for data collection of EH hazards in disasters.
  - Incorporate local indigenous knowledge to understand historical, EH-related disaster impacts and design the appropriate tribal Environmental Health interventions.
  - Develop standard templates and forms for tribal lessons-learned reports, community EH hazard assessments, and disaster surveillance to build capacity in preparedness and response to EH hazards in disasters.

RFA
https://files.constantcontact.com/4cd26bd1101/b8a71b85-4e52-4519-9280-0a014866c688.pdf

Improving Domestic Well Water Safety
3 Grants Awarded at $12,000 each
Available to federally recognized Idaho, Oregon, & Washington Tribes
- Project activities will include:
  - Tribal environmental health staff will identify, characterize, and evaluate the environmental health (EH) status of individual private wells and conditions that prevent access to safe drinking water.
  - NPAIHB will provide training as follows: Hydrogeology and groundwater basics, wellhead protection, safe drinking water standards and sampling, and using data to monitor and anticipate EH hazards and threats to groundwater

RFA:
https://files.constantcontact.com/4cd26bd1101/203e8dc1-ce63-48fb-9ab9-d41325562899.pdf
Applications are DUE: **Friday, February 12, 2021**
Anticipated Notice of Award by: Friday, February 26, 2021

New Award Anticipated

- CDC 5-year award around vaccine hesitancy to include COVID-19 and flu vaccine
- NWTEC will be the national coordinating center for all of the Tribal Epidemiology Centers, who choose to participate.

Key Emergency Room Data
- Oregon:
  - Suicide ideation increasing among AI/AN
  - COVID-like Illness (CLI) is decreasing among AI/AN
  - There were two vaccine adverse events in the last week among AI/AN (which vaccine was associated with the adverse event is not specified)
- Washington:
  - Total ED visits are low
  - Slight increase in drug overdose among AI/AN
  - CLI and pneumonia rates remain higher among AI/AN than non-AI/AN

Idaho Dashboard for ED Visits
- DPH Idaho COVID-19 Dashboard - Idaho Division of Public Health | Tableau Public

COVID 19 RESPONSE, CELESTE DAVIS, ENVIRONMENTAL HEALTH DIRECTOR

GOALS OF THE ICS RESPONSE TEAM
- Proactively manage the incident response
- Increased information sharing within NPAIHB and across jurisdictions
- Enhanced decision-making
- Accountability

Work with tribes in culturally respectful way to control the spread of COVID-19 and prevent cases and deaths from COVID-19

RESPONSE ROLES & ACTIVITIES TO DATE
- Public Health Operations
  - Clinical Education and Support: COVID-19 ECHOs
    - 69 COVID-19 Clinics since 3/18/20
    - 8647 Participants!!!
    - Responded to over 1000 Clinical Questions
  - Communicable Disease Prevention: Case Investigation & Contact Tracing
    - Approximately 100 Participants for Case Investigation & Contact Tracing Training
    - 4 Deployments with two Tribes to provide onsite assistance; Remote assistance for one Tribe
    - Developed a Tribal Resource Guide for Case Investigation & Contact Tracing
- Public Health Operations
  - Environmental/Occupation Health & Safety:
    - Over 50 Facility Reviews/Inspections, Risk Assessments

- Dozens of consults and professional advice/technical guidance
  - Reopening safely, Infection Prevention & Control, Occupational Health, Indoor Air Quality
- Communications: Health Promotion & Prevention Messaging & Materials
  - Website, Social Media, PSAs, Print
  - Big Foot Cut Outs; "Safe Sweats" and "Brothers" PSAs
  - Total Engagement and Reach ---- 200,000!!!
- Planning & Information
  - Surge Staffing & Resources
    - Management of Emergency CDC Funds Distribution to Tribes
    - CDC Foundation Staffing: 3 at NPAIHB, 4 at 2 Tribes
    - Resources to Tribes
      - Respiratory Fit Test Kits for Clinics
      - Diabetes Patients' Health Promotion Kits
      - PPE & Medical Supplies: 5800 nitrile gloves, 102 containers of hospital-grade disinfecting wipes, 378 containers of disinfecting wipes, 3550 disposable surgical masks, 1780 N95 respirators, and more
- Planning & Information
  - Data
    - Bi-weekly regional data reports
    - Technical Assistance in Data Analysis for Tribes
  - Medical Counter Measure Planning – VACCINES!
    - Guidance & Assistance on Pre-Planning
    - Coordinating with IHS and States
    - Technical Assistance with Data Management & Reporting

Situational Awareness & Liaison
- Oregon – Candice Jimenez
- Idaho – Jessica Leston
- Washington – Tam Lutz

LEADERSHIP & GUIDANCE
- Engaging with Tribal Health Leadership
  - Zoom Meeting Every Tuesday at 10, Forum for Information Exchange & Sharing
  - Individual Meetings with American Indian Health Commission, Oregon Health Authority, and Idaho Health & Wellness
  - Policy Advocacy
  - Technical Guidance & Support for Tribal Leader's Decision-Making

THE ROAD AHEAD
- Vaccine Rollout….SNAFU, Charlie Foxtrot, messy & uncoordinated

- Implementing the Vaccination Program
  - Be as transparent as possible – keep the community informed
  - Consider expanding vaccine availability to the next group when….
  - Demand in the current phase appears to have been met (e.g., appointments for vaccination are < 80% filled for several days)
  - Supply of vaccine increases substantially (e.g., more vaccine doses are available than are necessary to complete vaccination of persons in the current phase)
  - Most people in the current phase are vaccinated (e.g., when approximately 60-70% of the target population in a phase has been vaccinated)
    - https://www.cdc.gov/vaccines/covid-19/phased-implementation.html
- Anticipated Advancements & The New Federal Administration
  - Next COVID-19 Vaccine: Johnson & Johnson, expected to request FDA review soon – EUA Approval
  - More Contagious Virus Variant May Fuel a Spike in Cases & Deaths
    - https://www.cdc.gov/mmwr/volumes/70/wr/mm7003e2.htm?s_cid=mm7003e2_w
  - Imperative to Continue Promoting & Enforcing Practices & Policies That Prevent & Control COVID-19 Infections
  - Biden Administration Plans, https://joebiden.com/covid-plan/
  - ***A decisive public health response that ensures the wide availability of free testing; the elimination of all cost barriers to preventive care and treatment for COVID-19; the development of a vaccine; and the full deployment and operation of necessary supplies, personnel, and facilities.***
- Anticipate ICS and Emergency Operations to Continue
  - Dependent on situation and Federal, State, and Tribal States of Emergency and status of declarations
  - Hopeful goal of standing down by April 2021
- Integrating Efforts into new COVID-19 Plans
  - Hope to hire an Emergency Coordinator
    - After-Action Reviews
    - Update and Develop Emergency Response Plans
- Focus on Improving Health Disparities
  - Policy Advocacy
  - Research on COVID-19, Health Services & Policy Research

By Law Discussion with Nick Lewis and Laura Platero

Was decided to have a Special Board Meeting on February 4, 2021 at 10 am per request

LUNCH BREAK

January 19-20, 2021

MINUTES

1:00PM **2021 POLICY PRIORITIES LIZ CORONADO, HEALTH POLICY SPECIALIST, AND CANDICE JIMENEZ, HEALTH POLICY SPECIALIST**

Legislative and Policy Committee
Indian Health Service

- Fully fund the IHS. This was requested to be at the top of any document and high priority.
- Establish a separate and indefinite discretionary appropriation for 105(l) lease funding. This request was accomplished, but needs to be mandatory.
- Provide mandatory funding for IHS
- Amend IHCIA to authorize advance appropriations for IHS. Huge Priority.
- For Purchased and Referred Care, move access to care factor from category 3 to category 2 in funding formula. This will increase PRC funding to Portland Area.
- Tribes need to advocate for COVID-19 Response and Relief 2021.

Health Care Facility Funding

- Request GAO to issue a report on IHS Health Care Facilities Construction Priority System.
- Create equitable health care facilities funding opportunities for all IHS areas.
- Fund Regional Referral Specialty Care Demonstration Project in the Portland Area.
- Increase funding for small ambulatory programs and joint venture projects.
- Bill HR 2 reintroduced in Congress with health care facility funding.
- Funding for long term care, assisted living, hospice care under IHCIA. NPAIHB needs to look at the IHCIA to determine if it includes facilities

IHS IT Modernization

- For FY 2021, fund $25 million for planning and phased in maintenance of RPMS.
- Conduct tribal consultation in each IHS area on any efforts to modernize or replacement of RPMS.
- Provide ample transition period, training, and TA.
- Consider the many tribal facilities that have purchased commercial off the shelf systems. Consult with the tribes that have purchased COTS and are using tribal resources for upgrades, technical support and maintenance in order to guarantee interoperability. Reimbursement for the tribes who have purchased COTS and funding for maintenance, TA, replacement.
- 10-year transition period to a new EHR is unacceptable, tribes will have been forced to move away from RPMS to continue operations.
- All hospitals in NW are on EPIC

Workforce Development

- Establish HRSA TAC in FY 2021.
- Expand Title 38 authorities to ensure that IHS and tribal facilities can be competitive in the current job market.

- Fund IHCIA 112, 132, and 134 for additional resources to address recruitment and training programs.
- Fully fund IHS Indian Health Professionals scholarships and support Loan Repayment Program. This is a priority that IHCP scholarships are fully funded to support AI/AN workforce. Need to look at expanding the type of professions that qualify for the scholarships. Recommendation to look at the needs in Indian County for health professionals (IT, administration, etc.).

SDPI

- Permanently authorize SDPI at $200 million per year with medical inflation rate increases annually. (NPAIHB Res. No. 19-04-12)
- Create options for tribes to receive SDPI funds through Title I or Title V compacts or contracts.
- Allow areas to reallocate data infrastructure funds to Tribal Epi Centers to assist tribes in managing their SDPI data.

Patient Protection and Affordable Care Act / IHCIA

- Congress must protect ACA and IHCIA.
- Fully fund IHCIA, including long term care, recruitment and retention, and behavioral health.
- Fund Tribal Epi Centers to fulfill their role as a Public Health Authority. (TA, capacity building, evaluation, public health surveillance)

Medicaid/CHIP

- Protect 100% FMAP.
- Protect FFS (not subject to managed care or value-based payments).
- Support legislation that:
    - Extends Medicaid eligibility for all AI/AN with household income up to 138% of the federal poverty level.
    - Authorizes IHCPs in all states to receive Medicaid reimbursement for health care services delivered to AI/ANs
    - Extend full federal funding through 100% FMAP to states for Medicaid services furnished by urban Indian providers
    - Removes the limitation on billing by IHCPs for services provided outside the 4 walls of a tribal clinic

Elders Committee

Elders and Long-Term Care

- Congress must fund long term care services, assisting living services, hospice care and home/community-based services (*all authorized under IHCIA for AI/AN people*)
- HHS/CMS/IHS must create an encounter rate (*or enhanced rate*) for tribal nursing homes
- Congress must increase funding to IHS or ACL for elder access to no-cost eyeglasses
- No changes at this time.

Behavioral Health Committee
Behavioral Health (Mental Health & Substance Use)

- Strengthen partnerships for integrated care between behavioral health and medical care teams (*top priority)*
- SAMHSA –
    - Accessible funding: prevention, training for mid-level SUD providers, data waiver trainings for SUD providers, training & development of peer counselors
- Support funding for the IHS *Fully* fund a *Behavioral Health Programs for Indians* with option for tribal shares and non-competitive funding for direct service tribes (NPAIHB Res. No. 19-04-09)
- Increase support for AI/AN youth inpatient and outpatient mental health and substance use services
- Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/Ans with Substance Use Disorder (SUD)
- Fully fund IHCIA provisions for increases to Behavioral Health
    - Provide inpatient treatment, training for mental health techs, tele-mental health expansion and demonstration grants and *crisis intervention training*
- For IHS to ensure that all BH initiatives create option for tribes to receive funding through contracts and compacts
- For SAMSHA to *acknowledge and support* the development and implementation of Tribal Best Practices, traditional Indigenous knowledge and cultural practices in prevention and interventions
- Reduce restrictions of federal housing programs for tribal members in recovery; acknowledge houselessness as PH crisis and COVID-19
- Provide telehealth/telemedicine resources to increase accessibility

Community Health Aide & Oral Health Committee
Community Health Aide Program Nationalization & Dental Health Aide Therapists

- Support continued funding for Community Health Aide Program (CHAP) & Community Health Representative (CHR) program expansion in FY 2022
- Support unification of national CHAP program by removing state authorization requirements for the use of DHATs as part of a CHAP program
- Implement nationalization of CHAP in the Portland IHS Area (NPAIHB/CRIHB Joint Res No. 17-04-09)
- Support tribes to authorize/license/certify CHAP providers
- Creation of permanent series and classification of position descriptions CHA/Ps in federally-operated facilities (*for DHA/Ts*)

Public Health Committee
Note: Consideration that this section should include health factors that predispose community members to chronic and communicable disease – how can we uplift the multitude of needs, resources and challenges as voiced by NW tribal communities.

- Public Health –

- Infrastructure development
- Events of international importance incl. COVID-19
- Capacity development
- Emergency preparedness

Overall, a focus on Tribal practices that guide each of these areas

COVID-19 (Vaccine)
COVID-19 Pandemic has laid bare the structural inequities that lead to health disparities, including inadequate public health infrastructure.

- Hold agencies accountable to conduct ongoing and meaningful tribal consultation on all COVID-19 vaccine policies and plans
  - Ensure access to all 3 options to receive vaccine: federal, state and local
  - Ensure that tribes have resources needed to receive and store vaccine
- Honor tribes' authority to determine service & priority populations
- HHS and IHS must provide funding and infrastructure support to tribes for vaccine reporting

HCV & HIV Treatment and Funding

- For HCV, ensure that all AI/AN patients with HCV at I/T/U facilities have access to treatment
- Ensure that Indian Country is included in *Ending the HIV Epidemic Funds*
- IHS to support creation of a funding mechanism to receive Minority AIDS Initiative (MAI) funding for distribution via the Office of Infectious Disease and HIV/AIDS Policy
- For State Medicaid Agencies, make HCV treatment a clinical priority and ensure access to medications to all persons with medical need
  - as determined per American Association for the Study of Liver Diseases (AASLD) guidelines (NPAIHB Res No. 18-02-03)
- Ensure Administration's National Plan for HIV Elimination is inclusive of tribes and AI/AN communities

Public Health

- Appropriate funding directly to tribes for tribal public health infrastructure; tribally-determined
- Develop Tribal Public Health capacity; equitable access to services & gradual capacity improvement; equity reflected in all areas, not just funding – an equity-based framework
- Authorize Public Health Emergency Fund established through the Secretary of HHS that tribes can access for tribally-declared public health emergencies
  - analogous to tribal disaster declarations to access FEMA funding
- Fund Tribal EpiCenters to fulfill their role as a Public Health Authority
  - Outlined in IHCIA for activities such as technical assistance, capacity building, evaluation, public health surveillance, etc.
- Provide targeted funding through CDC for tribes to increase asthma treatment programs

    - Education and remediation of environmental triggers associated with poor asthma control and housing-related environmental hazards; a leading cause of illness and early mortality
- Support Good Health and Wellness in Indian Country (GHWIC) and Tribal Practices for Wellness in Indian Country (TPWIC) expansion
- Ensure equity in funding to address social and economic factors that impact health (SDoH)
    - Invest in Maternal Child Health (MCH) programs that address tribal priorities

Veterans Committee
- On Reimbursement agreements:
    - Pass legislation to preserve and strengthen VA reimbursement agreements
    - Ensure reimbursement at the OMB encounter rate & allow VA reimbursement of Purchased and Referred Care (PRC) dollars for specialist care to AI/AN veterans
- Streamline and improve process for establishing reimbursement agreements between the VA and tribal health programs
- Increase outreach & advocacy resources to ensure all AI/AN veterans are eligible for health care benefits available in their community including veterans' care coordination and mental health care needs
- Support and improved interoperability of the EHR for IHS, VA, and DOD
- Pass legislation creating VA Tribal Advisory Committee (NPAIHB Res No 19-04-11)
    - Passed! *See* HR 7105 (Sec. 7002) and HR 6237 (Amends IHCIA for Proper/Reimbursed care)

Youth Committee
- Fund initiatives that provide for AI/AN adolescents & young adults:
    - Fund tribes/IHS/Tribal Epi Centers to invest in safe and secure environments; places to live, learn and play; improve tribal capacity to support youth
        - *Brainstorm ways to continue supportive funding; sustainability w/o funding source*
- Prepare AI/AN youth in taking active role in their health and wellbeing
    - Engage youth, tribal youth councils – connect tribes to establish rapport and culture sharing across youth councils
    - Uplift youth delegates as future leaders; policy coordinators meet with youth and connect priority areas with adolescent youth action plan
    - Maintain opportunities for youth engagement/skill building alongside education

2021 Policy Priorities – *Moving Forward*
- Policy Team Follow-up
    - Review 2021 Leg & Policy requests and Biden transition priorities
    - Compile in draft form for tribal delegates; 'this is not a 'final draft'
    - Liz/Candice will follow-up for continuous feedback

January 19-20, 2021

MINUTES

Tribal Reports by Burns Paiute Tribe, Twila Teeman (A copy of the report is attached)

Committee Reports

Elders Committee – Clarice Charging, NPAIHB staff (A copy of the report is attached)

Veterans – Debra Jones, Samish Tribe, NPAIHB Staff (A copy of the report is attached)

Public Health – Andrew Shogren, didgwalic Wellness Center (A copy of the report is attached)

Behavioral Health – Danica Brown, NPAIHB Mental Health Program Manager (A copy of the report is attached)

Personnel – Cassie Sellards-Reck, Cowlitz (A copy of the report is attached)

Youth – Cassie Sellards-Reck, Cowlitz (A copy of the report is attached)

Legislative - Report Sue Steward, NPAIHB Deputy Director (A copy of the report is attached)

Resolutions

21-01-06 Ratification: ***Community Catalyst Funding Opportunity to Support Native Dental Therapy Initiative***

- Motion by Andy Joseph, Jr., Colville
- Motion 2nd by Libby Wantabe, Snoqualmie
- **Motion Carried**

21-01-07 Ratification: ***Lead Testing in School and Child Care Program Drinking Water Tribal Grant***

- Motion by Cassie Sellards-Reck, Cowlitz
- Motion 2nd by Cheryl Rasar, Swinomish
- **Motion Carried**

21-02-01 ***Support for Legislation to Amend Lease Compensation Provisions of the Indian Self-Determination and Education Assistance Act***

- Motion by Andy Joseph, Jr., Colville
- Motion 2nd by Cheryl Rasar Swinomish

- Motion Carried

21-02-02 ***Environmental Protection Agency Region 10 General Assistance Program (GAP)***
- Motion by Cheryl Rasar, Swinomish
- Motion 2nd by Andy Joseph, Jr., Colville
- **Motion Carried**

21-02-03 ***T1-21-007 Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMSHA) Tribal Opioid Response (TOR) Grant***
- Motion by Andy Joseph, Jr., Colville
- Motion by Libby Wantabe, Snoqualmie
- **Motion Carried**

21-02-04 ***Behavioral Health Aid Training and Support Project***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Cheryl Rasar, Swinomish
- **Motion Carried**

Adjourn at 3:35 PM
- Motion by Andy Joseph, Jr., Colville
- Motion 2nd by Cheryl Rasar, Swinomish
- **Meeting Adjourned**

_____ _____

Prepared by Lisa Griggs,
Executive Administrative Assistant **Date**

_____ _____

Reviewed by Laura Platero, JD
NPAIHB Executive Director **Date**

_____ _____

Approved by Greg Abrahamson
NPAIHB Secretary **Date**

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

QUARTERLY BOARD MEETING
ZOOM MEETING

January 19-20, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/97179532031?pwd=bnNrbUxPT1JWQUluTjU2V09NNExudz09
Meeting ID: **971 7953 2031** Passcode: **919138**
One tap mobile +16699006833,,97179532031# US (San Jose)

TUESDAY JANUARY 19, 2021

8:30 AM	Call to Order Invocation Welcome Roll Call	Nick Lewis, NPAIHB Chair Greg Abrahamson, NPAIHB Secretary
	1. Approve Agenda	
	2. Future Board Meeting Dates/Sites • April 20 – 22, 2021, TBD • July 20 – 22, 2021, TBD • October 19 – 21, TBD	
8:45 AM	3. Review and Approve October QBM Minutes	
	4. Election of Officers • Vice Chair • Treasurer • Sergeant-at-Arms	
9:30 AM	Chairman's Report **(1)** & Delegate of the Year	Nick Lewis, NPAIHB Chair
9:45 AM	5 MIN BREAK	
9:50 AM	Executive Director Report **(2)**	Laura Platero, NPAIHB Executive Director
10:05 AM	Financial Report & FY 2021 NPAIHB Budget **(3)**	Eugene Mostofi, Funding Accounting Manager
10:35 AM	IHS Area Director Report **(4)**	Dean Seyler, Portland Area IHS Director

January 19-20, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/97179532031?pwd=bnNrbUxPT1JWQUluTjU2V09NNExudz09
Meeting ID: **971 7953 2031** Passcode: **919138**
One tap mobile +16699006833,,97179532031# US (San Jose)

11:05 AM	5 MIN BREAK	
11:10 AM	Review of 2020 Policy Priorities **(5)**	Candice Jimenez, Health Policy Specialist and Liz Coronado, Health Policy Specialist
12:00 PM	Considerations for Setting 2021 Legislative Priorities	Cindy Darcy, D.C. policy strategist
12:15 PM	**LUNCH BREAK**	
12:45 PM	**Committee Meetings** 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Youth 7. Resolutions/Legislation	**Virtual Rooms:** Staff: Clarice Charging Staff: Don Head Staff: Victoria Warren-Mears Staff: Danica Brown Staff: Andra Wagner Staff: Paige Smith Staff: Sue Steward
2:00 PM	15 MIN BREAK	
2:15 PM	Legislative & Policy Update **(6)**	Veronica Smith, Policy Consultant
3:00 PM	Portland Area Tribal Advisory Committee (TAC) Reports	Sue Steward, Deputy Director w/TAC representatives and policy staff -will include Steve Kutz
3:45 PM	Strategic Plan Review **(7)**	Nora Frank-Buckner, Food Sovereignty Initiatives Director & Stephanie Craig-Rushing, Project Director
4:30 PM	Recess for Day	

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

QUARTERLY BOARD MEETING
ZOOM MEETING

January 19-20, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/97179532031?pwd=bnNrbUxPT1JWQUluTjU2V09NNExudz09
Meeting ID: **971 7953 2031** Passcode: **919138**
One tap mobile +16699006833,,97179532031# US (San Jose)

WEDNESDAY JANUARY 20, 2021

8:30 AM	Call to Order Invocation	Vice Chair
8:45 AM	Importance of Patient Screenings in a Virtual World **(8)**	Colbie Caughlan, THRIVE
9:15 AM	NPAIHB Washington Youth Sexual Health (WYSH) **(9)**	Celena McCray, WA DOH Parenting Teens Project Coordinator
9:45 AM	5 MIN BREAK	
9:50 AM	Epi Center Update **(10)**	Victoria Warren-Mears, NWTEC Director
10:20 AM	COVID-19 Response **(11)**	Celeste Davis, Environmental Health Director
10:50 AM	10 MIN BREAK	
11:00 AM	Bylaws Discussion	Nick Lewis, Chair
12:10 PM	**LUNCH BREAK**	
1:00 PM	2021 Policy Priorities	Liz Coronado, Health Policy Specialist, and Candice Jimenez, Health Policy Specialist
1:45 PM	Tribal Reports • Yakama Nation • Burns-Paiute • Chehalis	**Tribal Reports in April** • Coeur d'Alene • Colville • Coos, Lower Umpqua and Siuslaw

January 19-20, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/97179532031?pwd=bnNrbUxPT1JWQUluTjU2V09NNExudz09
Meeting ID: **971 7953 2031** Passcode: **919138**
One tap mobile +16699006833,,97179532031# US (San Jose)

2:15 PM	Board Committee Reports	Committee Leads
3:00 PM	Resolutions	Nick Lewis, Chairman
3:30 PM	Adjourn	
OPTIONAL	Tribal Caucus: IHS IT Modernization Comment Letter (due 1/24)	Veronica Smith, Policy Consultant and Liz Coronado, Health Policy Specialist

NPAIHB Activity Report

December 2020

Executive Summary: Project Activity Report

Cumulative Trainings Provided in December

- 200 trainings this month
- Number of training attendees: 2,714

Cumulative Technical Assistance Provided: The NPAIHB responded to 84 TA requests:

- NW Tribes: 154
- Other Tribes: 44
- Other Organizations, Agencies, and Programs 27

NW Tribal Site Visits: The NPAIHB conducted 0 site visit this period.

Trainings, Meetings, Presentations and Webinars

During this period, the project provided the following trainings, meetings, workgroups, and webinars:

Topic	Date	Type	Attendees
Crisis Textline	12/01/2020	Call	0
QI meeting with Cardea	12/01/2020	Meeting (External)	0
Weekly participation in the NPAIHB COVID-19 call with state partners, IHS, and Tribal members	12/01/2020	Webinar or Zoom	0
SPTHB DT Workgroup	12/01/2020	Call	0
Healing of the Canoe Check-in with Cowlitz	12/01/2020	Call	0
I.H.S. Community Health ECHO	12/01/2020	ECHO or Clinical Consultation, Training (Others)	60
Interview Development Meeting	12/01/2020	Webinar or Zoom	3
Native PE Project Meeting	12/01/2020	Webinar or Zoom	8
The Upswing Fund	12/01/2020	Webinar or Zoom	16
NPAIHB COVID-19 Update	12/01/2020	Webinar or Zoom	80
Clinical Programs Weekly Meeting	12/01/2020	Coalition, Alliance or Workgroup	11
Strategies of Support for Mental Health Providers - Empowering one another	12/01/2020	Webinar or Zoom	75

during times of crisis			
NPAIHB MAT Discussion	12/01/2020	Webinar or Zoom	3
Diabetes Management System training	12/01/2020	Training (Others)	30
Basic Tobacco Intervention Skills for Native Communities	12/01/2020	Training	0
Basic Tobacco Intervention Skills for Native Communities	12/01/2020	Training (Professional Development)	0
2020 Virtual Open Forum for Quality Improvement and Innovation in Public Health	12/01/2020	Training (Professional Development)	0
Community of Practice for Public Health Improvement and Innovation Open Forum	12/02/2020	Webinar or Zoom	0
COVID-19 ECHO Clinic	12/02/2020	ECHO or Clinical Consultation	101
Monthly call with Klamath and THRIVE	12/02/2020	Call	0
Heritage College Curriculum Development	12/02/2020	Webinar or Zoom	0
mHealth Impact Lab - BRAVE Study Check-in	12/02/2020	Webinar or Zoom	4
Healthy Native Youth Community of Practice	12/02/2020	Webinar or Zoom	65
HCV UNM ECHO	12/02/2020	Webinar or Zoom	12
Wellness Committee Meeting	12/02/2020	Webinar or Zoom	5
COVID-19 ECHO Clinic	12/02/2020	Webinar or Zoom	75

CSTE AI/AN COVID-19 Manuscript Workgroup Meeting	12/02/2020	Coalition, Alliance or Workgroup	20
TPP20 Performance Measures Database Training	12/02/2020	Webinar or Zoom, Training (Others)	60
The Oregon Pilot Project weekly internal call	12/02/2020	Call	0
The Oregon Pilot Project Weekly DHAT Coordinator Call	12/02/2020	Call	0
The Oregon Pilot Project Bi-weekly Check in with OHA	12/02/2020	Meeting (External)	0
NIH Technical Advisory Meeting	12/02/2020	Meeting (External)	0
AIHC Annual Meeting	12/02/2020	Meeting (External)	0
Oregon Nine Tribes	12/03/2020	Webinar or Zoom	0
Weekly attendance at the AIHC vaccine readiness call, tribal participation varies from week to week.	12/03/2020	Webinar or Zoom	0
Healing of the Canoe Check-in with CDA	12/03/2020	Call	0
Monthly call with PTHA and THRIVE	12/03/2020	Call	0
BRAVE Dissemination Call	12/03/2020	Call	0
SUD ECHO Clinic	12/03/2020	ECHO or Clinical Consultation	35
I.H.S. Behavioral Health Integration	12/03/2020	Webinar or Zoom	0
NWIC - Yellowhawk - didgwalic Education Program Monthly Meeting	12/03/2020	Webinar or Zoom	0
Youth and Prevention Strategies	12/03/2020	Webinar or Zoom	50

Health Needs Assessment Meeting	12/03/2020	Webinar or Zoom	3
Lived Experience Initiative	12/03/2020	Call	0
Food Sovereignty Team Meeting - WA FOOD survey	12/03/2020	Meeting (External)	0
NARCH 10 Workshop-NIH 101: Special Focus on American Indian and Alaska Native Health Research	12/03/2020	Training (Others)	11
OSATF meeting for collaboration.	12/03/2020	Call, Partnership, Webinar or Zoom	2
Lived Experience Initiative	12/03/2020	Call	0
GHWIC Community of Practice	12/03/2020	Meeting (External)	0
TPP20 Equitable Virtual Engagement Strategies - Workshop 4	12/03/2020	Webinar or Zoom	30
Oregon Pilot Project Evaluation Modification Discussion with Mekinak Consulting	12/03/2020	Call	0
Tribal COVID-19 Vaccine Readiness Planning	12/03/2020	Meeting (External)	0
NIH Technical Advisory Meeting	12/03/2020	Meeting (External)	0
49 Days of Ceremony Curriculum Development	12/04/2020	Webinar or Zoom	6
BHA Advisory Workgroup	12/04/2020	Webinar or Zoom	10
Coquille Tribal Health	12/04/2020	Call	0
DOH/NPAIHB Innovation Network Team Meeting	12/04/2020	Meeting (External)	0

Perinatal HIV Prevention Task Force FIMR/HIV subcommittee Interview review	12/04/2020	Meeting (External)	0
DOH/NPAIHB Innovation Network Team Meeting	12/06/2020	Meeting (External)	0
WPATH 2020 International Film Festival	12/07/2020	Webinar or Zoom	100
HIV/HCV Program weekly meeting	12/07/2020	Webinar or Zoom	0
COVID-19 ECHO Clinic	12/07/2020	ECHO or Clinical Consultation	117
Virtual Native Talking Circle	12/07/2020	Webinar or Zoom	75
COVID-19 ECHO Clinic	12/07/2020	Webinar or Zoom	75
BH Integration NPAIHB & AIMS	12/07/2020	Webinar or Zoom	3
December Webinar Prep	12/07/2020	Webinar or Zoom	5
OR PH Modernization Meeting with OHA	12/07/2020	Meeting (External), Webinar or Zoom	0
All Staff meeting	12/07/2020	Other	0
Portland Metro Native Student Union presentation on WeRnative/Youth Delegates.	12/07/2020	Presentation	15
OHSU Neurology Aging on Alzheimer's	12/07/2020	Call	0
DPP#100 Chart Review Results	12/07/2020	Call, Meeting (External)	0
Case Investigation Contact Tracing Team Meeting	12/07/2020	Webinar or Zoom	7
HCV AK ECHO	12/08/2020	ECHO or Clinical	18

		Consultation	
CHAP ECHO Learning Collaborative	12/08/2020	ECHO or Clinical Consultation	8
MarketCast Check-in: Phase 2	12/08/2020	Call	0
AK HCV ECHO Clinic	12/08/2020	ECHO or Clinical Consultation	21
Indian County ECHO CHAP Learning Collaborative	12/08/2020	ECHO or Clinical Consultation, Webinar or Zoom	20
BHA Education Program Course Registration	12/08/2020	Partnership	0
NPAIHB COVID-19 Update	12/08/2020	Webinar or Zoom	0
Clinical Programs Weekly Meeting	12/08/2020	Webinar or Zoom	11
CTCCCP Coalition: Lung Subcommittee	12/08/2020	Coalition, Alliance or Workgroup, Meeting (External)	8
NACCHO data work group planning meeting	12/08/2020	Call	0
HCV Medicaid Affinity Group	12/09/2020	Meeting (External)	0
COVID-19 ECHO Clinic	12/09/2020	ECHO or Clinical Consultation	96
Mental Health PPE	12/09/2020	Call	0
Community of Practice: How to Support Youth During COVID-19	12/09/2020	Training (Others), Training, Webinar or Zoom	150
49 Days of Ceremony Staff meeting	12/09/2020	Webinar or Zoom	0

49 Days of Ceremony Elder consultation	12/09/2020	Webinar or Zoom	0
Heritage College Curriculum Development	12/09/2020	Webinar or Zoom	0
HIV UNM ECHO	12/09/2020	Webinar or Zoom	7
Intimate Partner Violence Among Men in AI/AN Communities	12/09/2020	Webinar or Zoom	75
COVID-19 ECHO Clinic	12/09/2020	Webinar or Zoom	75
Bi-Weekly Meeting with Conf. Tribes of Grand Ronde	12/09/2020	Meeting (External), Webinar or Zoom	0
Diabetes/Cancer weekly staff meetings - Wed. at 2pm	12/09/2020	Other	0
Met with UNM to discuss Diabetes ECHO accreditation	12/09/2020	Meeting (External)	0
Tribal Researchers' Cancer Control Fellowship Training-Environmental Health Studies on the Navajo Nation	12/09/2020	Training (Others)	10
CSTE AI/AN COVID-19 Manuscript Workgroup Meeting	12/09/2020	Coalition, Alliance or Workgroup	10
NSSP Race/Ethnicity Data Quality Workgroup	12/09/2020	Coalition, Alliance or Workgroup	18
Intimate Partner Violence among men in AI/AN	12/09/2020	Training	0
Spending Plan work Session	12/09/2020	Call	0
NDTI Monthly Phone Call with Oregon Pilot Project Sites	12/09/2020	Call	0
Toolkit Meeting with Web Developer	12/09/2020	Webinar or Zoom	4

NW TOR Consortium Monthly Meeting	12/10/2020	Webinar or Zoom	28
Prep meeting with Siletz for CEDARR presentation	12/10/2020	Webinar or Zoom	2
ECHO Economic Evaluation	12/10/2020	Webinar or Zoom	0
CHAP TAG meeting	12/10/2020	Call	0
Native IYG 2.0 Development Workgroup	12/10/2020	Webinar or Zoom	8
Brain Health Action Institute	12/10/2020	Webinar or Zoom	65
Diabetes ECHO session	12/10/2020	ECHO or Clinical Consultation	28
December 2020 Diabetes ECHO	12/10/2020	ECHO or Clinical Consultation	15
Weekly check-in meeting with Shoshone Bannock sub-awardee	12/10/2020	Meeting (External)	0
Shoshone Bannock Weekly check -in	12/10/2020	Call	0
2SLGBTQ+ Youth Health Relationships	12/10/2020	Call	0
CDC Annual Progress Report for Comprehensive Cancer Grantees Guidance	12/10/2020	Call, Meeting (External)	0
Virtual Colorectal Cancer Planning Committee Meeting	12/10/2020	Call, Meeting Partnership	0
Tribal COVID-19 Vaccine Readiness Planning	12/10/2020	Meeting (External)	0
OHA Tribal Monthly Meeting	12/11/2020	Meeting (External), Webinar or Zoom	0
Met with Amanda Risser to discuss SUD	12/11/2020	Meeting (External)	0

case definition			
Tribal Youth Delegate Monthly Call	12/13/2020	Call	0
CHAP Advisory Workgroup	12/14/2020	Webinar or Zoom	0
Consultation: Marimn Health and Healing of the Canoe	12/14/2020	Call	0
Idaho Region 4 Behavioral Health Board - Recovery & Wellness Subcommittee Meeting	12/14/2020	Coalition, Alliance or Workgroup	25
CEDARR HR Conference: Indian Country ECHO HCV and Harm Reduction	12/14/2020	Presentation	11
COVID-19 ECHO Clinic	12/14/2020	ECHO or Clinical Consultation	119
Trans & Gender Affirming Care ECHO - Pediatric Track	12/14/2020	ECHO or Clinical Consultation	26
CEDARR Presents First Annual Harm Reduction Conference	12/14/2020	Webinar or Zoom	75
NPAIHB/CDC - OT1803 Opioid Overdose Prevention in Tribal Communities Project	12/14/2020	Meeting (External)	0
COVID-19 ECHO Clinic	12/14/2020	Webinar or Zoom	75
Wellness Holiday Party Planning Meeting	12/14/2020	Webinar or Zoom	5
Bi-Weekly Check-In with Klamath	12/14/2020	Meeting (External), Webinar or Zoom	0
Healthcare Post-Election: A Conversation With Senator Ron Wyden	12/14/2020	Webinar or Zoom	35

Motor Vehicle Injury Data Project Planning (NPAIHB with NWWIHB)	12/14/2020	Call, Partnership	0
Subaward Meeting on Statement of Work, Project Timeline, Contract	12/14/2020	Meeting (External)	0
Perinatal HIV Prevention Task Force Surveillance workgroup meeting	12/14/2020	Meeting (External), Call	0
Lines for Life and NPAIHB	12/15/2020	Call	0
Planning meeting with Lummi r/t ECHO Economic Evaluation/IRB	12/15/2020	Other, Meeting (External)	0
CEDARR Presents First Annual Harm Reduction Conference	12/15/2020	Webinar or Zoom	75
Monthly All-Grantee Meeting for Public Health Modernization	12/15/2020	Meeting (External), Webinar or Zoom	11
THRIVE December Webinar: Stress, Self-Care and the Holidays	12/15/2020	Webinar or Zoom	38
Follow-up discussion to Zero Suicide Initiative	12/15/2020	Call	0
NPAIHB and ICF Skin Cancer Pilot Project Monthly Call	12/15/2020	Call, Meeting (External)	0
WA DOH Vaccine Advisory Committee Meeting	12/15/2020	Meeting (External)	0
COVID-19 ECHO Clinic	12/16/2020	ECHO or Clinical Consultation	101
Walk in Balance Virtual Conference	12/16/2020	Webinar or Zoom	0
Native iCHAMPS Workgroup	12/16/2020	Webinar or Zoom	8
HCV UNM ECHO	12/16/2020	Webinar or Zoom	10

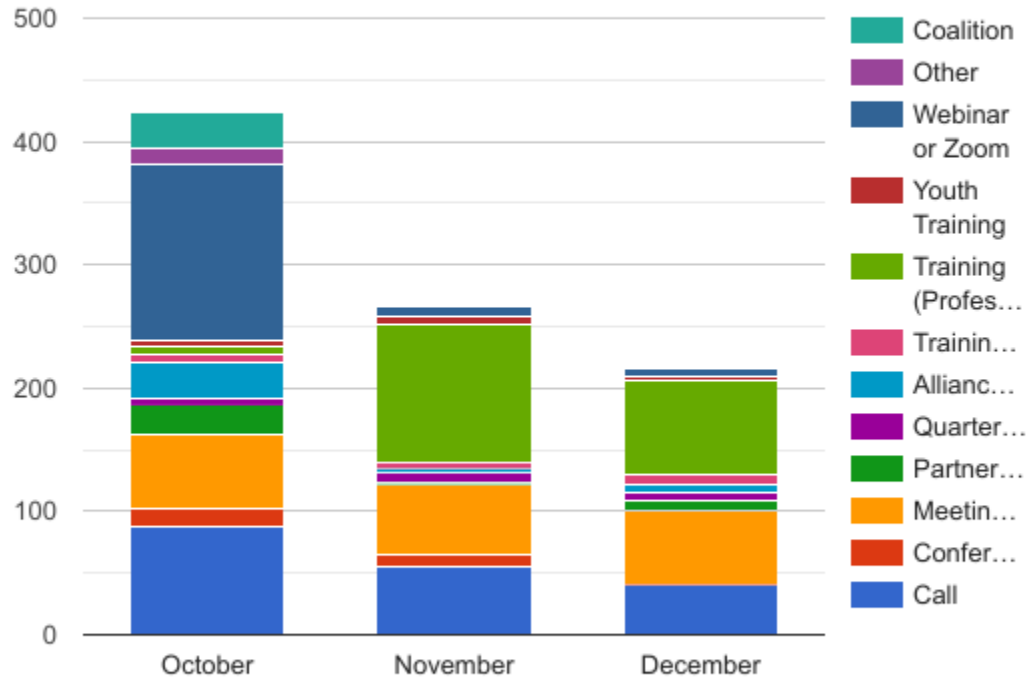
First Annual Harm Reduction Conference	12/16/2020	Presentation	26
Meeting w/ Lisa Rey Thomas	12/16/2020	Meeting (External)	0
NWATTC Webinar: Resilience and Wellness	12/16/2020	Webinar or Zoom	55
OR Tribal Emergency Preparedness Coalition	12/16/2020	Call, Meeting (External)	0
Psychological First Aid Online	12/16/2020	Training	0
Planning meeting with Colville sub-awardee	12/16/2020	Meeting (External)	0
RHNTC Meet and Greet	12/16/2020	Webinar or Zoom	8
Quality Improvement Meeting with Cardea (CME provider) for November Cancer Webinars	12/16/2020	Call, Meeting (External)	0
Subaward Meeting on Statement of Work, Project Timeline, Contract	12/16/2020	Meeting (External)	0
NPAIHB and WA DOH discussion on Suicide and ACES prevention during COVID	12/17/2020	Meeting (External)	0
WA DOH ED-SNSRO Workgroup	12/17/2020	Meeting (External)	0
WA DOH and Uncommon Solutions on ACES, Suicide, and IVP during COVID	12/17/2020	Meeting (External)	0
Suicide & ACES Prevention During COVID	12/17/2020	Webinar or Zoom	6
Weekly check-in meeting with Shoshone Bannock sub-awardee	12/17/2020	Meeting (External)	0

Tribal Epidemiology in Practice	12/17/2020	Presentation	12
Diabetes Webinar: Integrating Behavioral Health Care and Diabetes Management	12/17/2020	Webinar or Zoom	0
NIHB Monthly Tribal Dental Therapy Call	12/17/2020	Call, Meeting (External)	0
Tribal COVID-19 Vaccine Readiness Planning	12/17/2020	Meeting (External)	0
AIHC COVID-19 Tribal Check-in	12/17/2020	Meeting (External)	0
Crisis Textline	12/18/2020	Call	0
NNACoE Student Learner Check-in	12/18/2020	Webinar or Zoom	6
Monthly check-in meeting with Cowlitz sub-awardee	12/18/2020	Meeting (External)	0
OSATF and NPIAHB meeting	12/18/2020	Partnership	0
Toolkit discussion	12/18/2020	Meeting (External)	0
DOH/NPAIHB Innovation Network Team Meeting	12/18/2020	Meeting (External)	0
Project Officer one-on-one meeting	12/18/2020	Meeting (External)	0
"What I Wish I had Known" for Early Career Therapists and Graduate Students	12/19/2020	Conference Attendee	0
Meeting with Trisha Ives	12/21/2020	Call	0
Tribal and Urban Indian Health Immunization Coalitions Meeting	12/21/2020	Meeting (External)	0
Planning meeting with Cardea (CME	12/21/2020	Call, Meeting	0

provider) for January 2021 Cervical Cancer Webinar		(External)	
Monthly call w/Yakama	12/21/2020	Webinar or Zoom	4
Monthly call w/Nez Perce	12/22/2020	Webinar or Zoom	3
Native iCHAMPS Workgroup	12/28/2020	Webinar or Zoom	8
Healthy Native Youth Team Meeting	12/28/2020	Webinar or Zoom, Partnership	8
Native IYG 2.0 Development Workgroup	12/28/2020	Webinar or Zoom	8
MarketCast Check-in	12/28/2020	Webinar or Zoom	6
49 Days of Ceremony Advisory meeting	12/30/2020	Webinar or Zoom	9
Cooking Up Culture with Brian Yazzie	12/01/2020	Training (Professional Development)	0
Qualitative Interview: Food Security during COVID-19	12/01/2020	Meeting (External)	0
Qualitative Interview: Food Security during COVID-19	12/01/2020	Meeting (External)	0
Qualitative Interview: Food Security during COVID-19	12/02/2020	Meeting (External)	0
Qualitative Interview: Food Security during COVID-19	12/03/2020	Meeting (External)	0
Oregon Public Health Association 2020 Board Retreat	12/04/2020	Meeting (External)	0
ATNI Presidential Transition Planning Summit	12/08/2020	Meeting (External)	0

Food Sovereignty, Business Assistance & Financing Workshop	12/08/2020	Training (Others)	6
Oregon Community Food System Network: Leadership Team Meeting	12/09/2020	Meeting (External), Partnership	0
Oregon Land Justice Project	12/10/2020	Meeting (External), Partnership	0
WSU Food Systems HUB Presentation: NWTEC and NW Tribal Food Sovereignty Presentation	12/11/2020	Presentation	60
Qualitative Interview: Food Security during COVID-19	12/17/2020	Meeting (External)	0
Qualitative Interview: Food Security during COVID-19	12/18/2020	Meeting (External)	0
Total			2,714

Types of Trainings, Meetings, Presentations and Webinars:



Technical Assistance Requests

During this period, the project responded to 84 requests for technical assistance from tribes and other stakeholders, including:

Tribe, Organization, or Agency Requesting	Date	Purpose
Seneca Nation of Indians	12/01/2020	Assistance disseminating NPAIHB Resources/Tools to NW Tribes
Swinomish Tribe	12/01/2020	Assistance disseminating External Resources/Tools to NW Tribes
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians	12/01/2020	Clinical support (Goal 1)
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians	12/01/2020	Clinical support (Goal 1)
Squaxin Island Tribe	12/01/2020	
Klamath Tribes	12/01/2020	Assistance disseminating External Resources/Tools to NW Tribes
Quileute Tribe	12/01/2020	Grant writing
Warm Springs Tribes	12/01/2020	
Shoalwater Bay Tribe, Skokomish Tribe, Nez Perce Tribe, Makah Tribe, Uintah-Ouray Service Unit, Owyhee Community Health Facility, Oregon Veteran's Administration	12/01/2020	Assistance disseminating NPAIHB Resources/Tools to NW Tribes, Assistance identifying speakers, consultants, or topical experts, Data reports or fact sheets, RPMS/EHR support
Blackfeet Tribe of the Blackfeet Indian Reservation of Montana	12/01/2020	RPMS/EHR support
All NW Tribes	12/01/2020	Data reports or fact sheets
Yakama Indian Nation	12/01/2020	Data reports or fact sheets
Oregon Health Authority & Nine Tribes of Oregon and NARA-NW Planning Meeting Sessions	12/01/2020	IT assistance (Goal 1)

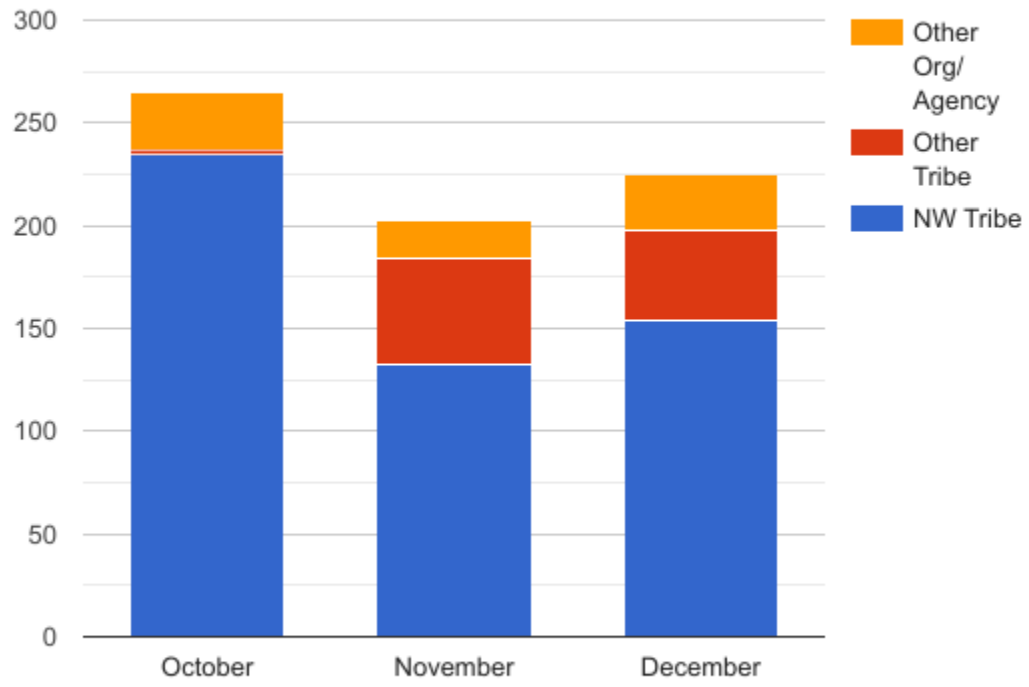
Siletz Tribes	12/02/2020	Assistance identifying speakers, consultants, or topical experts, Assistance locating resources, Assistance disseminating NPAIHB Resources/Tools to NW Tribes
Cherokee Nation	12/02/2020	Clinical support (Goal 1), Healthcare management (Goal 1)
Nisqually Tribe	12/02/2020	Assistance locating resources, Assistance identifying speakers, consultants, or topical experts
Warm Springs Tribes	12/02/2020	
Shoalwater Bay Tribe	12/02/2020	Assistance locating resources
Sauk-Suiattle Tribe	12/02/2020	Assistance locating resources, Clinical support (Goal 1)
Warm Springs Tribes	12/03/2020	
Crow Creek Sioux Tribe of the Crow Creek Reservation	12/03/2020	Assistance locating resources
Quileute Tribe	12/03/2020	Grant writing
Oregon Sexual Assault Task Force	12/03/2020	Grant writing
Tulalip Tribe	12/04/2020	Data reports or fact sheets
Puyallup Tribe	12/04/2020	Data reports or fact sheets
Warm Springs Tribes	12/04/2020	
Kootenai Tribe	12/04/2020	Grant writing
Snoqualmie Tribe	12/04/2020	Grant writing
Yakama Indian Nation	12/07/2020	IT assistance (Goal 1)
Cherokee Nation, USET	12/07/2020	Clinical support (Goal 1)
Great Plains Tribal Epidemiology Center	12/07/2020	Assistance locating resources, Data reports or fact sheets

Cowlitz Tribes	12/07/2020	
Cowlitz Tribes	12/07/2020	
Santee Sioux Nation	12/08/2020	Clinical support (Goal 1), Assistance disseminating NPAIHB Resources/Tools to NW Tribes, Assistance disseminating External Resources/Tools to NW Tribes
Sauk-Suiattle Tribe	12/08/2020	Assistance disseminating NPAIHB Resources/Tools to NW Tribes
Sauk-Suiattle Tribe	12/08/2020	
Diabetes ECHO faculty	12/09/2020	Clinical support (Goal 1), Evaluation planning and support (focus group planning and implementation, survey design and implementation)
Cowlitz Tribes, Cherokee Nation	12/09/2020	Clinical support (Goal 1)
Coeur d'Alene Tribe	12/09/2020	Assistance locating resources
Uintah-Ouray Service Unit	12/09/2020	RPMS/EHR support
Nisqually Tribe	12/09/2020	Assistance disseminating External Resources/Tools to NW Tribes, Assistance locating resources, Assistance disseminating NPAIHB Resources/Tools to NW Tribes
Quinault Indian Nation	12/09/2020	Grant writing
SPTHB	12/09/2020	
WA DOH	12/09/2020	
Tulalip Tribe	12/09/2020	Assistance locating resources
Kootenai Tribe	12/09/2020	Grant writing
Laura Platero, NPAIHB	12/09/2020	Data analysis or interpretation
Lower Elwha Klallam Tribe	12/10/2020	Clinical support (Goal 1)
Lower Elwha Klallam Tribe	12/11/2020	Assistance disseminating NPAIHB

		Resources/Tools to NW Tribes
WA DOH	12/11/2020	
Jackie Shannon, OHSU	12/11/2020	Data analysis or interpretation, Epidemiology skills or research methods (Goal 5)
Klamath Tribes	12/14/2020	Grant writing
Tribal organization: NARA Northwest	12/14/2020	Grant writing
Cowlitz Tribes, Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation	12/14/2020	Clinical support (Goal 1)
internal	12/14/2020	RPMS/EHR support
Penobscot Nation	12/14/2020	Assistance locating resources
Klamath Tribes	12/14/2020	Assistance disseminating External Resources/Tools to NW Tribes
Klamath Tribes	12/14/2020	Assistance disseminating External Resources/Tools to NW Tribes
Oklahoma Tribal Engagement Partners	12/15/2020	Assistance disseminating External Resources/Tools to NW Tribes
Tulalip Tribe	12/15/2020	Assistance disseminating NPAIHB Resources/Tools to NW Tribes, Assistance locating resources
Siletz Tribes	12/15/2020	Assistance disseminating External Resources/Tools to NW Tribes
Port Gamble S'Klallam Tribe	12/16/2020	
University of Oregon	12/16/2020	Assistance locating resources
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians, Confederated Salish and Kootenai Tribes of the Flathead Reservation, Norton Sound Health Corporation	12/16/2020	Clinical support (Goal 1)
Swinomish Tribe	12/16/2020	Clinical support (Goal 1)

NARA	12/16/2020	IT assistance (Goal 1)
National Council for Behavioral Health	12/17/2020	Assistance disseminating External Resources/Tools to NW Tribes
Coquille Tribe	12/17/2020	Grant writing
Upper Skagit Tribe	12/17/2020	Grant writing
Snoqualmie Tribe	12/17/2020	Grant writing
Colville Tribes	12/18/2020	Assistance locating resources
Native Youth are Medicine Self-Love Healing Kit mail out with CNAY and NWI	12/18/2020	Assistance disseminating External Resources/Tools to NW Tribes
All NW Tribes	12/18/2020	Assistance disseminating External Resources/Tools to NW Tribes, Assistance disseminating NPAIHB Resources/Tools to NW Tribes
Sauk-Suiattle Tribe	12/18/2020	IT assistance (Goal 1)
Victoria Warren-Mears, NPAIHB	12/18/2020	Data analysis or interpretation
University of Texas Health Science Center at Houston	12/18/2020	Assistance disseminating NPAIHB Resources/Tools to NW Tribes
Siletz Tribes	12/19/2020	Assistance locating resources
Port Gamble S'Klallam Tribe	12/21/2020	
Grand Ronde Tribes, Soboba Band of Luiseño Indians, Sherman Indian School - Riverside Indian Health Service California	12/22/2020	Health curricula
Out of Area Tribes	12/22/2020	Policy development
Santa Fe Indian Hospital	12/29/2020	Clinical support (Goal 1)
Quileute Tribe	12/29/2020	Grant writing
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians	12/29/2020	Assistance locating resources
SAMHSA	12/30/2020	

Requests for TA:



Site Visits

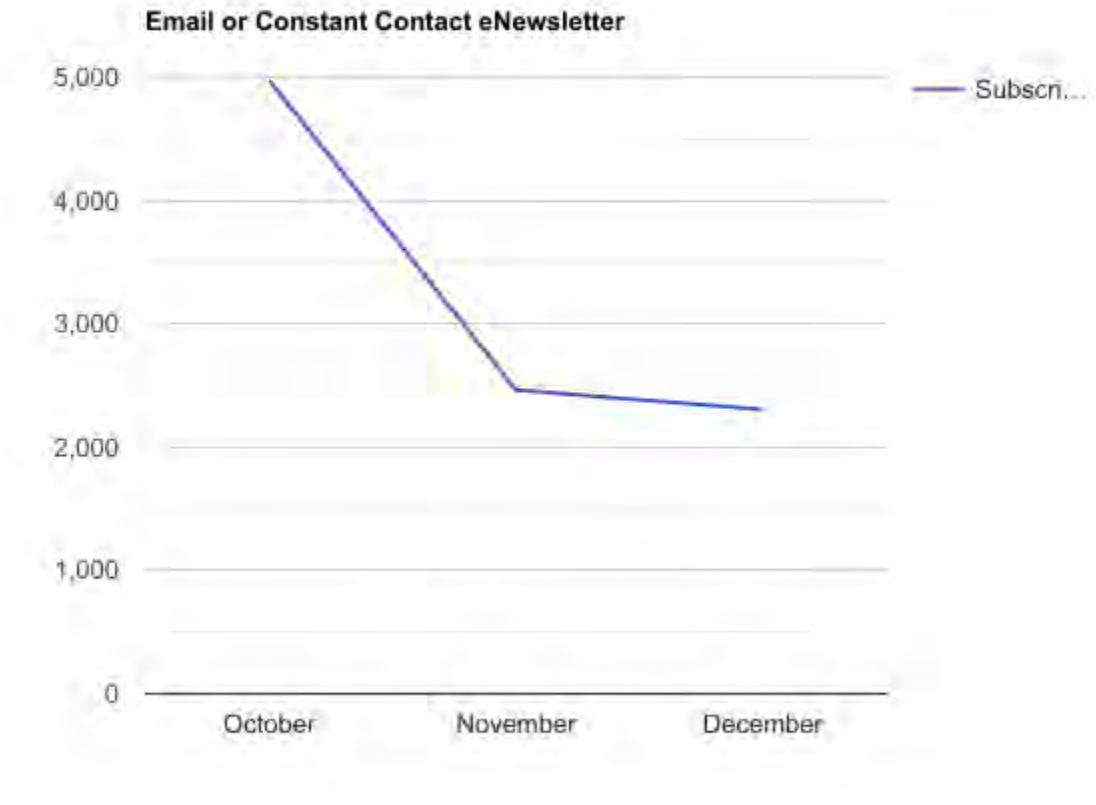
In December, the NPAIHB conducted 0 site visits.

Communications Campaigns

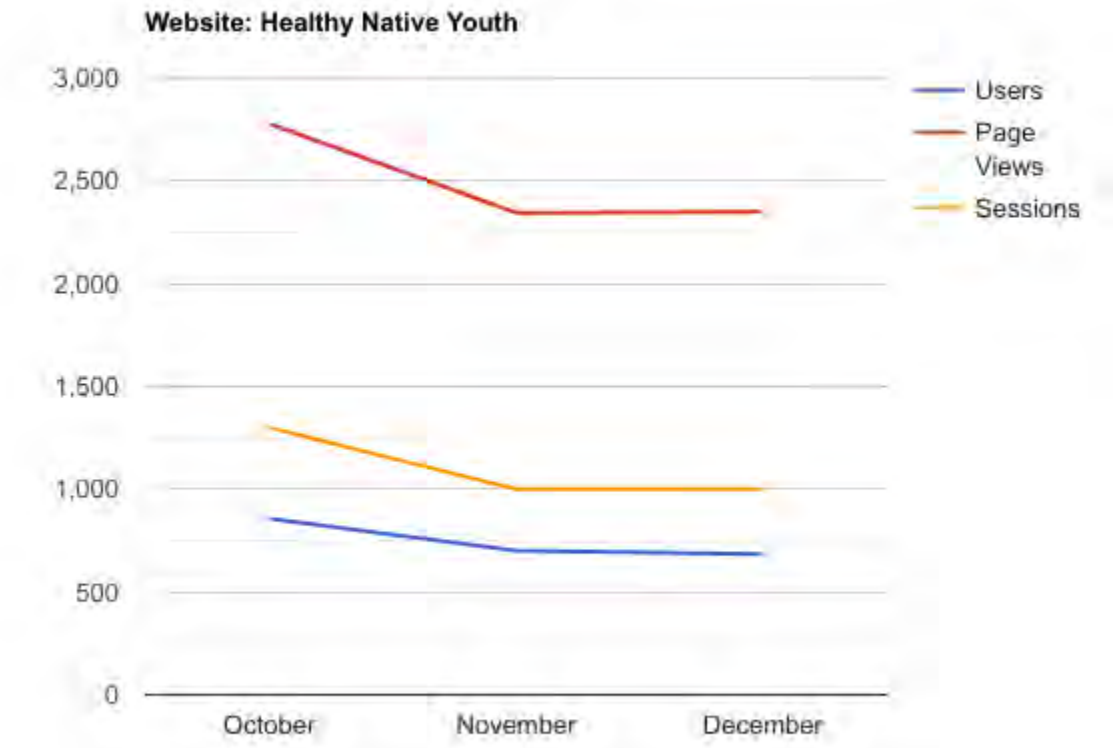
During this period, the project contributed to community education and outreach using the following channels:

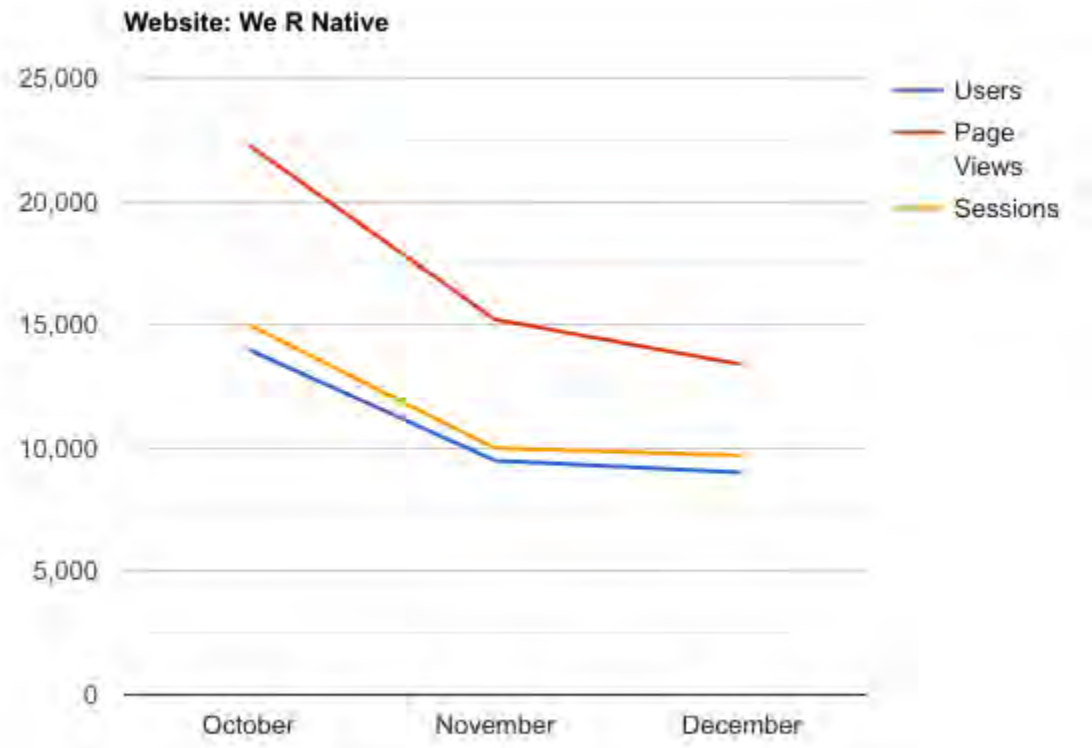
Date	Purpose
12/01/2020	We R Native
12/01/2020	Healthy Native Youth
12/01/2020	LGBTQ2S
12/01/2020	Mental Health (#WeNeedYouHere + indigiLOVE)
12/01/2020	Hep C (100-72)
12/01/2020	Indian Country ECHO
12/01/2020	Substance Use Disorder
12/01/2020	We R Native
12/01/2020	Healthy Native Youth
12/01/2020	We R Dine
12/01/2020	STEM
12/01/2020	The Talk (EMPOWER)
12/01/2020	We Are Healers
12/01/2020	BRAVE
12/01/2020	Caring Messages (GLS)
12/01/2020	Natives Vote

Email or Constant Contact eNewsletter	
Campaign	Subscribers
Healthy Native Youth	2306

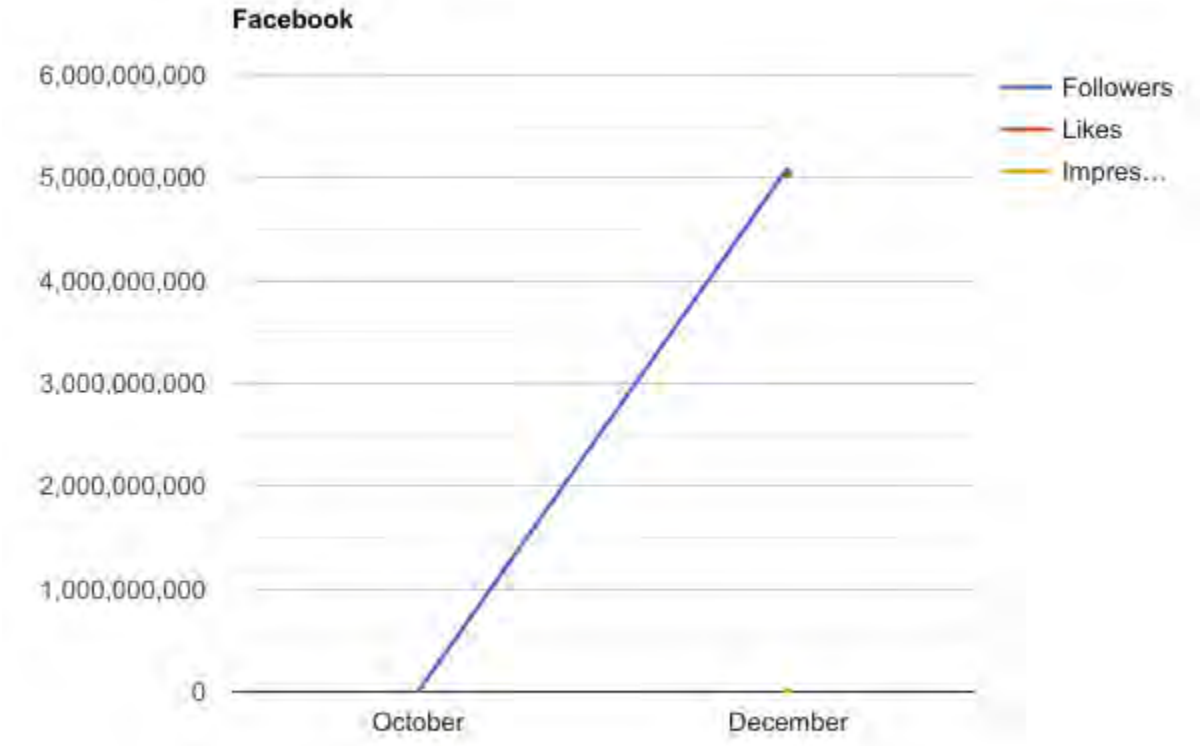


Website			
Campaign	Users	Page Views	Sessions
We R Native	9000	13401	9700
Healthy Native Youth	685	2349	1000

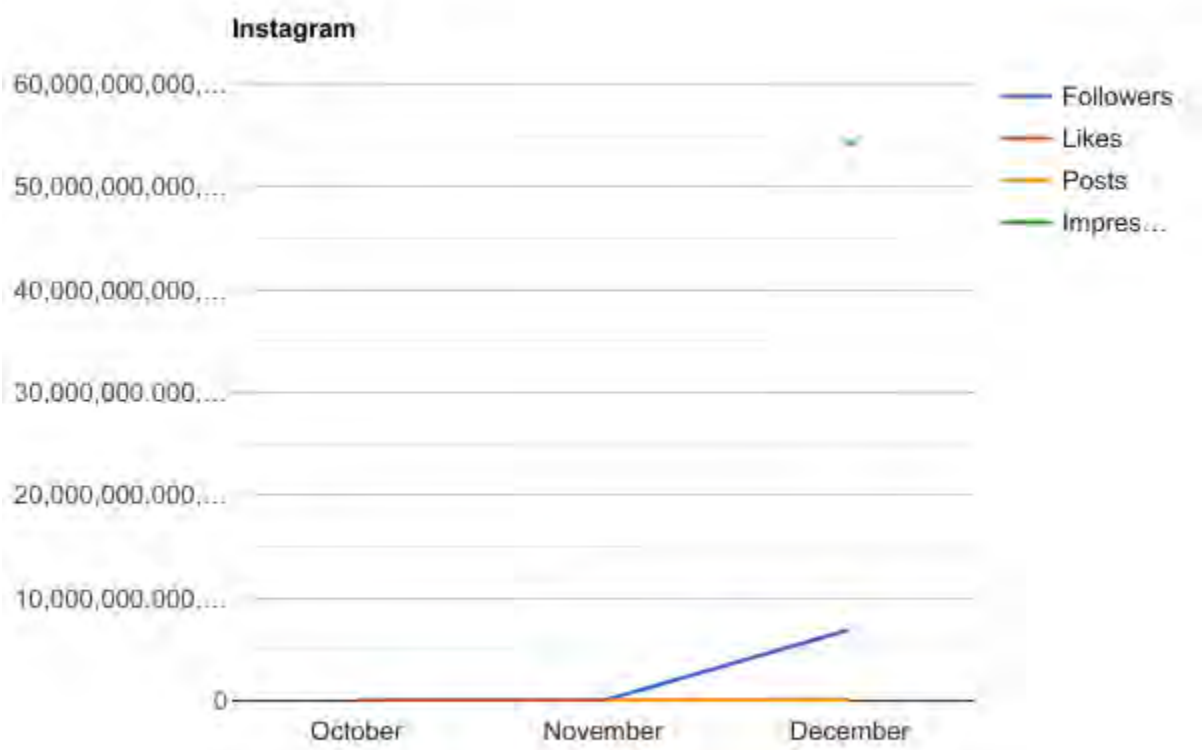



Website: We R Native
25,000
20,000
15,000
10,000
5,000
0
October
November
December
Users
Page Views
Sessions

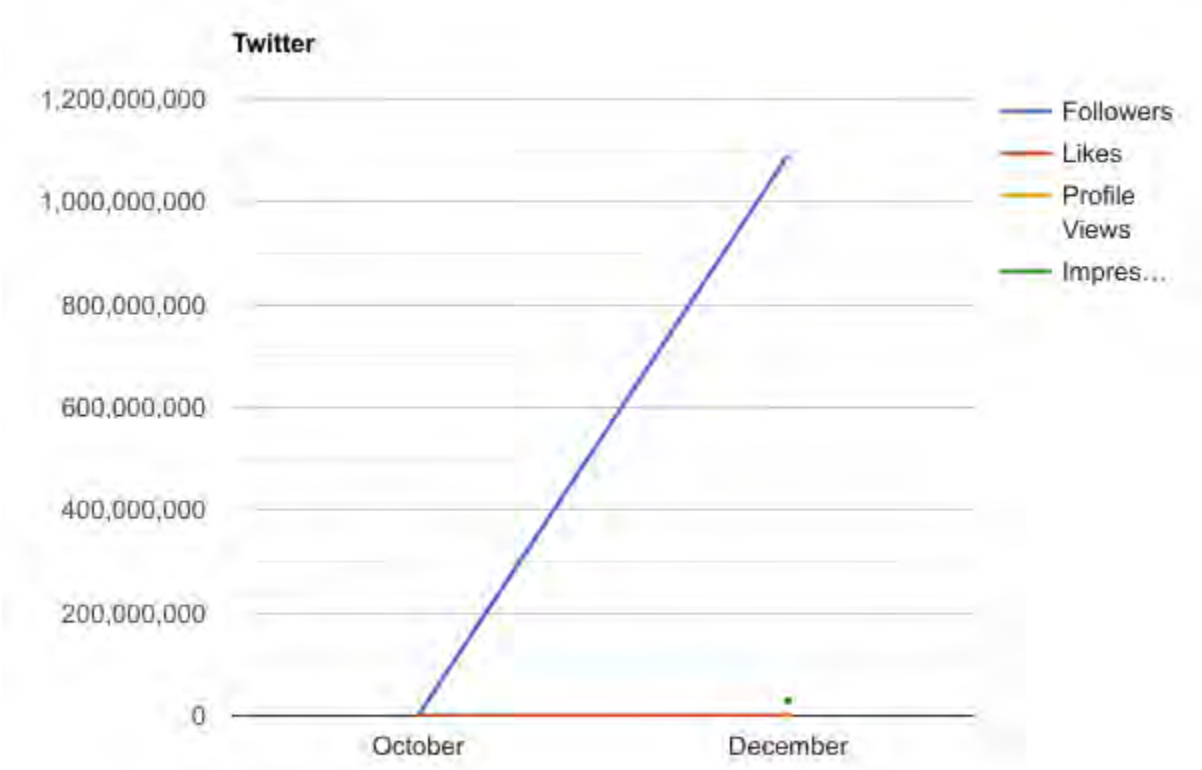
Facebook			
Campaign	Followers	Likes	Impressions
Mental Health (#WeNeedYouHere + indigiLOVE)			2362
We R Native	51029	50356	50132



Instagram				
Campaign	Followers	Likes	Posts	Impressions
LGBTQ2S	692	265	10	
Mental Health (#WeNeedYouHere + indigiLOVE)				5427
We R Native	13360	5286	29	79730



Twitter				
Campaign	Followers	Likes	Profile Views	Impressions
Mental Health (#WeNeedYouHere + indigiLOVE)			1811	
We R Native	10910	366	41200	2905



SMS Campaigns		
Campaign	Subscribers	Posts
LGBTQ2S	330	4
Hep C (100-72)	0	15
Indian Country ECHO	0	736
Substance Use Disorder	0	0
We R Native	25	17059
Healthy Native Youth	1	3586
We R Dine	48	3335
STEM	0	88
The Talk (EMPOWER)	14	585
We Are Healers	59	21471
BRAVE	0	19
Caring Messages (GLS)	17	1185
Caring Messages (GLS)	17	1185
LGBTQ2S	6	2283
Natives Vote	0	0

Articles, Reports, and Publications

Newsletters or Newspaper Articles	
Title	Date
Wrap up of executive summary report	12/11/2020

Journal Articles		
Title	Citation	Date
Long-term effects of a toddler-focused caries prevention program among Northwestern US tribal children: The TOTS-to-Tweens study.	Smith NH, Lutz T, Maupomé G, Lapidus J, Jimenez C, Janis M, Schwarz E, Becker T. Long-term effects of a toddler-focused caries prevention program among Northwestern US tribal children: The TOTS-to-Tweens study. Community Dent Oral Epidemiol. 2020;00:1–7. https://doi.org/10.1111/cdoe.1260	12/01/2020
Electronic Health Record Reminders for Chlamydia Screening in an American Indian Population	https://doi.org/10.1177/0033354920970947	12/01/2020
Long-term effects of a toddler-focused caries prevention program among Northwestern US tribal children: The TOTS-to-Tweens study	Smith NH, Lutz T, Maupomé G, Lapidus J, Jimenez C, Janis M, Schwarz E, Becker T. Long-term effects of a toddler-focused caries prevention program among Northwestern US tribal children: The TOTS-to-Tweens study. Community Dent Oral Epidemiol. 2020;00:1–7. https://doi.org/10.1111/cdoe.1260	12/03/2020
COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020	Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1853–1856. DOI:	12/11/2020

	http://dx.doi.org/10.15585/mmwr.mm6949a3	
Recruiting and Engaging American Indian and Alaska Native Teens and Young Adults in a SMS Help-Seeking Intervention: Lessons Learned from the BRAVE Study	Stephens, D.; Peterson, R.; Singer, M.; Johnson, J.; Rushing, S.C.; Kelley, A. Recruiting and Engaging American Indian and Alaska Native Teens and Young Adults in a SMS Help-Seeking Intervention: Lessons Learned from the BRAVE Study. Int. J. Environ. Res. Public Health 2020, 17, 9437.	12/17/2020
Developing Resources for American Indian/Alaska Native Transgender and Two-Spirit Youth, Their Relatives, and Healthcare Providers	doi:10.1353/cpr.2020.0056	12/30/2020

Reports	
Title	Date
Daily data pull from survey monkey for COVID-19 testing data, reported to IHS	12/01/2020
Weekly reports back to tribes in WA on testing data	12/02/2020
Weekly reports back to tribes in WA on testing data	12/02/2020
WYSH Grant Information close out PAF	12/08/2020
NW NARCH Trainees 2002-2020	12/09/2020
SASP Carryover Request	12/18/2020
Tribal Opioid Response consortium phase 2 Carryover Request	12/18/2020
Tribal Opioid Response consortium phase 2 annual report	12/18/2020
SAMHSA GLS Suicide Prevention Grant 18mo Report	12/21/2020
Tribal Opioid Response consortium annual report	12/21/2020
THRIVE SAMHSA 18 month report	12/22/2020

Web Articles or Blogs		
Title	Citation	Date
What is your vision of 2SLGBTQ+ liberation?	http://www.npaihb.org/2slgbtq-liberation/	12/01/2020

Research, Surveillance, and IRB

During this period, the project supported the development, implementation, and evaluation of culturally-relevant health promotion practices within the NW Tribes, by adapting and disseminating policies, educational materials, curricula, and evidence-based interventions to reflect the traditional values and teachings of the NW Tribes.

Dataset Preparation	
Title	Date
Continued work on Medicaid dataset	12/01/2020
Washington ESSENCE - prepared analytic dataset and data dictionary for assessing misclassification 5/15-9/15/20	12/01/2020
Analysis of 2SLGBTQ Survey Responses	12/09/2020

Linkage	
Title	Date
Performed record linkage between Oregon Death certificate data and FARS data. Examined and documented detailed information on matched and non-matched records. Analyzed death certificate data for a potential manuscript.	12/01/2020

Evaluations	
Title	Date
Cancer Survivorship Survey for Tribal Healthcare Professionals and Cancer Advocates	12/14/2020
TECPHI COVID-19 Evaluation Supplement	12/29/2020
Year 3 NCC National Evaluation	12/29/2020
CDC 4-page evaluation report	12/29/2020

Qualitative	
Title	Date
Cancer Survivorship Survey for Tribal Healthcare Professionals and Cancer Advocates	12/14/2020

Quantitative	
Title	Date
Continued work on Medicaid dataset	12/01/2020
COVID-19 syndromic surveillance weekly reporting	12/01/2020
COVID-19 syndromic surveillance weekly reporting	12/01/2020
Bi-weekly COVID-19 case surveillance analysis	12/01/2020
COVID-19 Case Surveillance Data	12/01/2020
Performed record linkage between Oregon Death certificate data and FARS data. Examined and documented detailed information on matched and non-matched records. Analyzed death certificate data for a potential manuscript.	12/01/2020
Washington ESSENCE - assessed misclassification for overall Washington hospital visits and specific CC and DD categories, prepared abstract	12/07/2020
Analysis of 2SLGBTQ Survey Responses	12/09/2020
Oregon Emergency Department Visit for Mental Health Indicators during COVID	12/10/2020
Communicable Disease Data Briefs/Profiles	12/15/2020

IRB Continuations	
Title	Date
Package: [1345586-21] Enhancing Control of Childhood Asthma in AI/AN Communities	12/15/2020

IRB Submissions	
Title	Date
Qualitative Interview Project with Native Two Spirit and LGBTQ People to Explore Pride, Community Connectedness, Self-Rated Health, and Healthcare Access	12/11/2020
Package: [1345586-21] Enhancing Control of Childhood Asthma in AI/AN Communities	12/15/2020
PA IHS IRB	12/16/2020

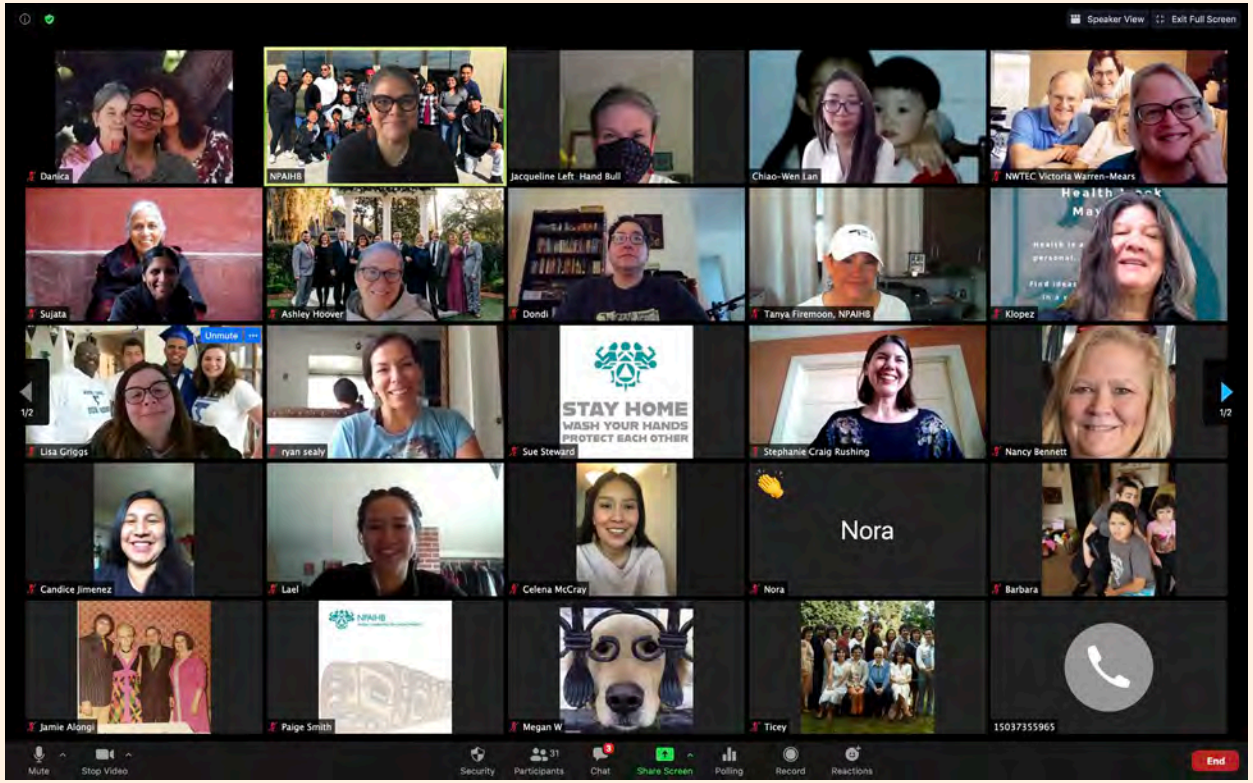
EXECUTIVE DIRECTOR REPORT
Virtual Quarterly Board Meeting
January 20, 2021

Laura Platero, JD

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Report Topics

1. QBM Highlights
2. HR/Personnel Updates
3. Office & Administration
4. Finance
5. Grant Update
6. Questions



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

QBM Highlights

- Delegate of the Year
- Policy Priorities for FY 2021 / Legislative Opportunities
- Tribal Advisory Committee Updates
- Strategic Plan 2020 to 2025
- Epi / COVID-19 work
- Bylaws Update

New Position: Deputy Director

Sue Steward

- Citizen of the Cow Creek Band of Umpqua Tribe of Indians
- Current Council/Board of Directors member
- Served as NPAIHB CHAP Director
- Extensive Experience in healthcare and leadership

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Personnel Updates

OTHER INTERNAL PROMOTIONS/TRANSFERS	
Birdie Wermy	Behavioral Health Program Manager
Danica Brown	Behavioral Health Program Director
Candice Jimenez	Health Policy Specialist

SEPARATIONS OR RETIREMENTS	
Corey Begay	Behavioral Health Manager
Jacqueline Left Hand Bull	Administrative Officer
Luella Azule	IP & PHIT Project Coordinator

New Employees

Carrie Sampson
CHAP Project Director

Liz Coronado
Health Policy Specialist

Samantha Wells
Temp Leg Field Organizer

Liz Coronado
TOR Project Specialist

Nick Cushman
ECHO Pharmacy Case Manager

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
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Recognitions – 10 years of Service

Jessica Leston
Clinical Programs Director

David Stephens
ECHO Clinic Director

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Special Recognition

Erik Kakuska

WTD Project Specialist

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

BEHAVIORAL HEALTH JANUARY 2020

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

HEALTH NEWS & NOTES

A Publication of the Northwest Portland Area Indian Health Board

FIND SASQUATCH!

1

IN THIS ISSUE:

NPAIHB
2121 SW Broadway, ste. 300
Portland, OR 97201
503.228.4185
www.npaihb.org

CREATIVE SELF-EXPRESSION ENRICHES ANNUAL YOUTH CONFERENCE

Celena McCray (Navajo)
Project Coordinator - WA DOH
Parenting Teens & THRIVE

For nine years, the THRIVE project has gathered Native youth together at the annual THRIVE youth conference to learn about health promotion and disease prevention with a focus on suicide prevention and mental health. Our goal of the conference is to provide youth with protective factors (i.e., healthy coping skills, positive communication, connectedness to friends/family, connectedness to culture/spirituality, etc.) as a means to address youth suicide. This year 64 Native youth representing 14 federally-recognized tribes gathered at the Portland State University Native American Student and Community Center (NASCC) in Portland, Oregon for the 9th year of the THRIVE Youth Conference on June 24-28, 2019.

Participants positively expressed themselves through five interactive workshops that incorporated AI/AN culture, traditional learning strategies, skill-building activities, and tips on healthy decision making. Special guest and Native artist, Jared Yazzie (Navajo) from the OXDX clothing line and Tommy Ghost Dog (Burns Paiute/Oglala Lakota, WeRNative Coordinator), led a NEW workshop called *Creative Design w/OXDX*. Youth created four meaningful social marketing campaigns by creating their own logos using digital designs inspired by the environment, culture, body and mind. Native youth amplified the advocacy for: Missing and Murdered Indigenous Women (MMIW); honoring tribal elders and sharing teachings passed down to them; reclaiming tribal identity through their ancestors and; being mindful of the environment and mother earth. These social marketing campaigns also include videos which were launched in November for Native American Heritage Month. Check the videos out at: http://www.npaihb.org/thrive/#1461959216954-454d5e19-bb03.

continues on page 16

Employee of the Year

Amy Franco

Grants Management Specialist

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Office & Administration

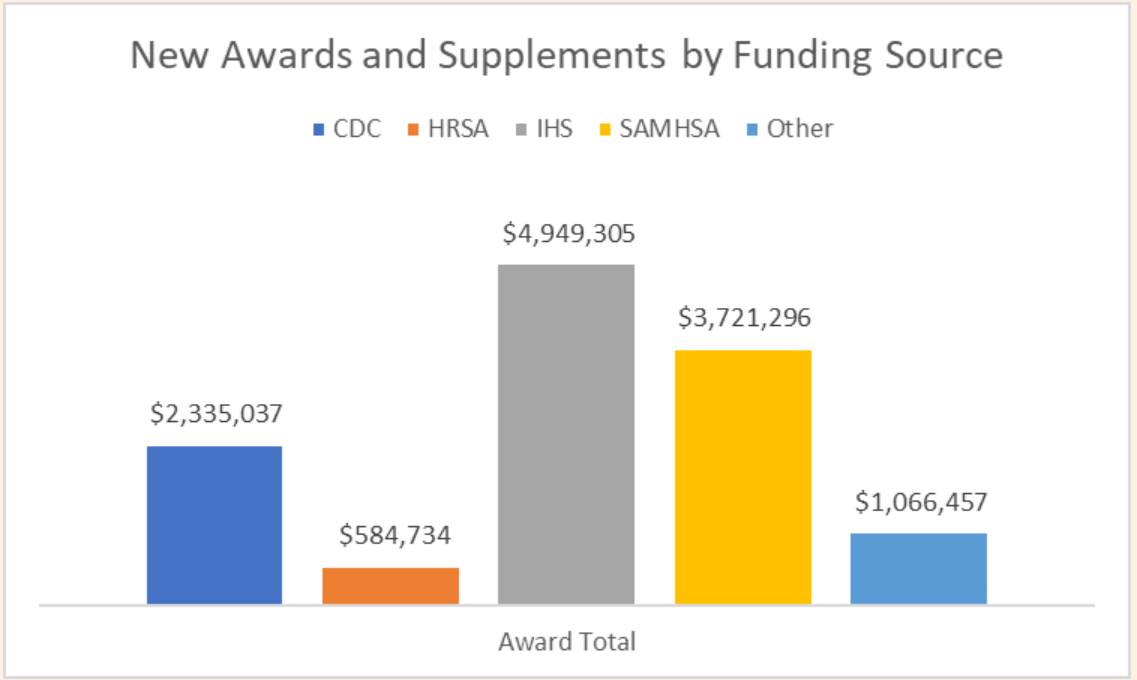
- Office Closed – Only Essential Staff in the Office; Project Staff Intermittently
- Staff to get COVID-19 vaccine
- Revisit Lease – Term is June 1, 2017 to May 31, 2024.
  - Attorney Opinion – July 2020
    - No early termination clause
    - Options: Negotiate termination/buy out or sublease space
  - Last year: Anticipated return to office in Spring or Summer
  - Now: Uncertain return to office; will explore options again

Finance

- Continue implementation of Microix - electronic purchase order system
- FY 2021organizational budget
- Administrative Officer (AO) retired 11/30/20. AO had oversight over Finance and Admin staff; now hiring Finance Director (position still open)
- Annual audit preparation has begun; date TBD

New Awards and Supplements 2020

- In 2020, NPAIHB received nearly 13 million dollars in new awards or supplements
- These new dollars funded projects related to COVID-19 response, Environmental Health, Tribal Elders, Dental Support, Food Sovereignty, Youth Sexual Health, Tribal Opioid Response, and Behavioral Health



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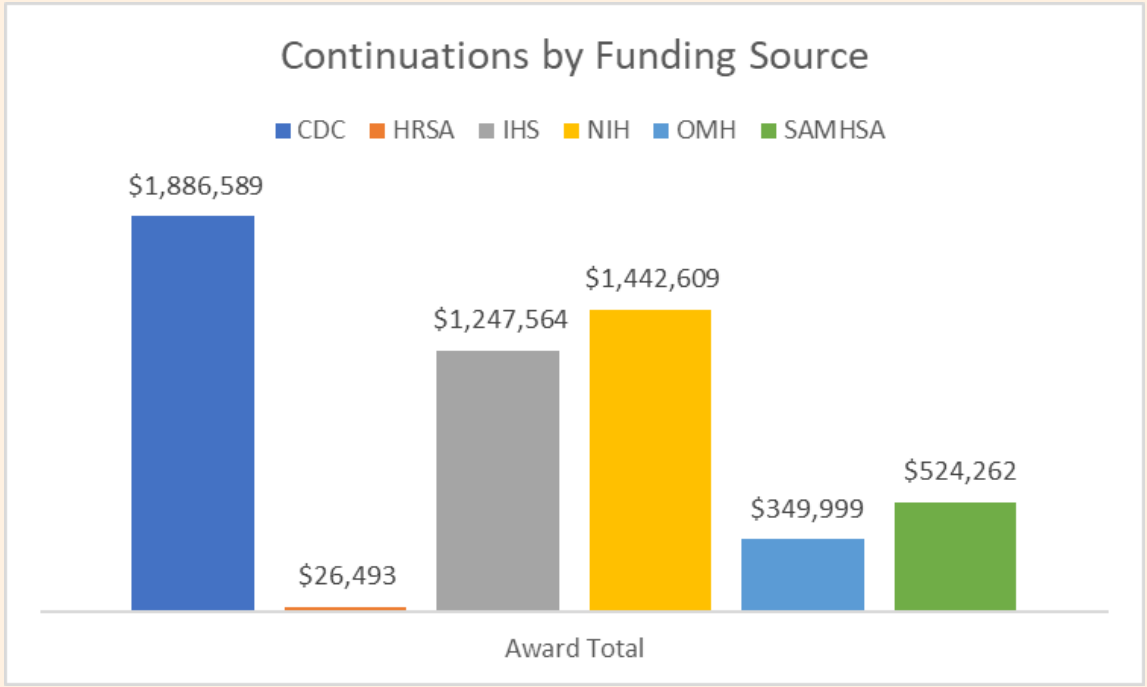
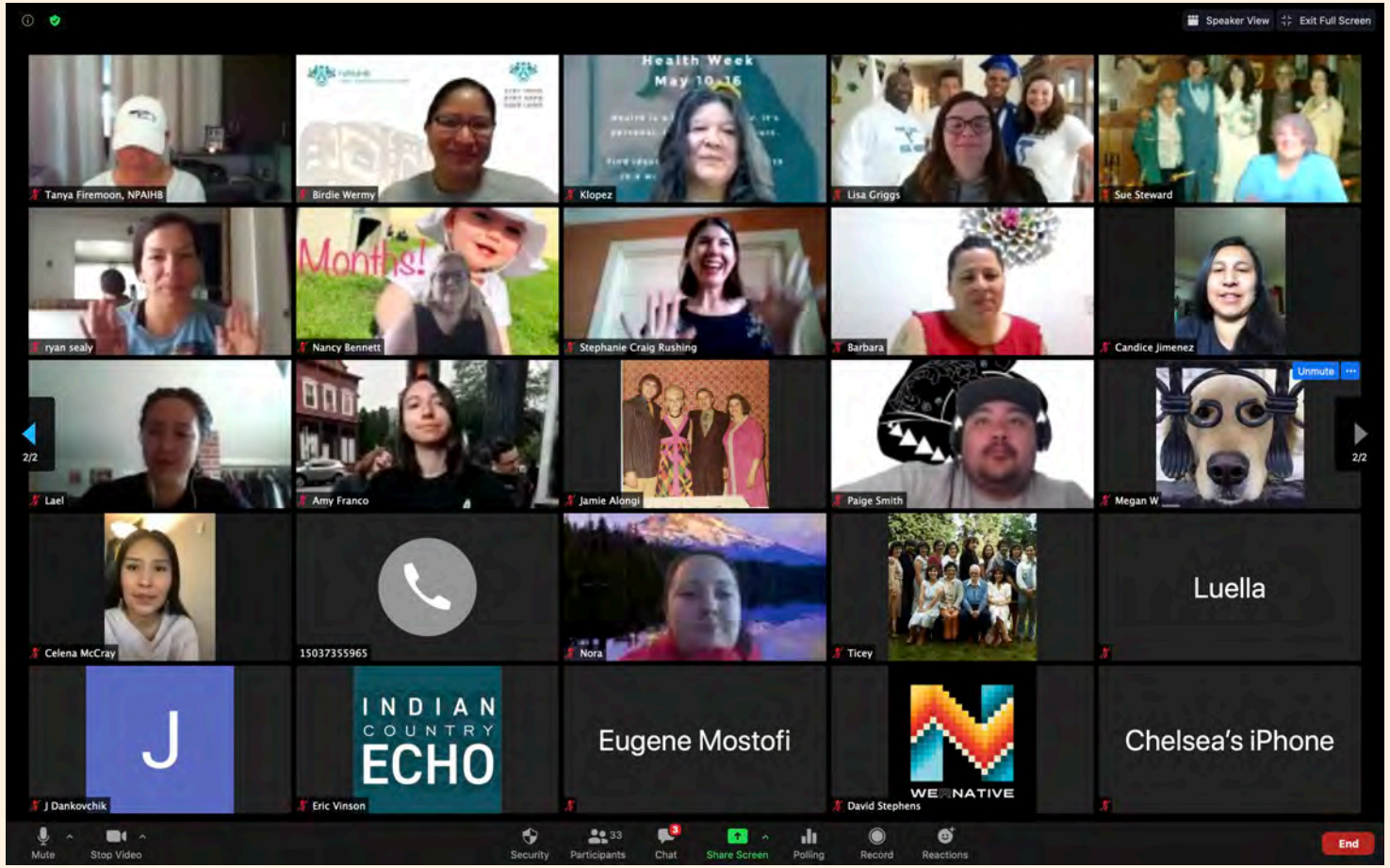
Continuations on Existing Grants

- In 2020, NPAIHB received approximately $5,477,000 in continued funding on existing projects
- Projects receiving continuing funding included Public Health Infrastructure and Training, the EpiCenter, THRIVE Area 4 and 2, Response Circles, Opioid-related projects, and NARCH 9 and X



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Questions…?



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Indian Leadership for Indian Health

Delegate of the Year

Greg Abrahamson

Vice Chairman
Spokane Tribe of Indians

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Indian Health Service

NPAIHB-QBM – ZOOM MEETING

DEAN M. SEYLER

DIRECTOR, PORTLAND AREA

JANUARY 19, 2021

Indian Health Service
Portland Area

Office of Tribal & Service Unit Operations

PPPHCEA – HHS Testing Funds Transfer (FY20 closeout)

- Sent week of June 1st, 2020
- Requires a comprehensive Budget, Signed Amendment & Testing plan
- Portland Still has 7 Tribes outstanding

Calendar Year Tribes Remaining

- 5 – Title I AFA's
- 4 – Title V FA's

Contract Support Costs

- Portland Area Continues to work on prior year reconciliations for prior years to true up payments and ensure all CSC amounts are brought up to current.

Indian Health Service
Portland Area

Division of Finance

- H.R. 133 – Consolidated Appropriations Act, 2021
  - FY 2021 IHS Budget, $6.2 billion
  - Became law on December 27, 2020

- Funding received by Area to date:
  - Exception Apportionment (Fiscal-Year Tribes Only)
  - CR1 PL 116-159: 10/01/20 – 12/11/20
  - CR2 PL 116-215: 12/12/20 – 12/18/20
  - CR3 PL 116-225: 12/19/20 – 12/20/20
  - CR4 PL 116-226: 12/21/20
  - CR5 PL 116-246: 12/22/20 – 12/28/20
  - 30-day apportionment of FY20 Recurring Base, which runs through 1/27/2021

Indian Health Service
Portland Area

Division of Finance

- On December 27, the President signed the Coronavirus Response and Relief Act, 2021 as part of a broader legislative package.
- The bill includes a total of $1 billion for IHS, Tribal, and Urban Indian health programs.
- The bill includes language stipulating that these funds are provided on a one-time, non-recurring basis, and can only be used for the purposes outlined in the statute.

Indian Health Service
Portland Area

Division of Finance

- These funds are appropriated to the CDC and the Public Health and Social Services Emergency Fund. The bill directs HHS to transfer the funds to the IHS for distribution.
- The $1 billion in new COVID-19 resources includes two separate appropriations:
- $210 million for vaccine-related costs, available through FY 2024, and
- $790 million for testing and related costs, available through FY 2022.

Indian Health Service
Portland Area

Division of Finance

- The bill provides the IHS a total of $210 million for the following activities:

- To plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage, and

- To restore, either directly, or through reimbursement, obligations incurred for coronavirus vaccine promotion, preparedness, tracking, and distribution prior to the enactment of this Act.

Indian Health Service
Portland Area

Division of Finance

- The bill provides the IHS a total of $790 million for the following activities:
- Testing, contact tracing, surveillance, containment, and mitigation to monitor & suppress COVID-19,
- Support for workforce, epidemiology, and personal protective equipment needed for administering tests,
- Use by employers, elementary and secondary schools, child care facilities, institutions of higher education, long-term care facilities, or other settings,
- Scaling up testing by public health, academic, commercial, and hospital laboratories,
- Community based testing sites, mobile testing units, health care facilities, and other entities engaged in COVID-19 testing, and
- Other activities related to COVID-19 testing, contact tracing, surveillance, containment, and mitigation.

Indian Health Service
Portland Area

Division of Finance

- The bill also requires that recipients of these funds update their COVID-19 testing plans required by the Paycheck Protection Program and Health Care Enhancement Act.
- It further requires the Secretary to make these plans publicly available.
- It also requires the IHS to provide a spend plan on the uses of funds to Congress within 60 days of enactment, and report to Congress on uses of funding, commitments, and obligations, quarterly thereafter.

Indian Health Service
Portland Area

FY19 Catastrophic Health Emergency Fund (CHEF)

Status as of January 11, 2021

- 92 Total Cases
- 41 Total Amendments
- $4,651,630.00 Reimbursed
- $0 Pending Reimbursements
- 100% Total Reimbursed
- **FY19 CHEF Balance: $0**

Indian Health Service
Portland Area

FY20 Catastrophic Health Emergency Fund (CHEF)

Status as of January 11, 2021

- 54 Total Cases
- 33 Total Amendments
- $1,839,066.00 Reimbursed
- $164,407.33 Pending Reimbursements
- 91% Total Reimbursed
- **FY20 CHEF Balance: $28,195,367**

Indian Health Service
Portland Area

FY21 Catastrophic Health Emergency Fund (CHEF)

Status as of January 11, 2021

- 1 Total Cases
- 0 Total Amendments
- $0 Reimbursed
- $13,883.16 Pending Reimbursements
- 0% Total Reimbursed
- **FY21 CHEF Balance: $53,000,000**

Indian Health Service
Portland Area

Division of Health Facilties Engineering

Combined Supportable Space Data Request

- **Requesting Space and Deficiency Data Updates**
- **Packets Sent By Email to Tribal Health Director and Tribal Chair week of January 11th**
  - **Notify lee.wermy@ihs.gov if you did not receive.**
- **Response Required to be Eligible for Project M&I (BEMAR) Funding**
- **Due February 15th**

Indian Health Service
Portland Area

Division of Sanitation Facilities Construction

- In FY20, the Portland Area DSFC initiated a total of 49 new projects and amended 8 previous projects using $18.5M from all funding sources.
- This included $10.6M from IHS and $7.9M in contributions from Tribes, EPA, USDA, and HUD.
- CARES Act funding: Portland Area DSFC received $421,017 in CARES Act funding for special projects to provide Personal Protective Equipment to Tribal operators and to help operate and maintain water and wastewater systems and support public health.
- 8 CARES Act projects were funded, benefitting 10 Tribes.

Indian Health Service
Portland Area

Division of Sanitation Facilities Construction

- In November, the Portland Area DSFC submitted its annual list of identified project needs to SFC Headquarters: 43 reportable projects valued at 59.6M.
- This list will be used to award projects in FY21.
- This represents a significant increase over the FY20 submission, which included 30 projects valued at $26.5M.

Indian Health Service
Portland Area

Division of Sanitation Facilities Construction

- This is the result of our continued partnerships with Tribes to identify needs, as well as changes in the guidance last year that allowed us to report needs that do not yet have a fully scoped project solution.

- We are currently beginning to schedule meetings with Tribes to identify needs for FY22 funding.

Indian Health Service
Portland Area

Division of Sanitation Facilities Construction

- DSFC Director: CAPT Alex Dailey, 503-414-7780, alexander.dailey@ihs.gov
- Western Oregon District Office: LT Derek Hancey, 503-414-7784, derek.hancey@ihs.gov
- Yakama Field Office: Samantha Handrock, 509-865-1775, samantha.handrock@ihs.gov
- Olympic District Office: CDR Roger Hargrove, 360-792-1235 x113, roger.hargrove@ihs.gov

Indian Health Service
Portland Area

Division of Sanitation Facilities Construction

- Port Angeles Field Office: CDR Craig Haugland, 360-452-1196, craig.haugland@ihs.gov
- Spokane District Office: CDR Steve Sauer, 509-455-3486, steve.sauer@ihs.gov
- Fort Hall Field Office: LT Kevin Remley, 208-238-5473, kevin.remley@ihs.gov


INDIAN HEALTH SERVICE
PHS · 1955 ·

2020 Policy Priorities

Presented by: Elizabeth J. Coronado and Candice Jimenez

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

NPAIHB Health Policy Team

- *New* Staff Introduction

Elizabeth J. Coronado, JD

Chukchansi

Candice B. Jimenez, MPH

Confederated Tribes of Warm Springs

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Legislative and Policy Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Indian Health Service

- Fully fund the IHS
- Establish a separate and indefinite discretionary appropriation for 105(l) lease funding.
- Provide mandatory funding for IHS
- Amend IHCIA to authorize advance appropriations for IHS.
- For Purchased and Referred Care, move access to care factor from category 3 to category 2 in funding formula.

Health Care Facility Funding

- Request GAO to issue a report on IHS Health Care Facilities Construction Priority System.
- Create equitable health care facilities funding opportunities for all IHS areas.
- Fund Regional Referral Specialty Care Demonstration Project in the Portland Area.
- Increase funding for small ambulatory programs and joint venture projects.

SDPI

- Permanently authorize SDPI at $200 million per year with medical inflation rate increases annually. (NPAIHB Res. No. 19-04-12)
- Create options for tribes to receive SDPI funds through Title I or Title V compacts or contracts.
- Allow areas to reallocate data infrastructure funds to Tribal Epi Centers to assist tribes in managing their SDPI data.

Patient Protection and Affordable Care Act / IHCIA

- Congress must protect ACA and IHCIA.
- Fully fund IHCIA, including long term care, recruitment and retention, and behavioral health.
- Fund Tribal Epi Centers to fulfill their role as a Public Health Authority. (TA, capacity building, evaluation, public health surveillance)

IHS IT Modernization

- For FY 2021, fund $25 million for planning and phased in maintenance of RPMS.
- Conduct tribal consultation in each IHS area on any efforts to modernize or replacement of RPMS.
- Provide ample transition period, training, and TA.
- Consider the many tribal facilities that have purchased commercial off the shelf systems.

Medicaid/CHIP

- Protect 100% FMAP.
- Protect FFS (not subject to managed care or value based payments).
- Support legislation that:
  - Extends Medicaid eligibility for all AI/AN with household income up to 138% of the federal poverty level.
  - Authorizes IHCPs in all states to receive Medicaid reimbursement for health care services delivered to AI/ANs
  - Extend full federal funding through 100% FMAP to states for Medicaid services furnished by urban Indian providers
  - Removes the limitation on billing by IHCPs for services provided outside the 4 walls of a tribal clinic

Workforce Development

- Establish HRSA TAC in FY 2021.
- Expand Title 38 authorities to ensure that IHS and tribal facilities can be competitive in the current job market.
- Fund IHCIA 112, 132, and 134 for additional resources to address recruitment and training programs.
- Increase funding in FY 2021 for IHS Indian Health Professionals in the amount of $10 million to fund scholarships and support Loan Repayment Program

Elders Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Elders and Long Term Care

- Congress must fund long term care services, assisting living services, hospice care and home/community-based services (*all authorized under IHCIA for AI/AN people*)

- HHS/CMS/IHS must create an encounter rate (*or enhanced rate*) for tribal nursing homes

- Congress must increase funding to IHS or ACL for elder access to no-cost eyeglasses

Behavioral Health Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Behavioral Health (Mental Health & Substance Use)

- Increase support for AI/AN youth inpatient and outpatient mental health and substance use services
- Support funding for the IHS Behavioral Health Programs for Indians
- Strengthen partnerships for integrated care between behavioral health and medical care teams
- Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/Ans with Substance Use Disorder (SUD)
- SAMHSA –
  - Accessible funding, tele-behavioral health, youth-focused, National BH agenda

Community Health Aide & Oral Health Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Community Health Aide Program Nationalization & Dental Health Aide Therapists

- Support continued funding for Community Health Aide Program (CHAP) expansion in FY 2022
- Support continued funding for the Community Health Representative (CHR) program
- Implement nationalization of CHAP in the Portland IHS Area (NPAIHB/CRIHB Joint Res No. 17-04-09)
- Support tribes to authorize/license/certify CHAP providers
- Creation of permanent series and classification of position descriptions for DHA/Ts and CHA/Ps in federally-operated facilities

Public Health Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

COVID-19 (Vaccine)

- Hold agencies accountable to conduct ongoing and meaningful tribal consultation on all COVID-19 vaccine policies and plans
  - Ensure access to all 3 options to receive vaccine: federal, state and local
  - Ensure that tribes have resources needed to receive and store vaccine
- Honor tribes' authority to determine service & priority populations
- HHS and IHS must provide funding and infrastructure support to tribes for vaccine reporting

HCV & HIV Treatment and Funding

- For HCV, ensure that all AI/AN patients with HCV at I/T/U facilities have access to treatment
- Ensure that Indian Country is included in *Ending the HIV Epidemic Funds*
- IHS to support creation of a funding mechanism to receive Minority AIDS Initiative (MAI) funding for distribution via the Office of Infectious Disease and HIV/AIDS Policy
- For State Medicaid Agencies, make HCV treatment a clinical priority and ensure access to medications to all persons with medical need
  - as determined per American Association for the Study of Liver Diseases (AASLD) guidelines (NPAIHB Res No. 18-02-03)
- Ensure Administration's National Plan for HIV Elimination is inclusive of tribes and AI/AN communities

Public Health

- Appropriate funding directly to tribes for tribal public health infrastructure
- Develop Tribal Public Health capacity; equitable access to services & gradual capacity improvement
- Authorize Public Health Emergency Fund established through the Secretary of HHS that tribes can access for tribally-declared public health emergencies
  - analogous to tribal disaster declarations to access FEMA funding
- Fund Tribal EpiCenters to fulfill their role as a Public Health Authority
  - Outlined in IHCIA for activities such as technical assistance, capacity building, evaluation, public health surveillance, etc.
- Provide targeted funding to CDC for tribes to increase asthma treatment programs
  - Education and remediation of environmental triggers associated with poor asthma control and housing-related environmental hazards.
- Ensure equity in funding to address social and economic factors that impact health (SDoH)
  - Support programs like Good Health and Wellness in Indian Country and invest in MCH programs

Veterans Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Veterans

- On Reimbursement agreements:
  - Pass legislation to preserve and strengthen VA reimbursement agreements
  - Ensure reimbursement at the OMB encounter rate & allow VA reimbursement of Purchased and Referred Care (PRC) dollars for specialist care to AI/AN veterans
- Streamline and improve process for establishing reimbursement agreements between the VA and tribal health programs
- Increase outreach & advocacy resources to ensure all AI/AN veterans are eligible for health care benefits available in their community including veterans' care coordination and mental health care needs
- Support and improved interoperability of the EHR for IHS, VA, and DOD
- Pass legislation creating VA Tribal Advisory Committee (NPAIHB Res No 19-04-11)
  - See HR 7105 and HR 6237

Youth Committee

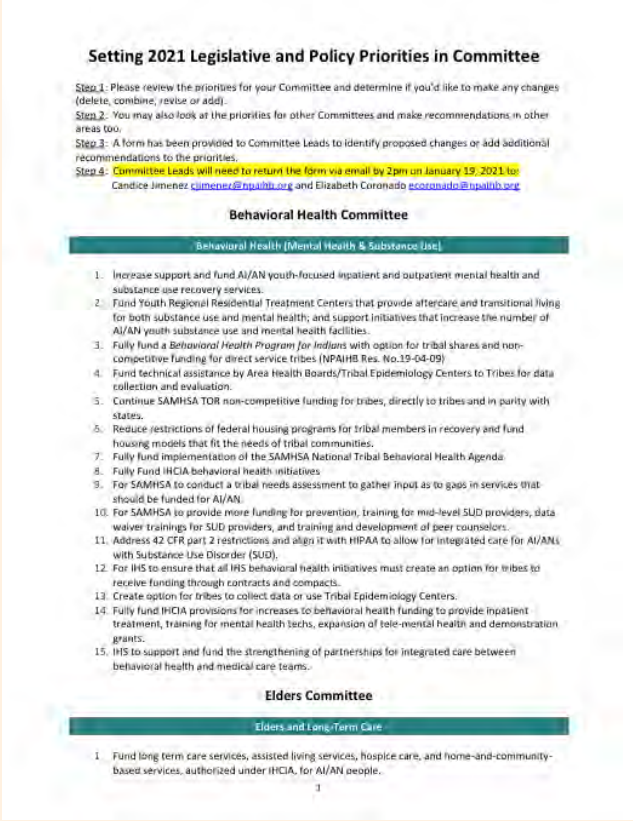
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Youth

- **Fund initiatives that provide for AI/AN adolescents & young adults:**
  - Fund tribes to invest in safe and secure environments; places to live, learn and play (*Safe schools, wellness centers, clinics, homes, social wraparound/coordinated care programs and services*)
  - Funds IHS Tribal Epi Centers to improve tribal capacity to support adolescent youth
- **Prepare AI/AN youth in taking an active role in their own health and wellbeing**

2021 Policy Priorities - Development

- **Committee instructions**
  - Review 2020 Leg & Policy requests and Biden transition priorities
  - Discussion during Committee on any additions/changes to 2021 policy requests
  - Committee leads will compile those changes/additions and return to Liz/Candice



Setting 2021 Legislative and Policy Priorities in Committee

Step 1: Please review the priorities for your Committee and determine if you'd like to make any changes (delete, combine, revise or add).
Step 2: You may also look at the priorities for other Committees and make recommendations in other areas too.
Step 3: A form has been provided to Committee Leads to identify proposed changes or add additional recommendations to the priorities.
Step 4: Committee Leads will need to return the form via email by 2pm on January 19, 2021 to: Candice Jimenez cjimenez@npaihb.org and Elizabeth Coronado ecoronado@npaihb.org

Behavioral Health Committee

Behavioral Health (Mental Health & Substance Use)

1. Increase support and fund AI/AN youth-focused inpatient and outpatient mental health and substance use recovery services.
2. Fund Youth Regional Residential Treatment Centers that provide aftercare and transitional living for both substance use and mental health; and support initiatives that increase the number of AI/AN youth substance use and mental health facilities.
3. Fully fund a *Behavioral Health Program for Indians* with option for tribal shares and non-competitive funding for direct service tribes (NPAIHB Res. No.19-04-09)
4. Fund technical assistance by Area Health Boards/Tribal Epidemiology Centers to Tribes for data collection and evaluation.
5. Continue SAMHSA TOR non-competitive funding for tribes, directly to tribes and in parity with states.
6. Reduce restrictions of federal housing programs for tribal members in recovery and fund housing models that fit the needs of tribal communities.
7. Fully fund implementation of the SAMHSA National Tribal Behavioral Health Agenda
8. Fully Fund IHCIA behavioral health initiatives
9. For SAMHSA to conduct a tribal needs assessment to gather input as to gaps in services that should be funded for AI/AN.
10. For SAMHSA to provide more funding for prevention, training for mid-level SUD providers, data waiver trainings for SUD providers, and training and development of peer counselors.
11. Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/ANs with Substance Use Disorder (SUD).
12. For IHS to ensure that all IHS behavioral health initiatives must create an option for tribes to receive funding through contracts and compacts.
13. Create option for tribes to collect data or use Tribal Epidemiology Centers.
14. Fully fund IHCIA provisions for increases to behavioral health funding to provide inpatient treatment, training for mental health techs, expansion of tele-mental health and demonstration grants.
15. IHS to support and fund the strengthening of partnerships for integrated care between behavioral health and medical care teams.

Elders Committee

Elders and Long-Term Care

1. Fund long term care services, assisted living services, hospice care, and home-and-community-based services, authorized under IHCIA, for AI/AN people.

1

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Mich gayis / Tai itukdi – Thank you!

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Confederated Tribes of Warm Springs

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

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2020 Legislative and Policy Requests

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, vision and values 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." In order to achieve this vision, NPAIHB delegates respectfully ask that lawmakers and policy makers consider the following values in all legislative and policy initiatives.

Tribal Sovereignty. The government-to-government relationship and treaty and trust obligations require meaningful tribal consultation on all initiatives impacting tribes and AI/AN people. Meaningful tribal consultation involves an open exchange of information, discussion and decision-making by tribes and the federal government.

***Traditional Knowledge*.** In AI/AN communities, health and wellness involves multiple facets of life including the environment, space, and health of the earth. Conceptual framework for treating health among AI/AN people should include the dimensions of caring, traditions, respect, connection, holism, trust, and spirituality. Overall and holistic health promotion and disease prevention are core to the health and well-being of the AI/AN seventh generation and must be included in all initiatives.

Culture as Health Promotion. Cultural and traditional interventions must be incorporated alongside existing health care promotion efforts to ensure a culturally tailored and culturally relevant approach to health promotion, prevention and health care delivery for AI/AN people. Inclusion of all community members from our children to our elders will promote wellness and healing across all generations.

With these values in mind, NPAIHB makes the following legislative and policy requests:

Indian Health Service Funding

Fully Fund the Indian Health Service (IHS). IHS is significantly underfunded compared to other federal health agencies. Funding for IHS is in fulfillment of the federal government's treaty and trust obligations to tribes and promise to provide health care to AI/AN people in exchange for peace and land, among other agreements. FY 2020 IHS appropriations included only a 4% increase above FY 2019 enacted level. These small increases year-to-year are not getting IHS closer to full funding.

Recommendations:

- For FY 2021, pursuant to recommendation of National Tribal Budget Formulation Workgroup, fund IHS at $9.1 billion to get IHS up to full funding of $37.6 billion.[1]
- Ensure that annual appropriations include population growth and medical inflation rate increases to maintain current services. For FY 2021, at least $200 million should be appropriated for population growth and medical inflation above 2020.

[1] National Tribal Budget Formulation Workgroup Recommendation, *FY 2021 Summary Recommendations*, https://www.nihb.org/legislative/budget_formulation.php (last visited Jan. 15, 2020).

- Make tribes whole as to 2013 sequestration and restore the $175.7 million that was lost in IHS appropriations.

ISDEAA Section 105(l) Lease Agreements. ISDEAA section 105(l) lease agreements are a growing expense requiring IHS, upon tribal request, to enter into a lease for a facility owned or leased by a tribe or tribal organization. IHS is legally bound to enter into and pay the negotiated full lease compensation under section 105(l). IHS has no separate appropriation or funding source for 105(l) leases. For FY 2018 and FY 2019 IHS has reprogrammed services appropriations to pay for the leases. This results in lost program increases for IHS and tribal facilities that will impact their ability to maintain current services. It is anticipated that IHS will continue to reprogram program increases every year until a separate indefinite appropriation is authorized by Congress.

Recommendation:

- Establish a separate and indefinite discretionary appropriation for ISDEAA Section 105(l) lease funding.

Provide Mandatory Funding for IHS. IHS funding should not be discretionary and should be changed to "entitlement" or "mandatory spending." This would be in alignment with the federal trust and treaty obligations for health care to AI/ANs.

Recommendation:

- Congress must make IHS funding mandatory, no longer subject to the constraints of the annual discretionary appropriations process. (NPAIHB/CRIHB Joint Res 17-04-08).

Amend IHCIA to Authorize 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 last year reduced AI/AN access to care and caused financial harm to IHS employees. This must be prevented in the future through advance appropriations.

Recommendation:

- Congress must enact legislation that would provide advance appropriations to the Bureau of Indian Affairs and Bureau of Indian Education of the Department of the Interior and the Indian Health Service of the Department of Health and Human Services; or legislation that would provide advance appropriations to the Indian Health Service. (NPAIHB Res. No. 19-04-02)

Move the IHS Budget to the Jurisdiction of Labor, Health and Human Services, Education (LHE) and Related Agencies Subcommittee. The LHE Subcommittee handles health care related bills, and understands the complexities of health care delivery, such as medical inflationary rates. The IHS appropriation would benefit by being in the same pool of health expenditures that programs like Medicare, Medicaid, CHIP, and other health programs appropriated out of the LHE Appropriations Subcommittee. The LHE Subcommittee has almost always been allocated appropriation increases that match or exceed medical inflation indexes. While the Interior Appropriations Subcommittee allocations reflect natural resource program inflation rates, which generally fall below medical inflation.

Recommendation:

- Congress should move the IHS budget from the Interior, Environment, and Related Agencies Appropriations Subcommittee to the Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee.

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Special Diabetes Program for Indians

Congress recently extended the Special Diabetes Program for Indians (SDPI) through May 22, 2020 at the current level of $150 million. Since 2004, SDPI has been funded at $150 million with no annual medical inflation increases. It is estimated that SDPI should be funded at over $234.5 million.[2] NPAIHB passed a resolution requesting permanent reauthorization of SDPI at $200 million per year with medical inflation thereafter (# 19-04-12).

In the Portland Area, 40 grantees receive funding under SDPI for diabetes treatment and prevention. These services have resulted in short-term, intermediate, and long-term positive outcomes for AI/AN in the Northwest. In addition, most Northwest Tribes have the expertise and capacity to directly manage SDPI funds and have been requesting an option to receive funds in ISDEAA Title I and Title V compacts and contracts.

Recommendations:

- Congress must permanently reauthorize SDPI at $200 million per year with medical inflation rate increases annually (NPAIHB Res. No.19-04-12); or reauthorize at $200 million for five years with medical inflation rate increases after year one.
- IHS must:
    - Provide an annual full and detailed accounting of IHS funding to headquarters and areas on SDPI funding.
    - Create the option for tribes to receive SDPI funds through Title I or Title V compacts or contracts. (NPAIHB Res. No. 19-04-12).
    - Allow areas to reallocate data infrastructure funds to Tribal Epidemiology Centers to assist tribes in managing their SDPI data.

Health Care Facility Funding

IHS Health Care Facility Construction Priority List. The 2016 IHS/Tribal Health Care Facilities' Needs Assessment Report to Congress stated that the current IHS Health Care Facilities Construction Priority List (Priority List) will not be complete until 2041. At the current rate of appropriations for construction and the replacement timeline, a new 2016 facility would not be replaced for 400 years. 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. In addition, Portland Area Tribes are a decade or two from receiving any funds under the Priority List. Until this funding mechanism is changed, NPAIHB does not support appropriations for IHS Health Care Facilities Construction.

Recommendations:

- Congress must fund the Indian Health Facilities account in the IHS budget to provide construction, repair and improvement, equipment, and environmental health and facilities support for all IHS Areas equitably, and for tribal governments through self-determination contracts and self-governance compacts. (NPAIHB/CRIHB Joint Res No. 17-04-12)

Regional Referral Specialty Care Centers. The Portland Area Facilities Advisory Committee (PAFAC) completed a pilot study in 2009 to evaluate the feasibility of regional referral centers in the IHS system. PAFAC recommends that the first specialty referral center be constructed as a demonstration project under Section 143 in the IHCIA.

[2] According to the U.S. Bureau of Labor Statistics average prices for medical care increased by 56.3% from 2004-2018 due to medical inflation

The facility would provide services such as medical and surgical specialty care, specialty dental care, audiology, physical and occupational therapy as well as advanced imaging, and outpatient surgery. It is anticipated that this facility could provide services for approximately 50,000 users within the regional service area as well as an additional 20,000 in telemedicine consults.

Recommendation:

- Congress must appropriate funding to demonstration projects under Section 143 so that Portland Area Tribes can move towards establishing a Regional Referral Specialty Care Center.

Small Ambulatory Grants Program and Joint Venture Funding. The Small Ambulatory Grants Program (SAP), IHCIA Section 305, provides funding for construction, expansion, or modernization of ambulatory health care facilities located apart from a hospital. In the Portland Area, this could mean replacing old, worn out trailers that serve as the health clinics in tribal communities with a small modern clinic facility. However, funding under SAP does not include staffing packages.

Joint venture, under ICHIA Section 818, authorizes IHS to partner with tribes or tribal organizations on health care facility construction projects. Through this program, tribes or tribal organizations are able acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for a period of 20 years. Tribes must use tribal, private or other available (non-IHS) funds to design and construct the facility. IHS then submits requests to Congress for funding for the staffing, operations, and maintenance of a facility pursuant to joint venture agreement requirements.

Recommendations:

- Congress must increase funding for Small Ambulatory Program Grants to support new facilities construction and include funding for staffing packages.
- Congress must increase funding for joint venture projects.

Patient Protection and Affordable Care Act / Indian Health Care Improvement Act

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.

Threats to the ACA are concerning to tribes because of the permanent authorization of the Indian Health Care Improvement Act (ICHIA) with the ACA. IHCIA has improved workforce development and recruitment of health professionals, provided new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs, and created opportunities to improve access and financing of health care services for AI/ANs. Two areas with significant need, authorized under IHCIA but not funded or fully funded, are long term care and behavioral health, respectively.

Recommendations:

- Congress must protect the ACA and IHCIA to ensure tribes and tribal members continue to obtain the benefits of these laws.

- Congress must fully fund ICHIA, including long term care, recruitment and retention, and behavioral health.
- Fund Tribal Epidemiology Centers 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.

Elders and Long Term Care

AI/ANs are living longer, with more functional disabilities, suggesting a growth for the population needing long-term care. In the Northwest, 1 – 2.9% of all AI/AN people are aged 65 and older, and the elder population is growing. AI/ANs older than aged 65 report their health as fair or poor more often than the overall population aged 65 and older. Our tribes want to keep elders in their homes and communities but they need funding opportunities that support hospice care, assisted living, long-term care ,and home-and-community based services. While IHCIA authorized the Secretary of HHS to fund these services, no funding has not been appropriated for these services.

In addition, American Indians are more likely to have poor eyesight from biological factors, such as a higher rate of refractive error and astigmatism, both easily corrected with eyeglasses. While some IHS/tribal facilities may provide eyeglasses, some do not have funding to do this.

Recommendations:

- Congress must fund long term care services, assisted living services, hospice care, and home-and-community-based services, authorized under IHCIA, for AI/AN people.
- HHS/CMS/IHS must create an encounter rate or enhanced rate for tribal nursing homes to overcome the significant payment-to-cost gap and provide hospice care.
- Congress must increase funding to IHS or ACL to ensure that elders have access to eyeglasses at no cost.

Behavioral Health (Mental Health & Substance Use)

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. 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.

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 begin to address the opioid epidemic in their communities; 28 of the 43 tribes applied through an NPAIHB consortium. While this funding has been supportive, it is mainly focused on Medication Assisted Treatment (MAT) which cannot comprehensively address the needs of AI/ANs related to opioid use, so broader funding opportunities with a broader array of services must be considered by SAMHSA.

Recommendations:

- Congress must:
    - Fund SAMHSA and IHS for AI/AN youth-focused prevention, treatment, recovery services.

- Increase SAMHSA and IHS 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 YRTCs.
- Fully fund the IHS Behavioral Health Program for Indians at $150 million with option for tribal shares (ISDEAA Title I and Title V contracts and compacts) and non-competitive funding for direct service tribes, with inclusion of prevention services, and cultural and traditional healing practices as evidence-based practices; and fund the provision of technical assistance by Area Health Boards/Tribal Epidemiology Centers to Tribes for data collection and evaluation. (NPAIHB Res. No.19-04-09).
- Enact legislation change that would allow all IHS behavioral health initiatives to be funded through tribal shares (ISDEAA Title I and Title V contracts and compacts).
- 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.
- 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.
- Fully Fund IHCIA 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.
- Enact and fund legislation that supports an AI/AN mentorship and training program for master's level programs (MPH, MSW, Indian/Tribal Law) with a focus on cultivating AI/AN professionals who are proficient on indigenous knowledge, tribal best practices, harm reduction, chemical dependency.
- Increase housing opportunities (increase funding and housing communities such as tiny homes and/or change housing restrictions) for AI/AN to access housing when they are in recovery.

- SAMSHA must:
  - Provide more funding for prevention, training for mid-level SUD providers, data waiver trainings for SUD providers, and training and development of peer counselors.
  - Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/ANs with Substance Use Disorder (SUD).
  - Support a compendium of tribal best practices (e.g., Oregon has done this through statute) that can be funded through grant initiatives.

Medicaid/CHIP

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

Recommendation:

- Congress must continue to honor the federal trust responsibility for Indian health care by protecting 100% FMAP for services received through the Indian health system (NPAIHB/CRIHB Joint Res No. 17-04-04).

Medicaid Initiatives. 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. For example, Medicaid work and community engagement requirements under 1115 waivers should not be left to the states to decide, but rather, HHS/CMS should provide an AI/AN exemption.

Most recently, Northwest Tribes are also concerned about recent guidance issued by CMS to states that support block granting. On January 30, 2020, CMS released a State Medicaid Director (SMD) Letter announcing the Healthy Adult Opportunity (HAO) initiative. The initiative invites states to submit 1115 waivers that set caps on Medicaid spending in exchange for increased program flexibility. Tribes are concerned about the impact to AI/AN beneficiaries in states that chose to implement this option.

Recommendations:

- HHS, CMS and states must:
    - 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 such as block granting and demonstration projects.
    - 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.
- Tribes are behind legislation(NPAIHB Res. No. 19-01-02). that support Medicaid program initiatives that meet the unique circumstances of the Indian health care system and Indian country. Congress must enact legislation that:
    - Creates the authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level;
    - Authorizes Indian Health Care Providers in all states to receive Medicaid reimbursement for health care services delivered to AI/ANs under IHCIA;
    - Extends full federal funding through 100% FMAP to states for Medicaid services furnished by urban Indian providers;
    - Excludes Indian-specific Medicaid provisions in federal law from state waiver authority; and
    - Removes the limitation on billing by Indian Health Care Providers for services provided outside the four walls of a tribal clinic

Community Health Aide Program Nationalization
& Dental Health Aide Therapists

NPAIHB has made great progress on establishing the framework in the Portland Area for Community Health Aide Program Expansion. The Portland Area has 12 Dental Health Aide Therapists working within Northwest Tribes and one more graduating from the Alaska program in June. There are also two Northwest tribal members in the Alaska Behavioral Health Aide education program and six more students starting in August. NPAIHB is also working on a establishing a Dental Health Aide Therapist education program in Washington state with the first cohort of students in FY 2021, and developing a Behavioral Health Aide education program with tribes in both Oregon and Washington.

Recommendations:

- Congress must:
  - Fund national expansion of CHAP in the lower 48 at $20 million for FY 2021 and ensure IHS direct service facilities are included in the expansion.
  - Support $5m of $20m for CHAP expansion in FY 2021 for Portland Area CHAP demonstration project.
- IHS must:
  - Support Portland Area CHAP demonstration project.
  - Finalize the IHS interim CHAP policy and support the development of regional certification boards with federal baseline standards that at a minimum meet Alaska CHAP standards for consistency of services provided by any CHAP program.
  - Create a permanent series and classification of position descriptions for all CHAP providers to be utilized in federally operated facilities
- In states of OR and WA:
  - Pass legislation that authorizes statewide practice of DHATs.

IHS IT Modernization

RPMS is now a legacy system and is inconsistent with emerging architectural electronic health record (EHR) standards. NPAIHB recognizes that the Veterans Administration's (VA) decision to move to a new Health Information Technology solution will create a gap for the parts of RPMS that are dependent on core coding from the VA. RPMS cannot meet these evolving needs without substantial investment in IT infrastructure and software.

Portland Area Tribes were disappointed that the IHS IT Modernization research project conducted in FY 2019 did not include any site visits to Portland Area IHS/Tribal facilities so the report issued does not reflect the IT profile of IHS/tribal facilities in our area. As IHS implements the first phases of the IT Modernization project, it must continue to conduct tribal consultation to ensure all areas needs are represented.

Recommendations:

- For FY 2021, NPAIHB recommends funding at $25 million for planning and phased-in maintenance of RPMS with ongoing tribal consultation and funding for support and technical assistance, with consideration of tribes that have purchased commercial off the shelf systems.
- In any modernization or phased-in replacement of RPMS, IHS must:
  - Conduct tribal consultation in each IHS area in its efforts to modernize or initiate a phased-in replacement of RPMS.

- Provide ample transition period, training, and technical assistance to IHS and tribal facilities once a decision is made.
- 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.
- Consider that many tribal facilities have purchased commercial off the shelf systems and are using tribal resources for upgrades, technical support and maintenance. IHS must take into consideration the main barriers of an EHR system for our tribes on a COTS system include costs, reporting, various ways of tracking, purchased and referred care (PRC) and integration.

Veterans

AI/ANs serve in the U.S. Armed Forces at higher rates per capita, are younger as a cohort and have a higher concentration of female servicemembers compared to all other servicemembers, yet they are underrepresented among veterans who access the services and benefits they have earned. In FY 2016, the National Center for Veterans Analysis and Statistics counted approximately 11,028 AI/AN veterans in the Northwest. AI/AN veterans are more likely to lack health insurance and to have a disability, service-connected or otherwise, than veterans of other races. In addition, Indian country has long recognized the growing concerns and frustrations of AI/AN veterans in obtaining coordinated health care services from IHS and the VA. For these reasons, the VA must work with IHS and tribes to address the health care needs of AI/AN veterans and fulfill the federal trust responsibility.

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. Moreover, tribal health programs use purchased referred care (PRC) dollars to pay for third party specialty care of AI/AN veterans, but do not get reimbursed from the VA for the specialty care. In addition, current regulatory barriers for AI/AN veterans' access to care include: restrictions on specialty care, assessment of co-pays, duplicative processes, overly-burdensome administrative requirements, lack of care coordination, and delayed access to care. With the VA transition to the Cerner EHR system there is a concern that further coordination of care issues could arise. Lastly, when AI/AN veterans leave the military, they are in need of culturally responsive transition services to integrate back into their communities. Establishing a VA Tribal Advisory Committee (TAC) through legislation would allow for many of these AI/AN veterans' care issues to be addressed.

Recommendations:

- As to reimbursement agreements:
  - Congress must pass legislation to preserve and strengthen VA reimbursement agreements, ensure reimbursement at the OMB encounter rate, and allow VA reimbursement of Purchased and Referred Care (PRC) dollars for specialist care to AI/AN veterans.
  - 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.
- As to AI/AN veterans' care coordination and needs:
  - VA must reduce barriers that further exacerbate AI/ANs ability to access care, and focus on improved care coordination for AI/AN veterans.
  - VA must enhance coordination of VA efforts regionally between VA facilities, states, Veterans Integrated Service Networks (VISNs), and tribes.
  - VA must conduct a tribal-specific needs assessment of AI/AN veterans in the twelve IHS Areas.

  - VA must work with the Department of Defense (DOD), IHS and tribes to create and expand culturally responsive transition services for AI/AN soldiers leaving the military and transitioning into civilian life following discharge, separation, or retirement.
- VA must engage IHS and tribes prior to the phased-in implementation of the Cerner EHR system to ensure there are no gaps in care coordination for our veterans.
- Congress must pass legislation creating a VA Tribal Advisory Committee (TAC) (NPAIHB Res No 19-04-01).

HCV and HIV Treatment and Funding

Hepatitis C (HCV) Treatment at IHS. The NPAIHB seeks to carry out the NPAIHB/CRIHB joint resolution #17-04-11 to eliminate Hepatitis C (HCV) among AI/AN people by "providing access to HCV treatment without restrictions" which was also enacted by the Affiliated Tribes of Northwest Indians (ATNI) and the National Congress of American Indians (NCAI). AI/ANs are disproportionately affected by HCV and have both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any US racial/ethnic group. 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.

Recommendations:

- Congress and IHS must 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.
- Congress must appropriate at least $120 million to IHS to provide HCV treatment to AI/AN patients.

Minority AIDS Initiative (MAI). MAI was established to respond to the growing concern about impact of HIV/AIDS on racial and ethnic minorities and address social disparities for communities of color. Congress appropriates annual MAI funding in the Labor, Health and Human Services, Education and Related Agencies (LHE) appropriations bill. The vast majority of MAI funds is directed to Department of Health and Human Service (HHS) agencies that serve racial and ethnic minority groups. Currently, the MAI allocates resources to CDC, HRSA, NIH, SAMHSA, and OMH. IHS does not have the eligibility to receive MAI dollars. It is not clear why this exclusion persists. Without direct appropriations to IHS of MAI dollars, IHS will have far reaching and harmful impacts on Indian Country's ability to maintain ongoing HIV/AIDS and HCV prevention, treatment, and outreach efforts.

Recommendation:

- Congress must enact legislation that authorizes IHS to receive MAI dollars.

Minority HIV/AIDS Fund (MHAF). Congress appropriates an average of $50 million to the Office of the HHS Secretary for General Department Management (GDM) to MHAF. The HHS Secretary delegates these funds to other agencies to be used for MAI-related activities, which support programs that distinctly target communities of color. In FY 2019, $7.9 million of MHAF dollars were allocated to IHS for HIV/AIDS and HCV prevention, treatment, outreach and education – out of the total $53.9 millions of SMAIF dollars. MHAF has created long-lasting and impactful programs in Indian Country, such as WERNATIVE.org, Indian Country ECHO and HealthyNativeYouth.org. Continued appropriation to MHAF and inclusion of Indian Country in allocation of these dollars is necessary to maintain staffing, capacity, and organizational infrastructure to address health disparities for not only our

Northwest Tribes, but also Tribes across Indian Country. Any elimination of MHAF funding for IHS will dissolve almost all current HIV and HCV efforts and programs in Indian Country.

Recommendation:

- Congress must fund MHAF for FY 2021 at $60 million for FY 2021 with at least $10 million targeted for the IHS.

Ending the HIV Epidemic: A Plan for America. On February 5, 2019, the President in his State of the Union announced his Administration's goal to end the HIV epidemic in the United States within 10 years. In order for tribes and AI/AN people to be included in the *Ending the HIV Epidemic: A Plan for America* funding must be allocated to IHS, Tribal and Urban Indian Programs to develop infrastructure and systems to diagnose, treat, prevent and respond to the HIV Epidemic. In FY 2020, $25 million was proposed in the President's IHS budget but final appropriations for IHS did not include this funding. We are deeply concerned that lack of funding for *Ending the HIV Epidemic* in Indian Country will likely lead to continued HIV health disparities and health outcomes for AI/AN people.

Recommendations:

- Congress must fund IHS at $25 million dollars in FY 2021 to support *Ending the HIV Epidemic* in Indian Country.
- HHS must ensure that the Administration's national plan *Ending the HIV Epidemic* is inclusive of tribes and AI/AN people as to eligibility, geography, as well as culturally specific education, prevention programs, and linkage to appropriate medical care.

Public Health

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.

Recommendations:

- Congress must appropriate funding directly to tribes for tribal public health infrastructure.
- HHS, CDC, IHS, and states must develop Tribal Public Health capacity, including equitable access to services and gradual capacity improvement.
- Congress must authorize a Public Health Emergency Fund established through the Secretary of Health and Human Services that tribes can access for tribally-declared public health emergencies (analogous to tribal disaster declarations to access FEMA funding).
- Fund Tribal Epidemiology Centers 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.
- State legislators must continue to provide funding at the state level for Washington Foundational Public Health Services and Oregon Public Health Modernization, including specific support to and involvement of tribes and tribal organizations.

Environment & Health Effects. In the Northwest, AI/AN people have rates of asthma nearly double that of the general population. They are more likely to report having asthma symptoms everyday as well as health status in the "fair" or "poor" category. AI/AN people are also exposed to many other contaminants within their communities (uranium, lead, etc.) and some within their homes (methamphetamine exposure). In addition, many tribes are located within areas that have been designated as Super Fund sites by EPA or experienced contamination from pesticides or other commercial activities which have contaminated surface and ground water in many tribal communities.

Recommendation:

- Congress must provide targeted funding to CDC and IHS for tribes to increase asthma treatment programs including education and remediation of the environmental triggers associated with asthma control, and for housing-related environmental hazards.

Workforce Development

Both IHS and tribally operated facilities have difficulty with recruitment and retention of qualified medical providers. Due to lack of funding, many recruiter positions have been abolished and those responsibilities have transferred to full time staff, making it difficult to devote meaningful time to these activities. In addition, not enough funding is provided for the IHS Scholarship Program and the Loan Repayment Program to assist with recruitment. It has been estimated that $33 million is needed for Indian Health Professions to fully fund the IHS Scholarship Program and Loan Repayment Program for all eligible applicants.

Recommendations:

- Congress must:
    - Expand Title 38 authorities for market pay for all provider positions including physician assistants to ensure that IHS and tribal facilities can be competitive in the current job market.
    - Fund IHCIA sections 112, 132 as well as 134, which would also provide additional resources to address recruitment as well as training programs to increase American Indian representation in provider positions.
    - Increase funding in FY 2021 for IHS Indian Health Professions in the amount of $10 million to fund scholarships for qualified applicants to IHS Scholarship Program and to support the Loan Repayment Program to fund physicians, nurse practitioners, physician's assistants, nurses and other direct care practitioners (NPAIHB Res. No.18-03-07).
    - Fund opportunities for leadership development and workforce development programs for AI/AN youth/adolescents.
- HHS agencies must partner with IHS and tribes to create funding opportunities specifically for the design and implementation of CHAP, BHA, DHAT education programs in partnership with tribes and education institutions.
- HRSA must be a key partner in working with tribes and IHS to support recruitment and retention efforts for tribal clinics and create set-asides for tribes. Funding opportunities must be streamlined and flexible as to HRSA grant application process for tribes with enhanced technical assistance.

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.

Recommendations:

- Congress and the Administration must:
  - Fund initiatives that provide safe environments for AI/AN adolescents, including safe schools, wellness centers, clinics, homes, and other social service programs, so that AI/AN adolescents have secure places to live, learn, and play.
  - Fund 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.
  - Fund IHS Tribal Epi Centers to improve tribal capacity to support adolescent health.

Prepared by the Northwest Portland Area Indian Health Board, 2121 S.W. Broadway Ave., Suite 300, Portland, OR 97201. For questions or additional copies, contact Laura Platero, Executive Director at (503) 416-3276 or email lplatero@npaihb.org or visit www.npaihb.org.

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.

Legislative and Policy Update

January 19, 2021

NPAIHB Quarterly Board Meeting

virtual

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Indian Leadership for Indian Health

Legislative and Policy Update Agenda

- Dental Therapy Legislative Activities
  - Pam Johnson, NPAIHB Native Dental Therapy Initiative
- FY 2021 Appropriations
- Coronavirus Response and Relief Supplemental Appropriations Act, 2021
- Recent Legislation
- New and Pending Federal Policy Changes
- Litigation
- Upcoming Regional and National Meetings

Oregon Dental Therapy Legislation

- HB 2528 allows Oregon Board of Dentistry to license dental therapists who have completed CODA accredited education program, or an education program approved by a state pilot project and passed an exam. Dental therapists could work in all practice settings under general supervision (off-site) with a signed practice agreement with dentist.
- NPAIHB convenes the Oregon Dental Access Campaign, a broad coalition of dental and health care organizations, educators, community organizations and Tribes. More information and a link to the bill at: odac.nationbuilder.com

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Washington Dental Therapy Legislation

- SB 5142 licenses dental therapists statewide, in limited practice settings: FQHCs; hospitals, nursing homes, schools and tribal clinics. Importantly, this allows Urban Indian Programs to hire dental therapists. Private practice settings were removed from this bill in response to lawmaker and opposition concerns. This year's bill also adds additional hours to the preceptorship.
- Tribal dental therapists will still work under the authority of a tribal license, but this bill would offer opportunity for dual licensure. This could allow for patient and community care outside of tribal lands, or care for non IHS-eligible patients.

FY 2021 Appropriations Department of Interior, Indian Health Service

	FY 2020 Final*	FY 2021 Final*	Increase/<Decrease>*
Clinical Services	$ 3,937,831	$ 3,901,877	$ <32,954>
Preventive Health	177,567	178,789	1,222
Other Services	202,807	220,725	17,918
TTL IHS Services	**$4,315,205**	**$ 4,301,391**	**$ 13,817**
Contract Support Costs	820,000	916,000	96,000
Facilities	911,889	917,888	5,999
Section 105 (l) Leases		101,000	101,000
Total	**$ 6,647,094**	**$ 6,236,279**	**$ 189,185**

*All $ in thousands

FY 2021 Appropriations IHS Clinical Services

Clinical Services	FY 2020 Final*	FY 2021 Final*	Increase/<Decrease>*
Hospitals & Clinics	$ 2,324,606	$ 2,238,087	$ <86,519>
Electronic Health Record	8,000	34,500	26,500
Dental Health	210,590	214,687	4,097
Mental Health	108,933	115,107	6,174
Alcohol and SUDS	245,819	251,360	5,757
Purchased/Referred Care	964,819	975,856	11,037
IHC Improvement Fund	72,280	72,280	--
Clinical Services TTL	**$ 3,934,831**	**$ 3,901,877**	**$ <32,954>**

*All $ in thousands

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

$5m for nationalization of CHAP
$2m for DHAT Training in ID, OR, WA, AK

FY 2021 Appropriations IHS Preventive Services

Preventive Services	FY 2020 Final*	FY 2021 Final*	Increase/<Decrease>*
Public Health Nursing	$91,984	$92,736	$752
Health Education	20,568	21,034	466
Community Health Reps	62,888	62,892	4
Immunizations (AK)	2,127	2,127	-
Preventive Services TTL	**$ 177,567**	**$ 178,789**	**$ 1,222**

*All $ in thousands

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

FY 2021 Appropriations – IHS Other Services

Other Services	FY 2020 Final*	FY 2021 Final*	Increase/<Decrease>*
Urban Indian Health	$ 57,684	$ 62,684	$ 5,000
Indian Health Professions	65,314	$67,314	2,000
Tribal Mgmt Grant	2,465	2,465	
Direct Operations	71,538	82,456	10,918
Self-Governance	5,806	5,806	
Other Services TTL	**$ 202,807**	**$ 220,725**	**$ 17,918**

*All $ in thousands

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

FY 2021 Appropriations – IHS Facilities

Facilities	FY 2020 Final*	FY 2021 Final*	Increase/<Decrease>*
Maintenance & Improvement	$ 168,952	$168,952	
Sanitation Construction	193,577	196,577	3,000
Facilities Construction	259,290	259,290	
Facilities/Environmental Health	261,983	263,982	1,999
Equipment	28,087	29,087	1,000
Facilities TTL	**$ 911,889**	**$ 917,888**	**$ 5,999**

*All $ in thousands

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Other FY 2021 Funding for Indian Country

Agency	Amount	Funding Focus
SAMHSA	$ 50m	Opioid Response Grants
SAMHSA	$ 41.5m	Tribal Behavioral Health Grants
CDC	$ 22m	Good Health and Wellness in Indian Country Program
HRSA	$ 15m	National Health Service Corps Officers in the Indian/Tribal/Urban health system
SAMHSA	$ 11m	Tribal set-aside for medication assisted treatment
SAMHSA	$ 2.931m	American Indian/Alaska Native Suicide Prevention Initiative
SAMHSA	$ 2.4m	Tribal set-aside for American Indian/Alaska Native Zero Suicide grants
	+ $ 1.5m	HIV/AIDS Prevention and Treatment Program

Coronavirus Response and Relief Supplemental Appropriations Act, 2021

Agency	Amount	Funding Focus
CDC/IHS	$790 m	COVID testing/tracing and surveillance. Consultation completed 1/8/2021
CDC/IHS	$210 m	Vaccine distribution, education, and COVID expense, Consultation 1/8/2021
FCC	$1 billion	Grants to tribes for broadband
HRSA	$ 1 billion	Addition to the Provider Relief Fund, new FAQ
SAMHSA	$125 m	Tribal set-aside
ACL	$ 7m	Tribal nutrition programs under the Older Americans Act

- Tribal governments have until Dec 31, 2021 to use CARES ACT received
- Unemployment insurance benefits will have addt'l $300/week through Mar 14, 2021
- Provider Relief Fund language changes re expenses and revenue losses

Provider Relief Fund changes

- “Lost revenues attributable to coronavirus” calculated as the difference between the budgeted and actual revenue budget for budgets developed prior to Mar 27, 2020.
- FAQ reverts back to the Jun 2020 guidance.
- “Payment” is defined as a pre-payment, prospective payment or retrospective payment, as determined appropriate by the Secretary

Hobbs, Straus, Dean & Walker Client Memo dated Dec 22, 2020: Congress Releases FY 2021 Funding Legislation and COVID-19 Relief Bill

Recent Legislation

Hill visit Feb 2020

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Legislation Impacting American Indian Alaska Native Veterans

- Other provisions of HR 133 Omnibus Appropriations
  - Tribal grant schools now have access to the Federal Employee Health Benefit program
  - Requires states consult with tribes, tribal organizations, urban organizations, and Native Hawaiian health care systems re. youth suicide intervention and prevention strategies
  - H.R. 4029 "Tribal Access to Homeless Assistance Act" makes tribes and tribally designated housing entities eligible for homeless assistance grants

Legislation Impacting American Indian Alaska Native Veterans

- **H.R. 6237 Proper and Reimbursed Care for Native Veterans Act**
  - Amends Indian Health Care Improvement Act
  - Requires Department of Defense to reimburse for services provided through Purchased/Referred Care

- **H.R. 7105 Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020**
  - Prohibits the VA from collecting copays from AI/AN Veterans
  - Forms a Tribal Advisory Committee at the Veterans Administration
  - Develops a MOU between the IHS and the VA for homeless veterans case management services

Legislation Impacting Special Diabetes Program for Indians

- Special Diabetes Program for Indians
  - Funded at $150m/year
  - Expires Sep 30, 2023

- NPAIHB Policy Positions
  - Permanent reauthorization at $200m/year with medical inflation rate increases (Reso17-03-08, 18-03-06, 19-04-12)
  - Subject to contracting requirements under P.L. 93-638 (Reso 12-03-07)
  - Funding in five year increments (Reso 12-03-07)
  - Contract support costs
  - Funding allocation for new programs should be made through Tribal consultation (Reso 06-04-08)

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Legislation Impacting Urban Indian Organizations

- **Health Care Access for Urban Native Veterans**
  - Adds UIO's to the list of eligible to receive reimbursement from the Veterans Administration for services provided to AI/AN veterans
- **H.R. 6535/S. 3650**
  - Extends Federal Tort Claims Act Coverage to UIO's and employees of UIO's

Recent and Upcoming Consultations

- **IHS Consultation Jan 04, 2021 - $790/$210 m Coronavirus Response Funds**
  - $790m distributed as follows
    - $50m – Urban Indian Organizations
    - $190m – Purchase of COVID-19 tests, test kits, testing supplies, therapeutics, and PPE
    - $550m – Program increases to Hospitals/Clinics, PRC, Alcohol and SUDS, MH, CHR, PH Nursing
  - $210m – expect a DTLL in the near future
- **Health IT Modernization, comments due Jan 24, 2021**
  - Four Options: Stabilize RPMS, Renew RPMS, Selective Replacement, Full Replacement
  - Stabilizing RPMS has to happen, IHS recommends full replacement
  - Current Funding: $8m FY 2020, $65m CARES Act, $34.5m FY 2021 appropriations
  - Full cost estimated between $3 – 8 billion over 10 years
  - Parity with the VA system, tribal decision-making in the project, interfacing, COTS

Recent and Upcoming Consultations

- Section 105(l) leases, FY 2021 appropriations Section 431(a) includes
  - Tribal lease payments to begin no earlier than the date the lease proposal is received
  - Secretaries of the Interior and Health and Human Services directed to hold consultation with tribes and tribal organizations re. the requirements of Section 105(l) leases, consistent and transparent implementation process for the payment of the leases
  - **Consultations will take place in FY 2021**

New and Pending Federal Policy Changes

- **4-Walls Extension moved from Jan 31, 2021 to Oct 31, 2021**
  - IMPACT: More time to make a decision re. Tribal FQHC designation, if necessary (only 9 states have SPA's)
- **HHS Eliminates X-Waiver Requirement for DEA-Registered Physicians for the Administration of Buprenorphine, Jan 14, 2021**
  - IMPACT: Expands access to MAT at tribal clinics
- **Final CMS Interoperability and Prior Authorization Rule, Jan 15, 2021**
  - IMPACT: Requires interoperability/HL7 between insurance companies and providers; 72 hours for urgent prior authorizations (2024)
- **Final SUNSET Rule, Jan 08, 2021**
  - IMPACT: Threatens the stability of specific provision w/in IHS, CMS, CHIP that protect AI/AN people

New and Pending Federal Policy Changes Cont'd

- **Final Medicare Program Changes to Part B Payment Policies, OUD Coverage, Telehealth, Jan 01, 2021**
  - IMPACT: Finalized expansion of Medicare telehealth services for opioid use disorder and other substance use disorders, added telehealth physical and occupational therapy
- **Proposed Modifications to HIPAA**
  - IMPACT: Allows disclosure of PHI to social service programs, reduces paperwork, gives patients right to inspect PHI in person, improves electronic information sharing, eliminates the requirement to obtain a signature on a Notice of Privacy Practices
- **Final Revisions to Safe Harbors under the Anti-Kickback Statute (AKS), Jan 19, 2021**
  - IMPACT: AKS does not provide safe harbors for I/T/U system, see TTAG priorities

Litigation

- **340B Contract Pharmacies**
  - Beginning in Q3 2020, some pharmaceutical manufacturers stopped making discounted drugs available through the 340B program to more than one contract pharmacy
  - Sep 28, 2020 NPAIHB Testimony in HRSA Consultation re impact on Northwest tribes without pharmacies, tribes rely on a network of pharmacies if they do not have a pharmacy (Jamestown S'Klallam, TTAG, NIHB letters)
  - Dec 11, 2020 American Hospital Association+ sued HHS re 340B
  - Dec 30, 2020 HHS Office of General Counsel Advisory Opinion issued, stating that drug manufacturers in the 340B program are required to deliver covered outpatient drugs to contracted pharmacies and to charge no more than the 340B ceiling price for those drugs.
  - Jan 13, 2021 Eli Lilly, Sanofi, and AstraZeneca sued HHS over the General Counsel Advisory Opinion

Litigation Cont'd

- **Contract Support Cost (CSC) Claims**
  - *Sage Memorial,* 2016 court decision finding that IHS owes CSC on health care services funded by third-party revenues.
  - In *Swinomish* and *San Carlos Apache* cases, courts ruled in favor of the IHS. *Swinomish* decision currently on appeal in the D.C. Circuit court. Decision expected soon.
  - IHS has agreed to pay CSC on most COVID-19 funding
- **Opioid Litigation**
  - Over 3,000 plaintiffs, trying to hold opioid manufacturers/distributors accountable for the opioid epidemic
  - Judge has identified specific cases to resolve claims and move toward settlement, including the Cherokee Nation's case.
  - Some defendants, including Purdue Pharmacy, have filed for bankruptcy
  - Movement toward a "global" settlement, Tribal Leadership Committee that HSDW serves on is working toward a "top-line tribal allocation"

Hobbs, Straus, Dean & Walker Article in the NPAIHB Newsletter

Litigation Cont'd

- **Texas vs. United States (Affordable Care Act litigation)**
  - Case heard by the Supreme Court on Nov 10, 2020
  - Appears unlikely that the Court will strike down the entire Affordable Care Act
- **JUUL Litigation**
  - 16 Tribes, one tribal school, and one tribal health organization have sued JULL (e-cigarette manufacturer) along with many non-tribal plaintiffs
  - Deceptive marketing, targeting tribal youth

Hobbs, Straus, Dean & Walker Article in the NPAIHB Newsletter

Biden Administration
Potential Appointments

- Deb Haaland (Pueblo of Laguna) – Secretary of Interior
- Dr. Don Warne, MD (Oglala Lakota) – Surgeon General
- Karina Walters, PhD (Choctaw) – Director, Office of Minority Health
- Mary Smith (Cherokee) – Office of Management/Budget Director or Deputy
- Victor Joseph (Native Village of Tanana)
- Aaron Payment, PhD (Sault Ste. Marie Tribe of Chippewa Indians)
- Terra Branson-Thomas (Muscogee (Creek) Nation)

NPAIHB Policy Resources

- Weekly Legislative and Policy Updates
- Regulations Tracker
- Weekly COVID-19 Call Lists
- 117th Congress Legislation Tracker
- Developing a TAC Call List
- Developing Policy Briefs

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Upcoming Meetings

Jan 25th – 28th	**Affiliated Tribes of Northwest Indians** *virtual*
Jan 26th – Jan 28th	**National Indian Health Board** *virtual*
Feb 11th – 12th	**National Tribal Budget Formulation FY 2023** *virtual*
Feb 21st – 25th	**National Congress of American Indians** *virtual*
Feb 25th – Feb 26th	**Secretary's Tribal Advisory Committee** *virtual*

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Questions or Comments

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Northwest Portland Area Indian Health Board

Established in 1972, the Board is a non-profit tribal organization serving the 43 federally recognized tribes of Oregon, Washington, and Idaho.

INDIAN LEADERSHIP FOR INDIAN HEALTH

NPAIHB: 2015-2020

Vision: Wellness for the 7th Generation

Mission: Eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest tribes in their delivery of culturally appropriate, high quality healthcare.

Goal 1 -	Goal 2 -	Goal 3 -	Goal 4 -	Goal 5 -
Be a national leader in healthcare delivery, and support health infrastructure development for our member tribes.	Strengthen regional and national partnerships to ensure tribal access to the best possible health services.	Maintain leadership in the analysis of health-related budgets, legislation, and policy.	Support health promotion and disease prevention activities occurring among the Northwest Tribes.	Support and conduct culturally-appropriate health research and surveillance among the Northwest Tribes.

Organizational Values: Tribal Sovereignty, Model Leadership, Holistic Health Promotion and Disease Prevention.

Timeline

- **September 2019:** All staff input
- **October:** Share staff-recommended edits to key delegates
- **October:** Brief discussion at October QBM for input from delegates
- **November-December:** incorporated edits/updates and share back to staff and delegates
- **January 2020:** Final plan put on pause at January QBM for involvement of new Executive Director
- ...PANDEMIC...
- **January 2021**: Finalize Strategic Plan for Approval

Goals for Update

- Streamline document
- Align with new electronic monthly activity reports (E-MARs)
- Include missing areas not reflected in current strategic plan, including COVID response
- Address major themes from staff and Delegate input collected in 2019
- Reflect vision of the new Executive Director and Executive Committee

Summary:
Staff and Delegate Input 2019

Summary of Staff Input

- Improve NPAIHB Activity collection and Reporting (E-MARs)
- Internal & External Communication
- External Project Outreach & Community Engagement
- EpiCenter: Tools, Technologies and Software
- Infrastructure: Workforce Development
- Support Delegates and Leadership

Delegates: What are you Proud of?

- NPAIHB and EpiCenter are a national leader in healthcare
- Proud of how we protect tribal Sovereignty (consultation
- State and federal involvement at Board meetings
- State and National Lobbying and Legislative efforts
- NPAIHB Staff
- Leverage collective knowledge to create change
- Tribes are able to access grants from the Board
- The Board is willing to try new efforts
- The Board partners on health research and promotion
- Data drives money – research and surveillance

What can we work on?

- Make sure new Delegates are supported (for both Adults and Youth Delegates)
- Restructure QBM meeting to condense schedule
- Identify the training needs of Health Directors; offer more trainings and education for Health Directors
- TA workshops via webinar on issues (learning how to lobby, learning how to caucus, practice)
- Increased youth participation across the Board's goals – integrating youth
- Robust Health Director meetings
- Increase: Youth, Veteran focus

What can we work on?

- Lobbying – Who do we send to Lobby. They want to see tribal leaders face-to-face
- How do we prepare tribal leaders to lobby and advocate? And get them involved and at the QBM table?
- Give our lobbying packets to other Tribal Leaders.
- Educate them on all aspects of healthcare; its complex
- Passing Resolutions: we never hear how/whether our resolutions are received by NCAI – how can we amplify our voices in those settings? Delegates could attend NCAI.
- Being knowledgeable about our traditional healing practices

5-year Vision

- Expand and support programs addressing: youth, MCH, elders, and veterans
- Tribal support staff need more engagement to support their ideas, training – come to Portland or offer other opportunities for networking
- Develop an Indian Health Leadership Program
- Offer training to Delegates and health Directors. We only get to see the good programs that tribes are doing during site visit… find other ways to highlight and share tribal programs

5-year Vision

- Certification board for CHAPS
- CHR & BHA Training
- Acquire larger facilities - clinics
- Demand facilities construction
- State-wide CHSDA?
- Own our own NPAIHB Building
- Bring in heavy hitters – Invite them to a QBM meeting (Group Health) – Make the pitch to support our programs

10-year Vision

- Expand on the CHAP process to grow our staff in a variety of positions; train staff on-site
- IHS Hospital
- Regional Specialty Referral Center
- Scholarship Program for students
- Hard funding for a training center
- Develop a training program for Indian Policy gurus – training the next wave of policy leaders
- Transfer State and DHHS functions to the Board

10-year Vision

- Full funding at the federal level
- All Delegate seats filled – representation
- Robust research agenda – Native-led and Native-staffed
- Robust Environmental Health program
- Youth Delegate program thriving
- Adolescent Health programs thriving

2020-2025

Discussion:

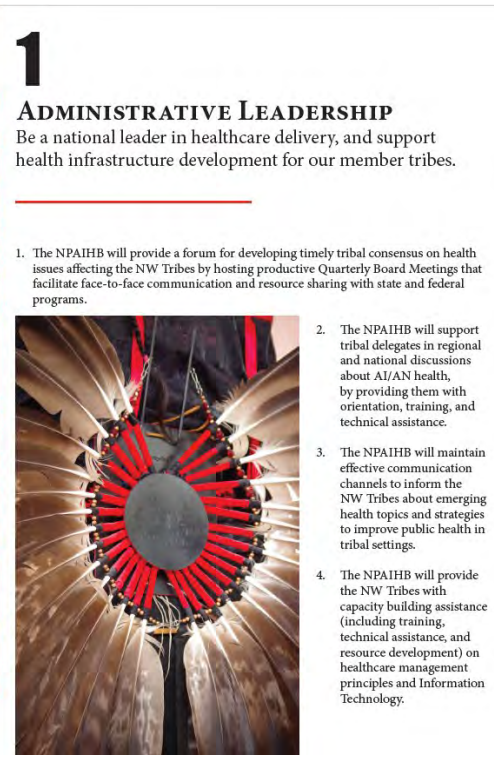
Update Mission Statement

Update Vision

Current Draft – Notable Changes

- Up for Consideration:
  - Update the Vision Statement?
  - Broadened the Mission Statement to make it inclusive of all health promotion strategies (beyond just healthcare)
- Added the 5- and 10-year Organizational Goals (a new section, on page 10)
- Will: Add an Executive Summary from NPAIHB's Executive Director and Chairman

New Design Layout



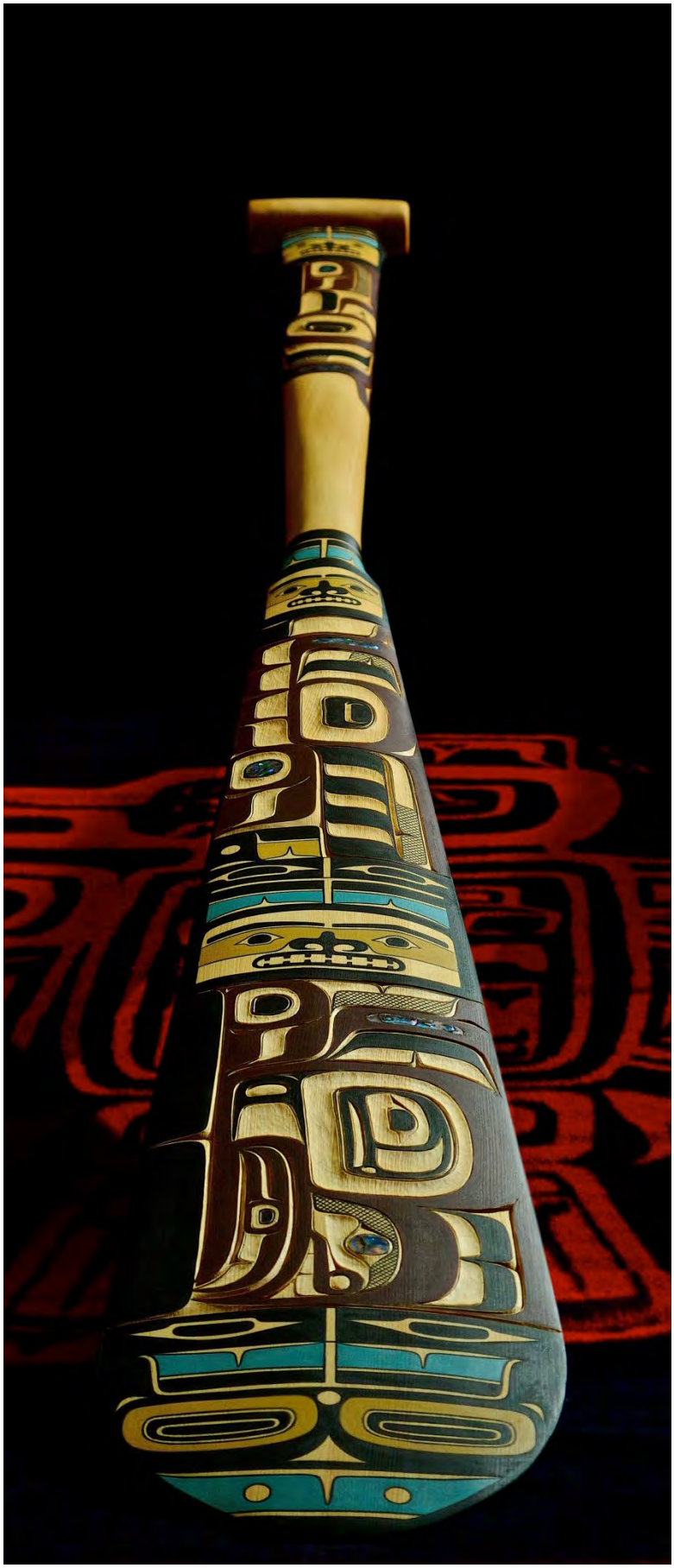
Northwest Portland Area Indian Health Board

Strategic Plan

2016 - 2020

NPAIHB

Indian Leadership for Indian Health



Northwest Portland Area Indian Health Board

The Northwest Tribes have long recognized the need to exercise control over the design and development of health care delivery systems in their local communities. To this end, they formed the Northwest Portland Area Indian Health Board (also referred to as NPAIHB or Board) in 1972. NPAIHB is a nonprofit tribal organization that serves the forty-three federally recognized tribes of Idaho, Oregon, and Washington on health-related issues. Tribes become voting members of the Board through resolutions passed by their governing body. Each member tribe designates a delegate to serve on the NPAIHB Board of Directors.

In keeping with the Board's strong advocacy for tribal sovereignty and control over the design and delivery of their own systems of care, Board delegates meet quarterly to provide guidance and leadership in establishing NPAIHB programs and services. Recognizing the need for accurate, culturally-relevant data, the NW Tribal EpiCenter was established in 1997 to engage the NW Tribes in public health research and surveillance. The NW Tribal EpiCenter houses the Portland Area IHS Institutional Review Board (IRB), which oversees protection of human subjects in research occurring in Northwest Indian communities. The EpiCenter serves as an essential resource for supporting community-based, participatory data collection.

"The Northwest tribes have faced difficult questions and issues, and have consistently put health improvement above all else. We have a bright future and a great team to continue our work."

Joe Finkbonner (Lummi), NPAIHB Executive Director

Executive Summary: 2015-2016 Strategic Plan

Vision: Wellness for the 7th Generation

Mission: Eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest tribes in their delivery of culturally appropriate, high quality healthcare.

Goal 1 - Be a national leader in healthcare delivery, and support health infrastructure development for our member tribes.

Goal 2 - Strengthen regional and national partnerships to ensure tribal access to the best possible health services.

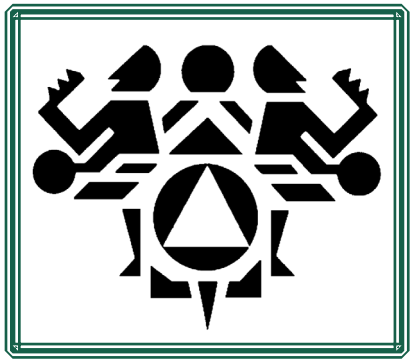
Goal 3 - Maintain leadership in the analysis of health-related budgets, legislation, and policy.

Goal 4 - Support health promotion and disease prevention activities occurring among the Northwest Tribes.

Goal 5 - Support and conduct culturally-appropriate health research and surveillance among the Northwest Tribes.

Organizational Values: Tribal Sovereignty, Model Leadership, Holistic Health Promotion and Disease Prevention.

Mission Statement



The mission of the Northwest Portland Area Indian Health Board is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

Vision for the Seventh Generation

The old people tell us to be careful in the decisions that we make today, as they will impact the seventh generation - our grandchildren's grandchildren. It was the spirit behind this teaching that guides our organization's mission and goals.

The People Spoke: This is their Vision

- The seventh generation will have balanced physical, mental, emotional, and spiritual lifestyles. They will have healthy diets, be fit, active, and happy.
- The seventh generation will live in sovereign communities that are politically effective, assertive, goal-oriented, thriving economically, and run by American Indian/Alaska Native (AI/AN) people.
- The seventh generation will live in a unified and poverty-free community made up of stable, loving families living in adequate housing.
- Children born to the seventh generation will be healthy and free of chemical substances. They will experience strong parenting, mentorship, and positive role models as youth and will become involved and empowered leaders.
- The seventh generation will live in accordance with their traditional values by knowing their native languages and practicing spiritual and cultural traditions.
- The seventh generation will live in a clean environment, have access to an abundance of natural resources, respect all life, and practice sustainable and socially responsible environmental stewardship.
- Every member of the seventh generation will have access to technologically advanced and culturally appropriate healthcare that includes well-equipped clinics, wellness centers, and health education; a health care delivery system that could serve as a national model.
- The seventh generation will have adequate resources to support healthcare delivery.
- The health of the seventh generation will be a model for the general population. They will experience no preventable illness and no substance abuse or addiction. Old age will be the leading cause of death.
- The seventh generation will respect and care for their elders and celebrate as they live to 100 years or more.

Goals and Objectives

GOAL 1: The NPAIHB will be a national leader in healthcare delivery, and will support health infrastructure development for our member tribes.

Objective A. NPAIHB will provide a forum for developing timely tribal consensus on healthcare issues affecting the NW Tribes by hosting productive Quarterly Board Meetings that facilitate face-to-face communication and resource sharing with state and federal programs.

Indicators for Monitoring and Evaluation: NPAIHB will conduct Quarterly Board Meetings at rotating tribal sites. Meeting content and outcomes will be documented in quarterly activity reports.

Objective B. NPAIHB will support tribal delegates in regional and national AI/AN healthcare discussions, by providing them with orientation, training, and assistance.

Indicators for Monitoring and Evaluation: NPAIHB staff will document orientation, training, and capacity building activities in monthly and quarterly activity reports. Delegate training will occur by their 3rd quarterly board meeting.

Objective C. NPAIHB will maintain effective communication channels to inform the NW Tribes about emerging public health topics and strategies to improve healthcare delivery in tribal settings (i.e. integration of mental and physical health systems).

Indicators for Monitoring and Evaluation: NPAIHB projects will post and disseminate health information on a weekly, monthly, or quarterly basis, and will use available tools to evaluate their utility and uptake, including tracking and recording website "hits" and active list-serve subscriptions.

Objective D. NPAIHB will provide the NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on healthcare management principles and Information Technology.

Indicators for Monitoring and Evaluation: NPAIHB staff will document training, health management tools and resources, and IT capacity building activities in monthly and quarterly activity reports.

Objective E. The NPAIHB will actively research health-related funding opportunities, will disseminate funding announcements to member tribes, and will educate federal agencies on strategies to ensure that federal funding opportunities align with the priorities, needs, and organizational capacities of the NW Tribes.

Indicators for Monitoring and Evaluation: NPAIHB staff will produce and circulate a weekly funding report, and will provide grant-writing technical assistance upon request.

Objective F. NPAIHB will build a strong organizational infrastructure by recruiting and retaining high-quality staff, by encouraging their ongoing education and training, and by actively implementing the organization's mission and values to provide employees with comprehensive wellness benefits.

Indicators for Monitoring and Evaluation: NPAIHB will document these policies and practices in its Program Operations manual and HR Procedures manual, and will update these documents on an annual basis.

Objective G. NPAIHB will help develop tribal youth into future leaders in healthcare by making NPAIHB meetings and trainings accessible to youth, and by offering internships to interested students. When appropriate, NPAIHB projects will integrate youth leadership training and travel opportunities into the scope of work of new projects.

Indicators for Monitoring and Evaluation: NPAIHB staff will include student interns, We R Native Youth Ambassadors, and youth leadership activities in monthly and quarterly activity reports.

GOAL 2: The NPAIHB will strengthen regional and national partnerships to ensure tribal access to the best possible health resources and services.

Objective A. NPAIHB will build and maintain effective, collaborative relationships with current and potential partners, including the NW Tribes, the Indian Health Service, Indian organizations, Federal agencies, State Health Departments, Universities, funding agencies, community-based organizations, and other interdisciplinary social service providers that promote AI/AN health.

Indicators for Monitoring and Evaluation: NPAIHB projects will document active relationships with relevant partners, recording meetings and outcomes in monthly and quarterly activity reports.

Objective B. The NPAIHB will actively contribute to regional and national workgroups, coalitions, and committees that address priority health topics identified by the NW Tribes, and key health promotion and disease prevention workgroups.

Indicators for Monitoring and Evaluation: NPAIHB projects will document their contributions to regional and national workgroups, coalitions, and committees in monthly activity reports.

GOAL 3: The NPAIHB will maintain leadership in the analysis of health-related budgets, legislation, and policy, with the ability to facilitate consultation and advocate on behalf of member Tribes.

Objective A. The NPAIHB will facilitate communication among Tribes, Federal and State agencies, and Congress to support tribal sovereignty, promote self-determination, and ensure that government-to-government consultation occurs on health-related budgets, legislation, policies, and services.

Indicators for Monitoring and Evaluation: NPAIHB staff members will document communication activities in monthly and quarterly activity reports and in periodic QBM presentations. Pertinent meeting dates and agendas will be added to the NPAIHB online calendar.

Objective B. The NPAIHB will advocate on behalf of the NW Tribes to ensure that tribal interests are taken into account as health policy is formulated, and that Congress, State legislatures, and external agencies have a full understanding of AI/AN health needs and concerns (particularly in relation to treaty rights and healthcare in Indian Country).

Indicators for Monitoring and Evaluation: NPAIHB staff members will document their advocacy work in monthly and quarterly activity reports and in periodic QBM presentations. Pertinent meeting dates and agendas will be added to the NPAIHB online calendar.

Objective C. The NPAIHB will stay at the forefront of budgetary, legislative, and policy initiatives affecting the NW Tribes, including the President's annual budget, national healthcare reform initiatives, IHS policies and strategies, and proposed changes to Medicare and Medicaid, and will assess their impact on the Northwest Tribes.

Indicators for Monitoring and Evaluation: The NPAIHB Policy Analyst will develop and disseminate timely policy reports and budget enhancement packages using existing NPAIHB communication channels to provide a strong voice on health related issues at the state and national level, assure equitable resource allocation methodologies are in place, and improve the efficient and effective delivery of health services to AI/ANs living in the Pacific Northwest.

Objective D. The NPAIHB will analyze new and existing healthcare delivery systems and will and advocate for tribal consultation and participation in their development.

Indicators for Monitoring and Evaluation: The NPAIHB will document policy analysis and advocacy in monthly and quarterly activity reports and in periodic QBM presentations.

Objective E. The NPAIHB will evaluate the feasibility of assuming certain Portland Area Office programs, functions, services, or activities on behalf of Portland Area Tribes, and if approved and selected, will carry them out in an agreement negotiated under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

Indicators for Monitoring and Evaluation: The NPAIHB will produce a report for tribal leaders and Board delegates outlining the legal and budgetary issues associated with such an assumption, will carry out requisite planning and organizational preparation, and will apply for a planning and negotiation grant if deemed appropriate and applicable.

GOAL 4: The NPAIHB will support health promotion and disease prevention activities occurring among the Northwest Tribes.

Objective A. The NPAIHB will focus its efforts on preventing avoidable morbidity and mortality - promoting the physical, mental, social, and spiritual health of AI/AN people throughout all phases of life.

Indicators for Monitoring and Evaluation: Priority health topics and intervention strategies will be identified on an annual basis by the NW Tribal EpiCenter, and will be considered when seeking new funds and designing new services.

Objective B. The NPAIHB will provide capacity building assistance (including training, technical assistance, and resource development) on priority health promotion and disease prevention topics (i.e. SDPI, MSPI, DVPI, behavioral health and Long Term Care services) and on key public health principles identified by the NW Tribes.

Indicators for Monitoring and Evaluation: NPAIHB projects will document capacity building activities in their monthly and quarterly activity reports, and in articles, newsletters, case studies, and funding reports.

Objective C. NPAIHB projects will support the development, implementation, and evaluation of culturally-relevant health promotion practices within the NW Tribes, and will adapt existing policies, educational materials, curricula, and evidence-based interventions to reflect the traditional values and teachings of the NW Tribes.

Indicators for Monitoring and Evaluation: NPAIHB projects will document these activities in monthly and quarterly activity reports, and in articles, newsletters, case studies, toolkits, and funding reports. Projects will promptly share these resources with the NW Tribes and relevant partners using existing NPAIHB communication channels.

Objective D. To improve tribal awareness about important health topics, the NPAIHB will facilitate community education and public relations efforts by developing social marketing campaigns, cultivating media contacts, and by producing press releases and "expert" health articles for placement in tribal papers.

Indicators for Monitoring and Evaluation: The NPAIHB will maintain up-to-date media contact lists, and will document the dissemination of community awareness materials in monthly and quarterly activity reports.

Objective E. NPAIHB projects will facilitate regional planning and collaboration by developing and implementing intertribal action plans that address priority health topics, and by hosting regional trainings, meetings, webinars, and conference calls that produce a coordinated, regional response to tribal health needs.

Indicators for Monitoring and Evaluation: NPAIHB projects will document regional planning activities and outcomes in their monthly and quarterly activity reports, and in articles, newsletters, case studies, and funding reports.

GOAL 5: The NPAIHB will support and conduct culturally-appropriate health research and surveillance among the Northwest Tribes.

Objective A. The NW Tribal EpiCenter will respond to the needs and interests of the NW Tribes by obtaining regular feedback and guidance from tribal advisory groups, target audience members, and key personnel during all phases of the research process, and by conducting an annual survey to prioritize public health topics, capacity building needs, and research activities.

Indicators for Monitoring and Evaluation: The EpiCenter will document strategies used to obtain community input and guidance in quarterly and annual activity reports.

Objective B. The NW Tribal EpiCenter will assess the health status and health needs of the NW Tribes by conducting culturally-appropriate research and by accessing new and existing AI/AN health data.

Indicators for Monitoring and Evaluation: EpiCenter projects will document quantitative and qualitative research activities in monthly and quarterly activity reports, and will generate or locate data using data collection tools, RPMS, and state and national data sources.

Objective C. The NW Tribal EpiCenter will communicate the results of its research, surveillance, and capacity building activities to appropriate stakeholders. This information will be designed to: 1) assist the NW Tribes in their community outreach activities, public health planning, and policy advocacy; 2) share important findings across Indian Country and extend the scholarly AI/AN research agenda; and 3) increase public awareness about the function and benefits of tribal EpiCenters.

Indicators for Monitoring and Evaluation: EpiCenter projects will document research and surveillance reports, publications, presentations, and other data-sharing activities in quarterly and annual activity reports.

Objective D. The NW Tribal EpiCenter will protect the rights and wellbeing of the NW Tribes and tribal research participants by using and housing the Portland Area IHS Institutional Review Board (IRB). The IRB and EpiCenter projects will recognize tribal research methods and requirements, and will work to ensuring tribal ownership of resultant data.

Indicators for Monitoring and Evaluation: EpiCenter projects will obtain IRB approval before initiating research with the NW Tribes, and will carry out research protocols required by the IRB and the NW Tribes.

Objective E. The NW Tribal EpiCenter will provide the NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on epidemiologic skills and research methods.

Indicators for Monitoring and Evaluation: The EpiCenter will document capacity building activities that address epidemiologic skills and research methods in monthly and quarterly activity reports.

Core Organizational Values

The Northwest Portland Area Indian Health Board:

- Is a tribally driven organization, which respects tribal leadership, recognizes the diverse needs of tribes, is inclusive and equitable, values consensus decision making, and seeks to preserve the unity of Northwest Tribes.
- Acknowledges and actively supports efforts to uphold the federal trust responsibility.
- Is a role model of holistic health (physical, mental, spiritual, and emotional), derived from traditional values – both in personal and organizational behavior.
- Respects the traditional and cultural values of all member tribes and communities.
- Strives to provide service to member tribes at the highest possible standard in the quality of work performed.
- Models leadership, which is visionary, courageous, progressive, hardworking, dedicated, resilient, committed, knowledgeable, creative, respectful, and trusting.
- Provides Northwest Tribes with influential and effective advocacy, which supports tribal sovereignty and strong government-to-government relations.
- Believes in and promotes community education, health promotion and disease prevention.
- Is a credible resource for health-related technical assistance, education, information, and coordination.
- Is family centered and provides for work-family-community balance.
- Acknowledges, respects, and values the wisdom of our tribal elders.

This organization was formed as a result of the President's desire to promote self-determination of Indian people. Its purpose is to advise Indian Health Service in the development and implementation of health care and delivery to Indians in the tristate area of Washington, Oregon and Idaho. It provides resource help and training to Indian Community Health Representatives, health education designed to promote Indian community development and conducts research activities designed to evaluate current government programs and to suggest areas of improvement in current programs of Indian reservations as well as the development of new programs. We are currently providing a monthly Health Newsletter designed to foster inter-tribal communications between the tribes in the Northwest. On-going training is developed in health related areas. Research at the present involves the evaluation of the Indian Health Service Contract Health Service System. We also carry out a counseling and recruitment program for Indian students preparing for health related careers.

Signed by: *Delbert Frank Jr., Violet Hillaire, & Melvin Sampson*

Northwest Portland Area Indian Health Board

Strategic Plan 2020-2025

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Executive Summary

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Background

The Northwest Tribes have long recognized the need to exercise control over the design and development of health care delivery systems in their local communities. To this end, they formed the Northwest Portland Area Indian Health Board (also referred to as NPAIHB or Board) in 1972. NPAIHB is a nonprofit tribal organization that serves the forty-three federally recognized tribes of Idaho, Oregon, and Washington on health-related issues. Tribes become voting members of the Board through resolutions passed by their governing body. Each member tribe designates a delegate to serve on the NPAIHB Board of Directors.

In keeping with the Board's strong advocacy for tribal sovereignty and control over the design and delivery of their own systems of care, Board delegates meet quarterly to provide guidance and leadership in establishing NPAIHB programs and services. Recognizing the need for accurate, culturally-relevant data, the NW Tribal Epidemiology Center (NWTEC) was established in 1997 to engage the NW Tribes in public health research and surveillance. The NWTEC houses the Portland Area IHS Institutional Review Board (IRB), which oversees protection of human subjects in research occurring in Northwest Indian communities. The EpiCenter serves as an essential resource for supporting community-based, participatory data collection. As designated in Title 25 Ch 18 Indian Health Care §1621(m) of the Patient Protection and Affordable Care Act, tribal epidemiology centers are designated public health authorities.

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Our Vision: Wellness for the 7th Generation (current)

Some options for consideration:

Our Vision: Health and Wellness for the 7th Generation

Our Vision: Optimal Health for Tribes in the Pacific Northwest

Our Vision: Optimal Health for American Indian People in the Pacific Northwest

Our Mission: Eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest tribes in their delivery of culturally appropriate, high quality healthcare. (current)

Some options to broaden its scope:

Our Mission: Eliminate health disparities and improve the quality of life of American Indians and Alaska Natives living in the Pacific Northwest.

Our Mission: Eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest tribes in their delivery of culturally appropriate, high quality health programs and services.

Our Mission: Eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest tribes in their delivery of culturally-appropriate health services and public health initiatives.

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Strategic Priorities

1. **Leadership**
   Be a national leader in tribal public health initiatives and support health infrastructure development for our member tribes.

2. **Partnerships**
   Strengthen regional and national partnerships to ensure tribal access to the best possible health resources and services.

3. **Policy and Legislation**
   Maintain leadership in the analysis of health-related budgets, legislation, and policy.

4. **Health Promotion**
   Support health promotion and disease prevention activities occurring among the Northwest Tribes.

5. **Research and Surveillance**
   Support and conduct culturally-appropriate health research and surveillance in partnership with the Northwest Tribes.

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Priority 1: Leadership

Be a national leader in tribal public health initiatives and support health infrastructure development for our member tribes.

1. The NPAIHB will provide a forum for developing timely tribal consensus on health issues affecting the NW Tribes by hosting productive Quarterly Board Meetings that facilitate face-to-face communication and resource sharing with state and federal programs.

2. The NPAIHB will support tribal delegates in regional and national discussions about AI/AN health, by providing them with orientation, training, and technical assistance.

3. The NPAIHB will provide the NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on healthcare management principles and Health Information Technology, when needed.

4. The NPAIHB will maintain effective communication channels to inform the NW Tribes about emerging health topics and strategies to improve public health in tribal settings. To determine preferred channels for delegates, health directors, and other community health advocates, the NPAIHB will develop (and annually update) a communications plan that includes organization branding, channels, and audience.

5. The NPAIHB will maintain a reporting system to generate reports that document how NPAIHB activities align with its strategic plan.

6. The NPAIHB will actively research health-related funding opportunities, will disseminate funding announcements to member tribes, and will educate federal agencies on strategies to ensure that federal funding opportunities align with the priorities, needs, and organizational capacities of the NW Tribes.

7. The NPAIHB will build a strong organizational infrastructure by recruiting and retaining high-quality staff, by encouraging their ongoing education and training, and by actively implementing the organization's mission and values to provide employees with comprehensive wellness benefits.

8. The NPAIHB will help develop tribal youth into future leaders by making NPAIHB meetings and trainings accessible to youth, and by offering internships to interested students. When appropriate, NPAIHB projects will integrate youth leadership opportunities into the scope of work of new projects.

Priority 2: Partnerships

Strengthen regional and national partnerships to ensure tribal access to the best possible health resources and services.

1. The NPAIHB will build and maintain collaborative relationships with current and potential partners, including the NW Tribes, the Indian Health Service, Indian organizations, Federal agencies, State Health Departments, Universities, funding agencies, community-based organizations, and other interdisciplinary social service providers that promote AI/AN health.

2. The NPAIHB will actively contribute to regional and national workgroups, coalitions, and committees that address priority health topics identified by the NW Tribes, and key health promotion and disease prevention workgroups.

3. The NPAIHB will engage with NW tribal communities by sharing best practices during site visits and by actively participating in tribal events when NPAIHB projects and staff are invited.

Priority 3: Policy and Legislation

Maintain leadership in the analysis of health-related budgets, legislation, and policy, with the ability to facilitate consultation and advocate on behalf of member Tribes.

1. The NPAIHB will facilitate communication among Tribes, Federal and State agencies, and Congress to support tribal sovereignty, promote self-determination, and ensure that government-to-government consultation occurs on health-related budgets, legislation, policies, and services.

2. The NPAIHB will advocate on behalf of the NW Tribes to ensure that tribal interests are taken into account as health policy is formulated, and that Congress, State legislatures, and external agencies have a full understanding of AI/AN health needs and concerns (particularly in relation to treaty rights and healthcare in Indian Country).

3. The NPAIHB will stay at the forefront of budgetary, legislative, and policy initiatives affecting the NW Tribes, and will assess their impact on the Northwest Tribes.

4. The NPAIHB will analyze new and existing healthcare delivery systems and will and advocate for tribal consultation and participation in their development.

5. When appropriate, the NPAIHB will assume Portland Area Office programs, functions, services, or activities on behalf of Portland Area Tribes, and will carry them out in an agreement negotiated under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

6. The NPAIHB will provide training and resources for tribal leaders for advocacy on policy initiatives affecting NW Tribes.

Priority 4: Health Promotion

Support health promotion and disease prevention activities occurring among the Northwest Tribes.

1. The NPAIHB will focus its efforts on preventing avoidable morbidity and mortality - promoting the physical, mental, social, and spiritual health of AI/AN people throughout all phases of life.

2. The NPAIHB will provide capacity building assistance (including training, technical assistance, and resource development) on priority health promotion and disease prevention topics and on key public health issues identified by the NW Tribes.

3. NPAIHB projects will support the development, implementation, and evaluation of culturally-relevant health promotion practices within the NW Tribes, and will adapt existing policies, educational materials, curricula, and evidence-based interventions to reflect the traditional values and teaching modalities of the NW Tribes.

4. To improve tribal awareness about important health topics, the NPAIHB will facilitate community education and public relations efforts by developing social marketing campaigns, cultivating media contacts, and by producing press releases and "expert" health articles for placement in tribal papers.

5. NPAIHB projects will facilitate regional planning and collaboration by developing and implementing intertribal action plans that address priority health topics, and by hosting regional trainings, meetings, webinars, Extension for Community Healthcare Outcomes (ECHO) trainings, and conference calls that produce a coordinated, regional response to tribal health needs.

Priority 5: Research and Surveillance

Support and conduct culturally-appropriate health research and surveillance in partnership with the Northwest Tribes.

1. The NWTEC will fulfill the "7 Core Functions" of Tribal Epidemiology Center by assessing the health status and priority health needs of the NW Tribes, conducting culturally-appropriate research, and by accessing new and existing AI/AN health data.
2. The NWTEC will respond to the needs and interests of the NW Tribes by obtaining regular feedback and guidance from tribal advisory groups, target audience members, and key personnel during all phases of the research process, and by conducting an annual survey to prioritize public health topics, capacity building needs, and research activities.
3. The NWTEC will communicate the results of its activities to appropriate stakeholders. This information will be designed to: 1) assist the NW Tribes in their community outreach activities, public health planning, and policy advocacy; 2) share important findings across Indian Country and extend the scholarly AI/AN research agenda; and 3) increase public awareness about the function and benefits of Tribal EpiCenters.
4. The NWTEC will protect the rights and wellbeing of the NW Tribes and tribal research participants by using and housing the Portland Area IHS Institutional Review Board (PA IHS IRB).
5. The Portland Area Indian Health Service IRB and NWTEC projects will recognize and employ tribal research methods and will work to ensure tribal ownership of data.
6. The NWTEC will provide the NW Tribes with capacity building assistance on epidemiologic skills and research methods.

Organizational Values

Tribal Sovereignty

The government-to-government relationship and treaty and trust obligations require meaningful tribal consultation on all initiatives impacting tribes and AI/AN people. Meaningful tribal consultation involves an open exchange of information, discussion and decision-making by tribes and the federal government.

Traditional Indigenous Knowledge

In Indigenous communities, health and wellness involves multiple facets of life including the environment, space, and health of the earth. Conceptual framework for treating health among AI/AN people should include the dimensions of caring, traditions, respect, connection, holism, trust, and spirituality. Overall and holistic health promotion and disease prevention is the key to the health and well-being of the AI/AN seventh generation and must be included in all initiatives.

Culture as Health Promotion

Cultural and traditional interventions must be incorporated alongside existing health care promotion efforts to ensure a culturally tailored and culturally relevant approach to health promotion, prevention and health care delivery for AI/AN people. Inclusion of all community members from our children to our elders will promote wellness and healing across all generations.

Vision for the Seventh Generation

The old people tell us to be careful in the decisions that we make today, as they will impact the seventh generation – our grandchildren's grandchildren. It was the spirit behind this teaching that guides our organization's mission and goals.

5-Year Organizational Goals

- Board leadership will guide and manage organizational growth: Larger Board staff, Acquire own building
- Board staff will offer new avenues to share tribal best practices and feature model programs in the Pacific NW
- QBM meetings will be fully represented by NW Tribes and Youth Delegates, and will be well-attended by other community stakeholders
- Thriving Board programs will address our most vulnerable community members: maternal and child health, youth, elders, and veterans
- Board staff will design and deliver innovative training modalities (in person and virtually) to support Delegates, Tribal staff and clinicians:
  - ECHOs
  - Communities of practice
  - Indian Health Leadership Program
  - Certification Board for CHAPS
  - CHR Training
  - BHA Training
- Our Board will work collaboratively to tackle challenging regional issues, including: Facilities construction, State-wide CHSDA, pandemics, climate change, and environmental health

Commented [SC1]: These are new, brainstormed by Delegates in 2019

10-Year Organizational Goals

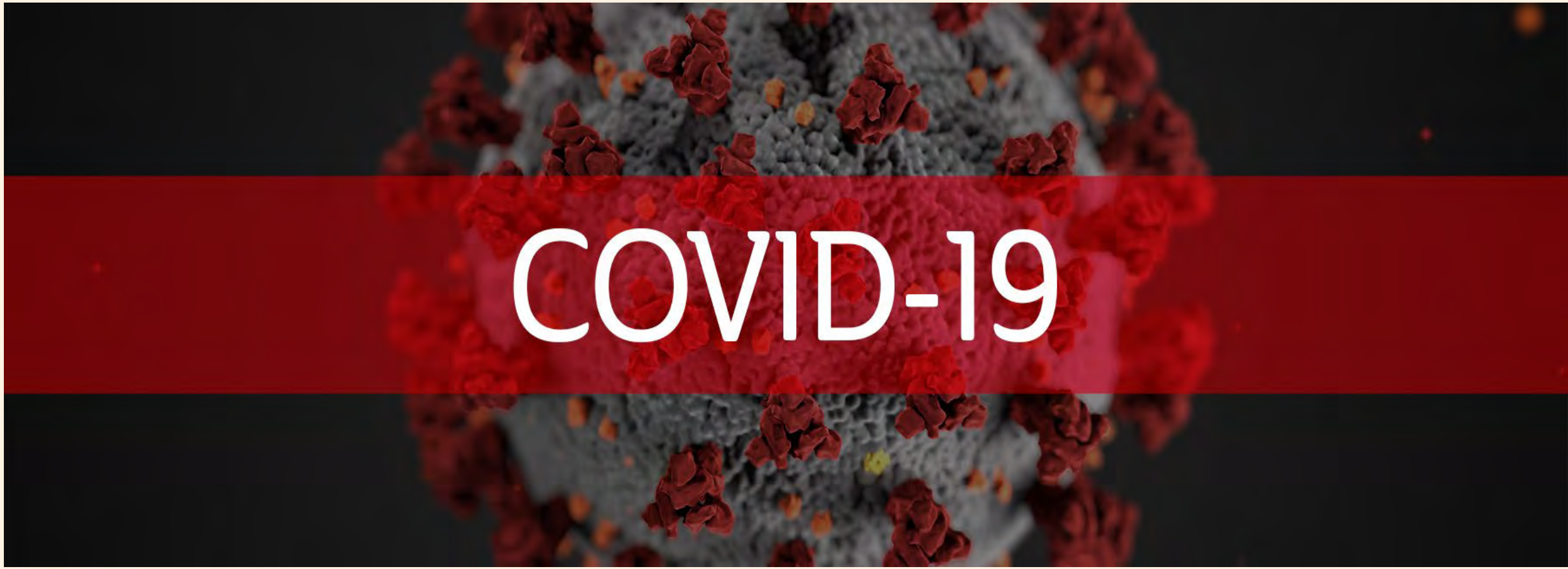
- Our Board will successfully advocate for and receive full funding for health services at the State and Federal level
- Our Board will inspire and prepare our Tribal Public Health workforce, including the next wave of Indian policy leaders
- Our EpiCenter will have a robust research agenda that is tribally-driven, Native-led and Native-staffed
- Our Board will tackle challenging regional issues, including: building a Regional Specialty Referral Center(s) and/or IHS Hospital(s)
- Our Board will be prepared to assume DHHS, IHS, and State functions when best for our Tribes or those programs

The People Spoke: This is their Vision

Commented [SC2]: These are from our original Strategic Plan

- The seventh generation will have balanced physical, mental, emotional, and spiritual lifestyles. They will have healthy diets, be fit, active, and happy.
- The seventh generation will live in sovereign communities that are politically effective, assertive, goal-oriented, thriving economically, and run by American Indian and Alaska Native (AI/AN) people.
- The seventh generation will live in a unified and poverty-free community made up of stable, loving families living in adequate housing.
- Children born to the seventh generation will be healthy and free of chemical substances. They will experience strong parenting, mentorship, and positive role models as youth and will become involved and empowered leaders.
- The seventh generation will live in accordance with their traditional values by knowing their native languages and practicing spiritual and cultural traditions.
- The seventh generation will live in a clean environment, have access to an abundance of natural resources, respect all life, and practice sustainable and socially responsible environmental stewardship.
- Every member of the seventh generation will have access to technologically advanced and culturally appropriate healthcare that includes well-equipped clinics, wellness centers, and health education; a health care delivery system that could serve as a national model.
- The seventh generation will have adequate resources to support healthcare delivery.
- The health of the seventh generation will be a model for the general population. They will experience no preventable illness and no substance abuse or addiction. Old age will be the leading cause of death.
- The seventh generation will respect and care for their elders and celebrate as they live to 100 years or more.

Mental Health Screening in a Time of Crisis



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Assessing the Need for Suicide Intervention Training(s) for Providers

Colbie Caughlan, MPH – THRIVE Project Director

Dr. Danica Brown, PhD – Behavioral Health Project Director

Possible Suicide Risk Factors and Warning Signs

Risk Factors	
☐ Mental illness	☐ Local suicide cluster
☐ Substance use disorder	☐ Lack of social support and sense of isolation
☐ Hopelessness	☐ Asking for help is associated with stigma
☐ Impulsive/aggressive tendencies	☐ Lack of healthcare
☐ Trauma or abuse history	☐ Exposure to a suicide death
☐ Major physical or chronic illness	☐ Non-suicidal self-injury
☐ Previous suicide attempt	☐ Cultural/religious beliefs that suicide is an acceptable solution to coping challenges
☐ Family history of suicide	
☐ Recent loss of relationship	☐ Other: _____
☐ Access to lethal means	_____

Warning Signs	
☐ Talks about wanting to die/kill self	☐ Acts anxious, agitated, or reckless
☐ Looks for ways to kill self	☐ Sleeps too little or too much
☐ Reports feeling hopeless	☐ Withdraws or reports feeling isolated
☐ Reports feeling having no purpose	☐ Shows rage or talks about seeking revenge
☐ Reports feeling trapped	☐ Displays extreme mood swings
☐ Reports feeling in unbearable pain	☐ Other: _____
☐ Talks about being a burden	_____
☐ Increasing use of alcohol or drugs	_____

☐ **Call 911 if there is a direct and imminent suicide threat**

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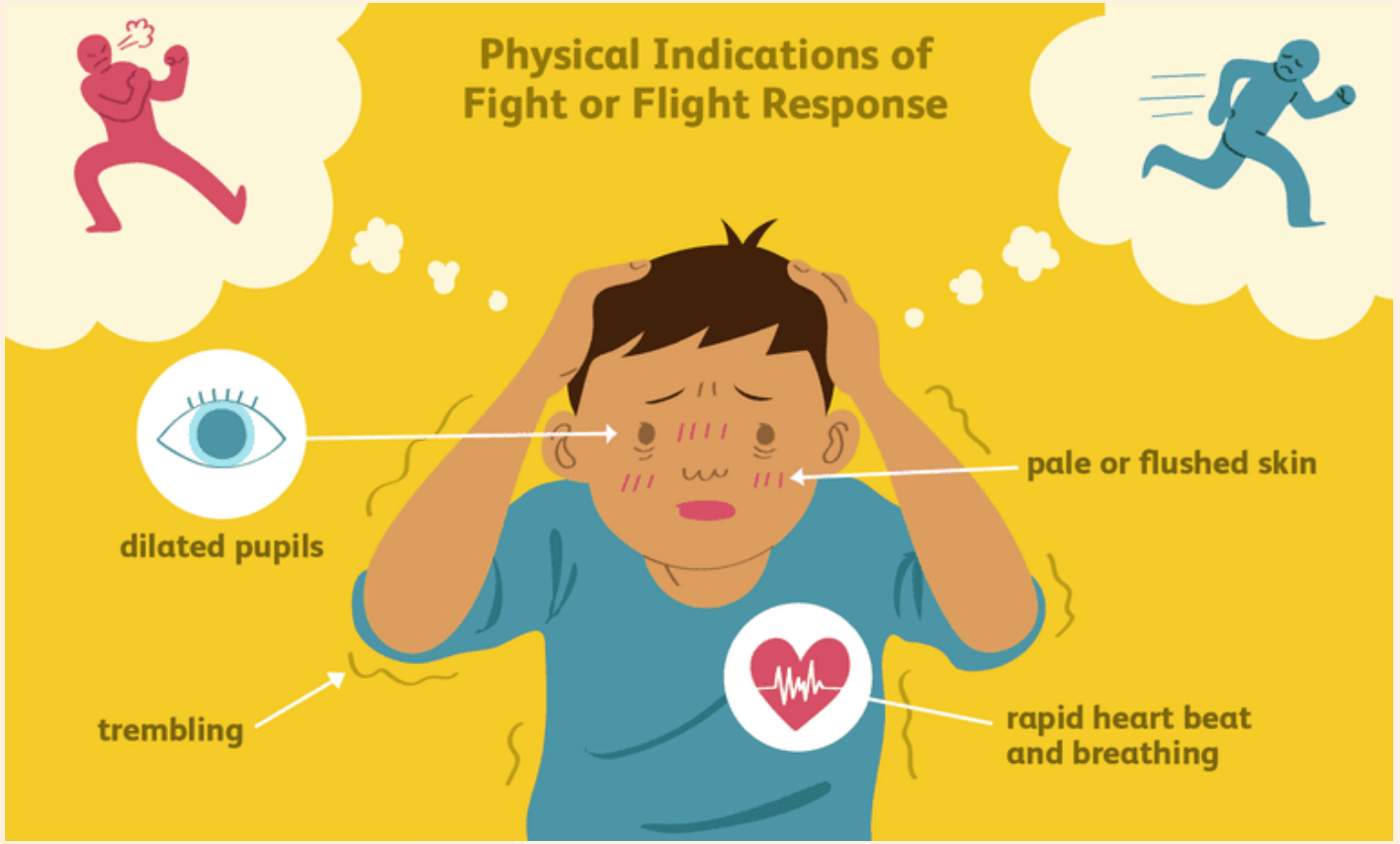
Stress

ANCIENT SURVIVAL RESPONSES TO LIFE THREATENING CIRCUMSTANCES



What is your go to survival response?

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Why Screening is Needed

- Increased symptoms of a trauma- and stressor-related disorder (TSRD) related to the pandemic
- Increased substance use because of COVID-19.
- Suicidal ideation was also elevated in the previous 30 days than did adults in the United States in 2018, referring to the previous 12 months (10.7% versus 4.3%).
- Increased anxiety disorder and depressive disorder increased considerably in the United States during April–June of 2020, compared with the same period in 2019.
- Youth Risk Behavior Survey (YRBS) stats indicate disturbing trends in mental illness and suicide-related behaviors

Source: Centers for Disease Control and Prevention (CDC 2020)

Why Screening is Needed Cont.

- US high school students have reported significant increases in suicidal ideation and making a suicide plan
- School closures and requirements for social distancing have the potential to generate feelings of isolation and loneliness
- 25.5% of young US adults (ages 18 to 24 years) reported having seriously considered suicide at some point during late May and June 2020.
- Among adults currently being treated for PTSD, 44.8% reported suicidal ideation.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
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Source: and Brock, S.E., Lieberman, R., Cruz, M.A. *et al.* Conducting School Suicide Risk Assessment in Distance Learning Environments. *Contemp School Psychol* (2021). https://doi.org/10.1007/s40688-020-00333-6

Screening Over Tele-Health

- Just like in person, asking regular screenings to patients can often fill a gap – if we don't ask patients don't disclose. There are models to help such as behavioral health integration and the Zero Suicide Model.
- Examining existing suicide prevention policies, procedures, protocols, and workflows
  - Identifying local resources (e.g., local law enforcement, mobile crisis response teams, children, and family services) that are available to immediately respond to a client's location.
- All staff members should be trained to be aware of suicide risk factors and warning signs.
- Keep patients informed and educated on the benefits of screening
- Review Telehealth HIPPA flexibility, waivers and other regulations (https://www.hhs.gov/coronavirus/telehealth/index.html)
- New Simulations Prepare Clinicians to Build Patient Relationships in a Telehealth World (https://kognito.com/products/telehealth-encounters) – NPAIHB can help purchase this for NW Tribes if you like the training!

Keys to Selecting a Screener

- Right for defined population
  - Age
  - Diagnose, symptom or disability
- Can be used frequently (not just annually)
- Will identify changes
- Easy, short
- Clinically relevant

A tip to successful screenings:
Training staff on expectations & screening protocols for the clinic

Validated Suicide Screeners

- PHQ-9: Patient Health Questionnaire
- PHQ-A: Patient Health Questionnaire- Adolescent
- ASQ: Ask Suicide Screening Questions
- GAD-7: General Anxiety Disorder
- CYW ACE-Q: Adverse Childhood Experiences Questionnaire-Child
- CYW ACE-Q: Adverse Childhood Experiences Questionnaire-Teen

COVID-19 Learning Needs Assessment

- The NPAIHB assessed the needs of thirty six NW Tribal medical and behavioral health providers in the wake of COVID-19.
- The purpose of the needs assessment was to identify necessary resources, knowledge, and skills to effectively continue activities (suicide, interpersonal violence, substance misuse prevention) during the COVID-19 pandemic.
- The survey was administered from October – November 2020 via survey monkey.

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Survey Results

- **Suicide Prevention:**
  - 93% of respondents provide suicide prevention and/or intervention services.
  - 44% reported having highly developed screening specific to suicide.
  - 38% indicated they have a highly developed suicide specific risk assessment when someone presents with suicide.
  - 67% reported developing or enhancing appropriate patient/family education and resources on suicide prevention
  - 42% provide highly developed coordinated care for patients at risk of suicide.
- **Mental Health:**
  - 88% of respondents indicated that they provide mental health services
  - 68% reported having highly developed regular screening specifically for depression and anxiety
  - 58% provide a highly developed risk assessment
  - 74% indicated that they were either developing or enhancing appropriate patient/family education and resources on Mental Health
  - 56% provide highly developed coordinated care for patients at risk for mental health concerns
- **Substance Use/Misuse Prevention, Treatment & Recovery (SUD/OUD):**
  - 73% of respondents provide substance use/misuse medication assisted treatment and recovery prevention and/or intervention services
  - 60% reported having highly developed screening for SUD/OUD, however only 36% reported providing specific screening such as SBIRT.
  - 64% provide a highly developed SUD/OUD assessment when someone is at risk of SUD/OUD

Survey Results Cont.

Clients Current Concerns:

1. Mental health care
2. COVID-19 specific resources
3. Health care overall

Potentially **negative** experiences that clients are reporting:

1. Increase in depression, anxiety, or other mental health concerns
2. Increase in alcohol or drug use
3. Being fired from their job/becoming homeless.

Telehealth Waivers from the Centers for Medicare & Medicaid Services (CMS)

Temporary policy changes during the COVID pandemic:

- Conduct telehealth with patients located in their homes and outside of designated rural areas
- Practice remote care, even across state lines, through telehealth
- Deliver care to both established and new patients through telehealth
- Bill for telehealth services (both video and audio-only) as if they were provided in person

For more information visit: (https://www.hhs.gov/coronavirus/telehealth/index.html)

Development of Telehealth Informed Consent Procedures

a) Describe telehealth service delivery and specify technical considerations
b) Explain how service providers operate and the limits of telehealth
c) Delineate client expectations and responsibilities of all parties involved
d) Identify emergency contacts and specify multiple communication options
e) Obtain consent for specific service providers to offer telehealth
f) Telehealth consent procedures should be reviewed by legal counsel to ensure compliance with state and federal regulations

Patient Health Questionnaire (PHQ-9)

PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is a tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.

- Incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self- report
- Rate the frequency of the symptoms which factors into the scoring severity index
- Q.9 screens for the presence and duration of suicide ideation
- Screens and assigns weight to the degree to which depressive problems have affected the patient's level of function

Article: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/

Questionnaire: https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf

Ask Suicide Screening Questions (ASQ)

- Validated tool for use among both youth and adults
- A set of four screening questions that takes 20 seconds to administer
- Can be administered in multiple settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care)
- Ask Suicide-Screening Questions (ASQ) Toolkit: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml

Generalized Anxiety Disorder-7 (GAD-7)

- Self administered 7 item instrument that uses some of the DSM-V criteria for GAD (General Anxiety Disorder) to identify probably cases of GAD along with measuring anxiety symptom severity
- Clinicians will still need to use their clinical interviewing skills
- Tool can be used to measure longitudinal changes and track treatment progress
- 2-5 min to complete
- One resource: https://www.mdcalc.com/gad-7-general-anxiety-disorder-7

Suicide Interventions and Therapeutic Frameworks

- Traditional and Cultural Interventions
- Making it Matter with Micro Interventions: Simple Tools To Support Ourselves and Others in Stressful Times (https://training.ursulawhiteside.org/p/micro-interventions/?affcode=346122_682vo98u)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Cognitive Therapy for Suicidal Patients (CT- SP)
- Motivational Interviewing (MI)
- Distress Tolerance Skills
- Problems Solving Treatment in Primary Care (PST-PC)

CAMS Suicide Status Form Initial Session

Patient: Kevin Clinician: David Jokes Date: 6/23 Time: noon

Section A (Patient):

Rate and fill out each item according to how you feel right now.
Rank: Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank: 3
1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind; not stress; not physical pain*):
Low pain: 1 2 3 (4) 5 :High pain
What I find most painful is: being stuck in my own skin

Rank: 5
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):
Low stress: 1 2 3 4 (5) :High stress
What I find most stressful is: being here

Rank: 4
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; not irritation; not annoyance*):
Low agitation: 1 2 3 (4)/(5) :High agitation
I most need to take action when: someone does something untrustworthy

Rank: 1.5
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):
Low hopelessness: 1 2 3 4 (5) :High hopelessness
I am most hopeless about: anything changing

Rank: 1
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):
Low self-hate: 1 2 3 4 (5) :High self-hate
What I hate most about myself is: everything

Rank: N/A
6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 (5) :Extremely high risk (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 (4) 5 : completely
2) How much is being suicidal related to thoughts and feelings about others? Not at all: 1 2 3 (4) 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
3	my mom	1	people don't get it / they don't care
2	maybe something will get better	3	nothing is going to change
		4	I don't contribute to society
1	See how Breaking Bad ends	1	people would be better off if I was dead

I wish to live to the following extent: Not at all: 0 (1) 2 3 4 5 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 (4) 5 6 7 8 : Very much
The one thing that would help me no longer feel suicidal would be: MiB flash thing on everyone and then myself

CAMS Suicide Status Form Initial Session

Section B (Clinician):

(Y) N Suicide ideation — Describe: I think about it a lot - since 7
- Frequency: ✓ per day ✓ per week ✓ per month
- Duration: ✓ seconds ✓ minutes ✓ hours all the time

(Y) N Suicide plan — When: At home before GF comes home
When: At home
How: knife — Access to means (Y) N
How: Belt — Access to means (Y) N

(Y) N Suicide preparation — Describe: Think about death scene - tried out belt

(Y) N Suicide rehearsal — Describe: Put belt around neck

(Y) N History of suicidal behaviors
- Single attempt — Describe:
- Multiple attempts — Describe: 6x hanging

(Y) N Impulsivity — Describe: GF says yes

Y (N) Substance abuse — Describe:

Y (N) Significant loss — Describe:

(Y) N Relationship problems — Describe: GF/ GF's mom/ mother

(Y) N Burden to others — Describe:

(Y) N Health/pain problems — Describe:

(Y) N Sleep problems — Describe: Only sleeps 3-4 hours a night

Y (N) Legal/financial issues — Describe:

(Y) N Shame — Describe: everything

Section C (Clinician): **TREATMENT PLAN** (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization* Plan Completed ☑	3 months
2	Self-hate	↓ Self-hate	Insight Rx CBT BA Voc counseling	3 months
3	People don't get it / Betrayal	Find ways to help others get it increase ↑ trust	Psychodynamic Tx CBT BA CT?	3 months

YES ✓ NO ___ Patient understands and concurs with treatment plan?
YES ___ NO ✓ Patient at imminent danger of suicide (hospitalization indicated)?

Kevin
Patient Signature

Clinician Signature

Cognitive Therapy for Suicidal Patients (CT-SP)

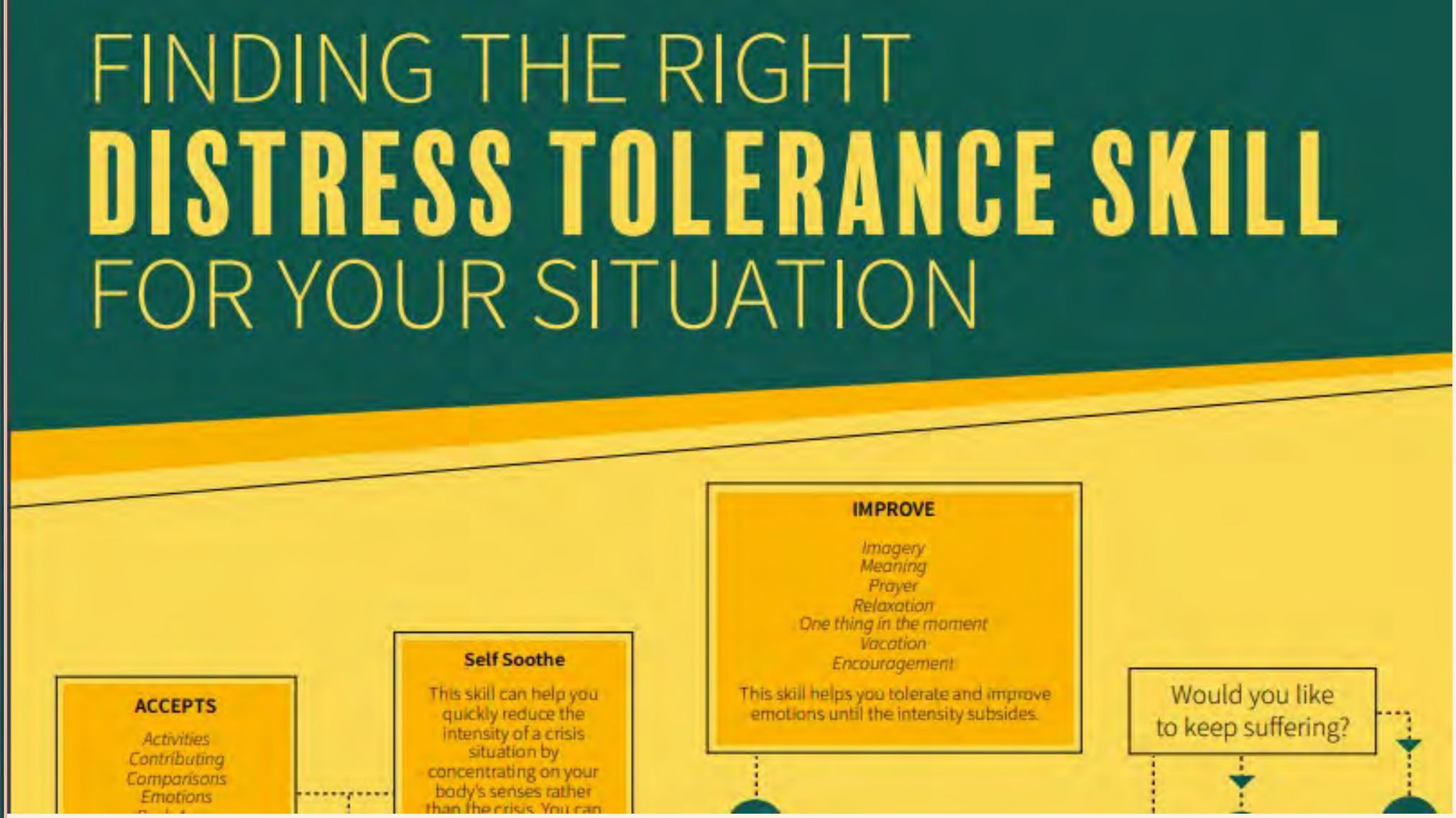
CT-SP is an evidence-based, manualized cognitive-behavioral treatment for adults with suicidal ideation and behaviors that treat problems and boosts happiness by modifying dysfunctional emotions, behaviors, and thoughts.

- Solution orientated
- Encourages patients to challenge distorted cognitions
- Changes destructive patterns of behavior

Motivational Interviewing (MI)

MI is a counseling method that helps people solve ambivalent feeling and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes.

- Used to address addiction and the management of physical health conditions such as diabetes, heart disease and asthma
- Helps people become motivated to change the behaviors that are preventing them from making healthier choices
- Prepares individuals for further, more specific types of therapies



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Distress tolerance skills refer to a type of intervention in Dialectical Behavioral Therapy (DBT) where clients learn to manage distress in a health way. These skills are helpful for situations where a client might not be able to control a situation, but they need to mange their own response. https://www.sunrisertc.com/wp-content/uploads/2017/09/Distress-Tolerance-Decision-Tree.pdf

Problems Solving Treatment in Primary Care (PST-PC)

PST-PC is a form of therapy that involves providing patients with tools to identify and solve problems that arise from life stressors, both big and small, to improve overall quality of life and reduce the negative impact of psychological and physical illness.

- Studied in a wide range of settings
- Teaches and empowers patients to solve the here-and-now problems contributing to their depression and helps increase self-efficacy
- Involves six to ten sessions, depending on the patient's needs

Questions?

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Washington Youth Sexual Health (WYSH) Project

IMPROVING YOUTH ACCESS TO AND EXPERIENCE WITH SEXUAL HEALTH CARE

January QBM 2021

Adolescent Health Updates & Trending Topics

- Ending the HIV Epidemic (EHE) in Indian Country – Project Red Talon
  - Recruit 6-10 partners to improve HIV prevention and care.
  - Develop and disseminate HIV/STI texting and PrEP use campaign
- Teen Pregnancy Prevention (TPP) Innovation and Impact Network
- 2020 Youth Health Tech Survey
  - Native Identity or Cultural pride
  - Mental Health
  - Social Justice and Equality

Adolescent Health Trending Topics

- Native youth are comfortable engaging with conversations around sex, pregnancy, and abortion
  - **More than 1.1K Mentions** around pregnancy, birth control, abortion, rape, sexual assault, and domestic violence from Native youth since March 2020.
- Personal experiences of being a young mom – especially those that were single.
- Native youth advocate for inclusive health resources/education for Trans, Two-Spirit, and Non-Binary youth

Overview of WYSH Project

- Improve access to and experience with sexual health care
  - Intervention focused on clinical setting, but network includes stakeholders from all sectors.
  - Encourage preventive health screenings for youth
  - Improve linkages between prevention programs and health service settings
  - Ongoing youth engagement through local and state planning committees.

Recruitment

- 4-6 WA Tribal Health Departments, school-based health programs, local I/T/U clinics, and youth engagement programs who have a bi-directional impact on youth and their access to and experience with sexual healthcare.
- Tribal subcontracts will range from $65,000 - $100,000 per year
- 3-year project
  - July 2020-June 2023

Grant specifics

- Carryout local needs assessments that include youth, caregiver, and clinical perspectives;
- Select local goals and priorities to improve youth's access to and experience with sexual health services;
- Implement selected clinical trainings, sexual health messaging campaigns, culturally-relevant curricula, quality improvement initiatives, and referral services (if selected);

Grant specifics

- Offer youth-friendly, gender affirming preventive health screenings for youth, including sexual health services for straight and 2SLGBTQ teens and young adults;
- Improve communication and linkages between youth-serving programs and local health services, to improve youth engagement in clinical services; and,
- Engage youth throughout the project to guide the selection of sexual health services, project goals, interventions, and activities.

Support Activities

- Staff FTE and training
- The implementation of community-selected interventions
- Federally-approved indirect rates
- Point of contact (Site coordinator)
- Participate in partner meeting with State, regional, and local partners.

RFA Timeline

- Applications will open the first week of February
- Applications will be reviewed on a rolling basis, the last week of each month.
- Applications will be accepted until all funds have been disbursed to WA Tribes/sites (a total of $400,000 per year).
- Subcontracts will be renewed annually for three years, contingent on approved DOH funding and completion of project deliverables.

Informational Webinars

- Thursday's 11 AM (PST)
- Thursday, February 4th, 2021
- Thursday, February 11th, 2021
- Thursday, February 18th, 2021

Zoom video conference platform

Contact

WYSH Project

- Stephanie Craig Rushing, PI
  - scraig@npaihb.org
- Celena McCray, Project Coordinator
  - cmccray@npaihb.org
- Asia Brown, Sexual Health Communications Specialist

NWTEC Quarterly Report

Victoria Warren-Mears, PhD, RDN,FAND

Director, Northwest Tribal Epidemiology Center

vwarrenmears@npaihb.org

503-998-6063

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Overview

- Overview of NWTEC
- Update on Data Sharing with Idaho
- New Data products – WA Public Health Modernization
- Update on Food Security during COVID-19 assessment
- COVID-19 Training and Technical Assistance Report
- COVID-19 Data
- Questions

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NWTEC

- Formed in 1996 with first funding 1997 – 25 years of tribally directed activities
  - Tribal leaders had approved the concept and function of a tribal research and epidemiology center prior to this time.
- Guided by the Public Health Committee of the NPAIHB, and report to the NPAIHB Board
- Every action undertaken is a result of tribal resolution from our Board *(tribally driven research and public health agenda)*
- Functions as a departmental designation with oversight of over 55 employees
- NWTEC staff have trained 3 CDC EIS Officers with another who will begin in August and 2 PHAP assignees from CDC.

Update on Idaho Data Sharing

- On January 13, 2021 a data use agreement was signed between the Idaho Department of Health and Welfare and the NWTEC.
- This will allow us to do data linkages quarterly or more often with COVID-19 data.
  - The state will transmit the corrected data to CDC
  - This likely will give Idaho the most accurate AI/AN data in the nation

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Public Health Modernization Projects

- **NPAIHB is supporting efforts for all three states.**
- **The NWTEC has funding to:**
  - Enhance data for Washington Tribes,
  - Conduct capacity surveys with Oregon Tribes, provide summaries and assist with tribal health improvement plans and implementation (project includes NARA).
- Conduct assessments to determine ways to improve the state BRFSS to meet the needs of the Oregon Tribes
- Support work toward Public Health Accreditation for all NW Tribes

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NPAIHB WTPHI Project Objectives

- Ensure AI/AN disease surveillance, investigation, and control
  - Produce communicable disease data briefs
  - Train and deploy NPAIHB staff for disease outbreak investigations
- Participate in surveillance and epidemiology committees and task forces with FPHS partners, including DOH, local health jurisdictions, tribal government, and tribal health organizations

WA AI/AN Communicable Disease Data Briefs

To be released January 2021:

- Hepatitis B & C
- HIV/AIDS
- Sexually Transmitted Infections
- Tuberculosis

Summaries of available data to describe disease burden experienced by AI/AN communities in Washington

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WA AI/AN Communicable Disease Data Briefs

- Topic Overview
- Data Summaries
- Data Figures
- Resources
- NPAIHB Project Contacts, within the NWTEC staff

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WTPHI Data Partners Meeting

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February 3, 2021
10:00 AM – 1:00 PM
Topics:

- Intro to NPAIHB WTPHI Project
- WA AI/AN Data Linkage Update
- Communicable Disease Data Review
- Facilitated Discussions
  - Data Access
  - Data Needs

Registration:
https://www.surveymonkey.com/r/DataPartnersMtg

For more information, contact Nancy Bennett, NPAIHB: nbennett@npaihb.org

Food Sovereignty and Food Security Survey

- Received IRB approval
- Finished qualitative interviews with 10 tribal leaders and/or program staff
- Beginning to analyze information to finish adapting the quantitative survey
- Working with AIHC to recruit and receive tribal resolutions
- What's next?
  - Launching the quantitative survey by February
  - Completing analysis and reporting by end of March

- Still seeking funding for Idaho and Oregon to expand this survey further.

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Environmental Public Health Grants

- Two opportunities
- Available to tribes in Idaho, Oregon and Washington
- 7 total awards will be made

ENVIRONMENTAL HEALTH RESPONSE, RECOVERY, MITIGATION AND OTHER EXPENSES RELATED TO 2018/2019 DECLARED DISATERS

4 Grants Awarded at $50,000 each

- **Project activities will include:**
  - Improve EH data and informatics capacity to strengthen tribal data and data systems for monitoring, diagnosing, investigating, & mitigating EH hazards resulting from disasters.
  - Develop standard templates and forms for data collection of EH hazards in disasters.
  - Incorporate local indigenous knowledge to understand historical, EH-related disaster impacts and design the appropriate tribal Environmental Health interventions.
  - Develop standard templates and forms for tribal lessons-learned reports, community EH hazard assessments, and disaster surveillance to build capacity in preparedness and response to EH hazards in disasters.

RFA

https://files.constantcontact.com/4cd26bd1101/b8a71b85-4e52-4519-9280-0a014866c688.pdf

IMPROVING DOMESTIC WELL WATER SAFETY

3 Grants Awarded at $12,000 each

Available to federally recognized Idaho, Oregon, & Washington Tribes

- Project activities will include:
  - Tribal environmental health staff will identify, characterize, and evaluate the environmental health(EH) status of individual private wells and conditions that prevent access to safe drinking water.
  - NPAIHB will provide training as follows: Hydrogeology and groundwater basics, wellhead protection, safe drinking water standards and sampling, and using data to monitor and anticipate EH hazards and threats to groundwater

RFA:

https://files.constantcontact.com/4cd26bd1101/203e8dc1-ce63-48fb-9ab9-d41325562899.pdf

Applications are DUE: Friday, February 12, 2021

Anticipated Notice of Award by: Friday, February 26, 2021

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COVID-19 Technical Assistance

Table 1B: COVID -19 requests for technical assistance

Source of Request	Total	Responded To	Unable to Respond
Northwest Tribes (including deployments for contact tracing)	2,008 These figures may under represent total response due to inaccurate tracking, in face of pandemic, initially.	2,008	0
Tribes Outside of Area	125	125	0
Other Requests	1232 Includes collaborative meetings with states and universities	1232	
TOTAL	**3365**	**3365**	**0**

Wrote for an additional $5,000,000 of COVID-19 funding, of which $4.5 million is going to tribes

COVID-19 Weekly Informational Calls	Training, Technical Assistance, and Question and Answer	Weekly call initiated in early March. Average attendees 175 per call. As we have move forward, we have continued with about 70 attendees.	
COVID-19 Clinical ZOOM	Clinician Informational training calls regarding the public health emergency – nationwide coverage	200 + clinicians – COVID-19 twice per week and has also been integrated in SUD ECHO, Diabetes ECHO and HCV ECHOS which are held once to 3 times per month.	For the time period March 2020 – September 30, 2020, there have been 49 COVID-19 ECHO Clinics with 6,662 attendees from throughout the US, Canada, Guam and Puerto Rico

New Award Anticipated

- CDC 5 year award around vaccine hesitancy to include COVID-19 and flu vaccine
- NWTEC will be the national coordinating center for all of the Tribal Epidemiology Centers, who choose to participate.

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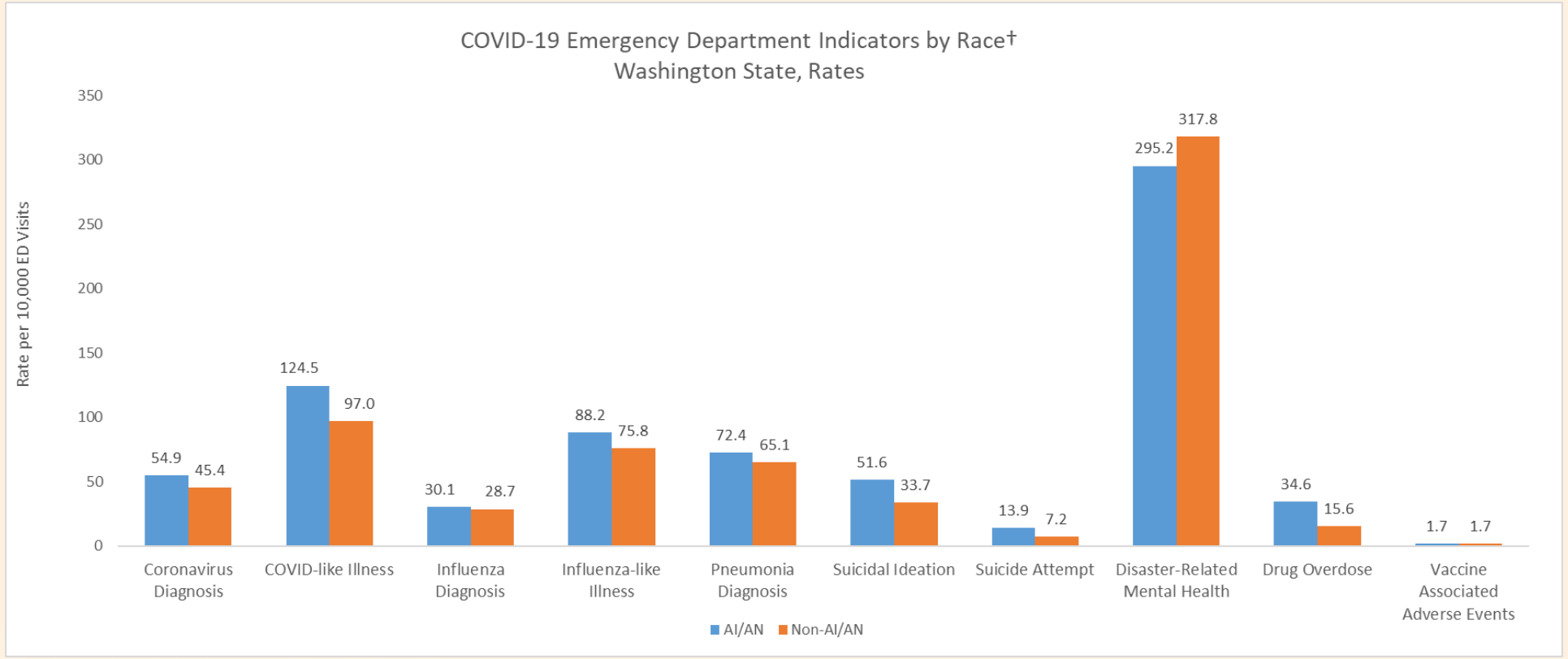
Key Emergency Room Data

- Oregon:
  - Suicide ideation increasing among AI/AN
  - COVID-like Illness (CLI) is decreasing among AI/AN
  - There were two vaccine adverse events in the last week among AI/AN (which vaccine was associated with the adverse event is not specified)
- Washington:
  - Total ED visits are low
  - Slight increase in drug overdose among AI/AN
  - CLI and pneumonia rates remain higher among AI/AN than non-AI/AN

Washington Emergency Department Indicators – through 1/12/21



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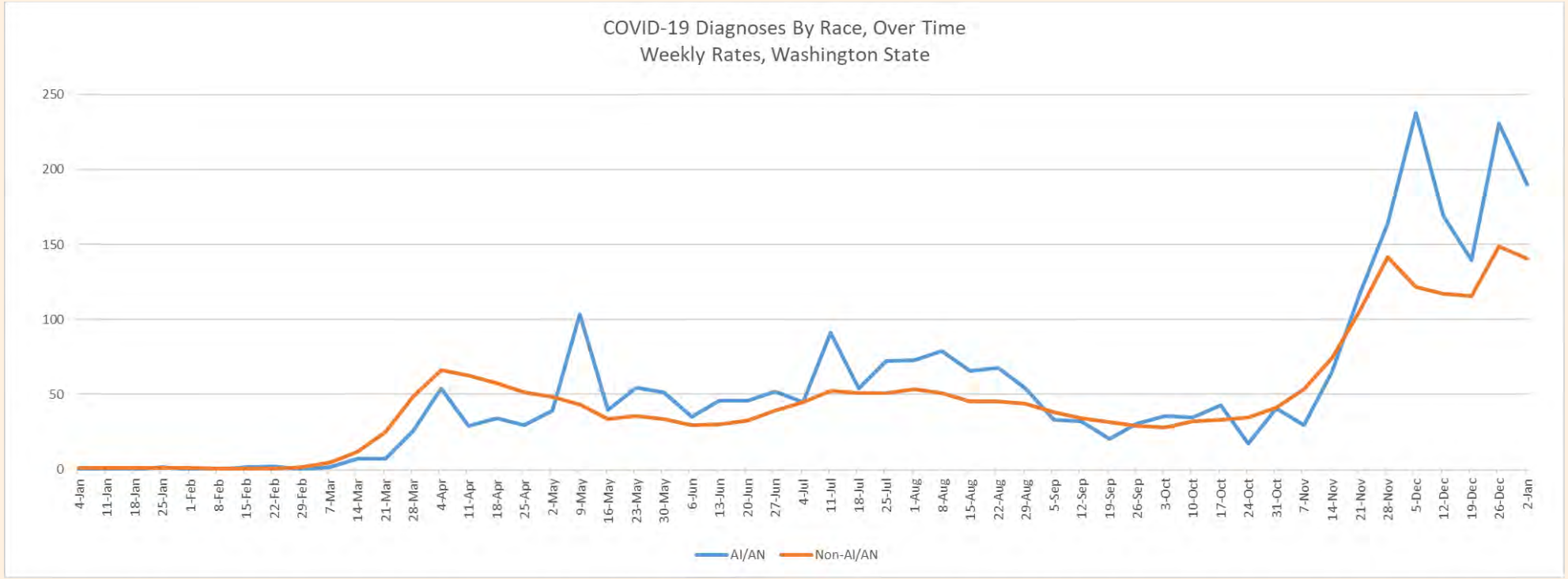
COVID-19 Diagnosis by Race (1 Year) ED Data- Washington State



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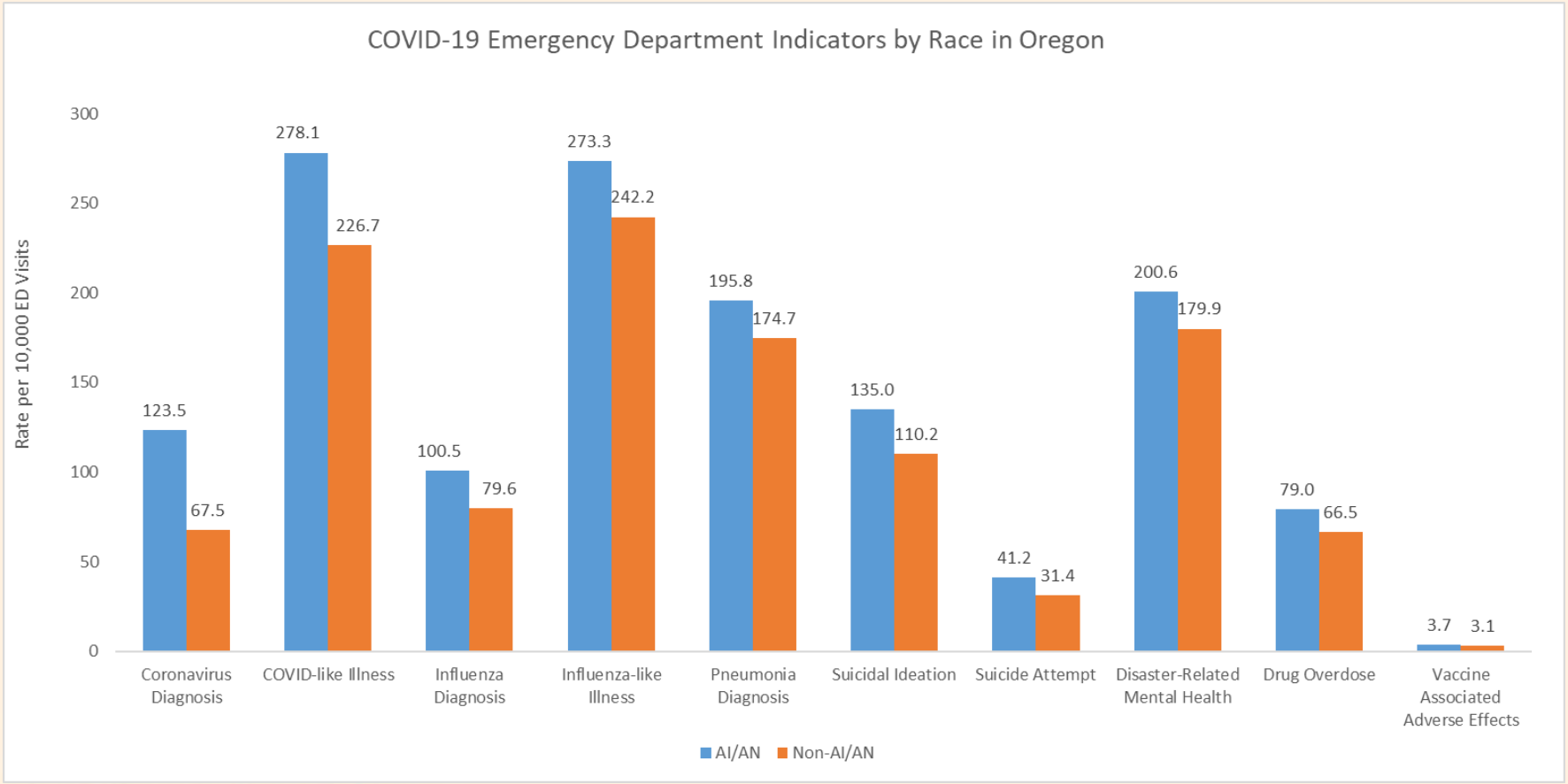
Oregon Emergency Department Indicators – through 1/12/21



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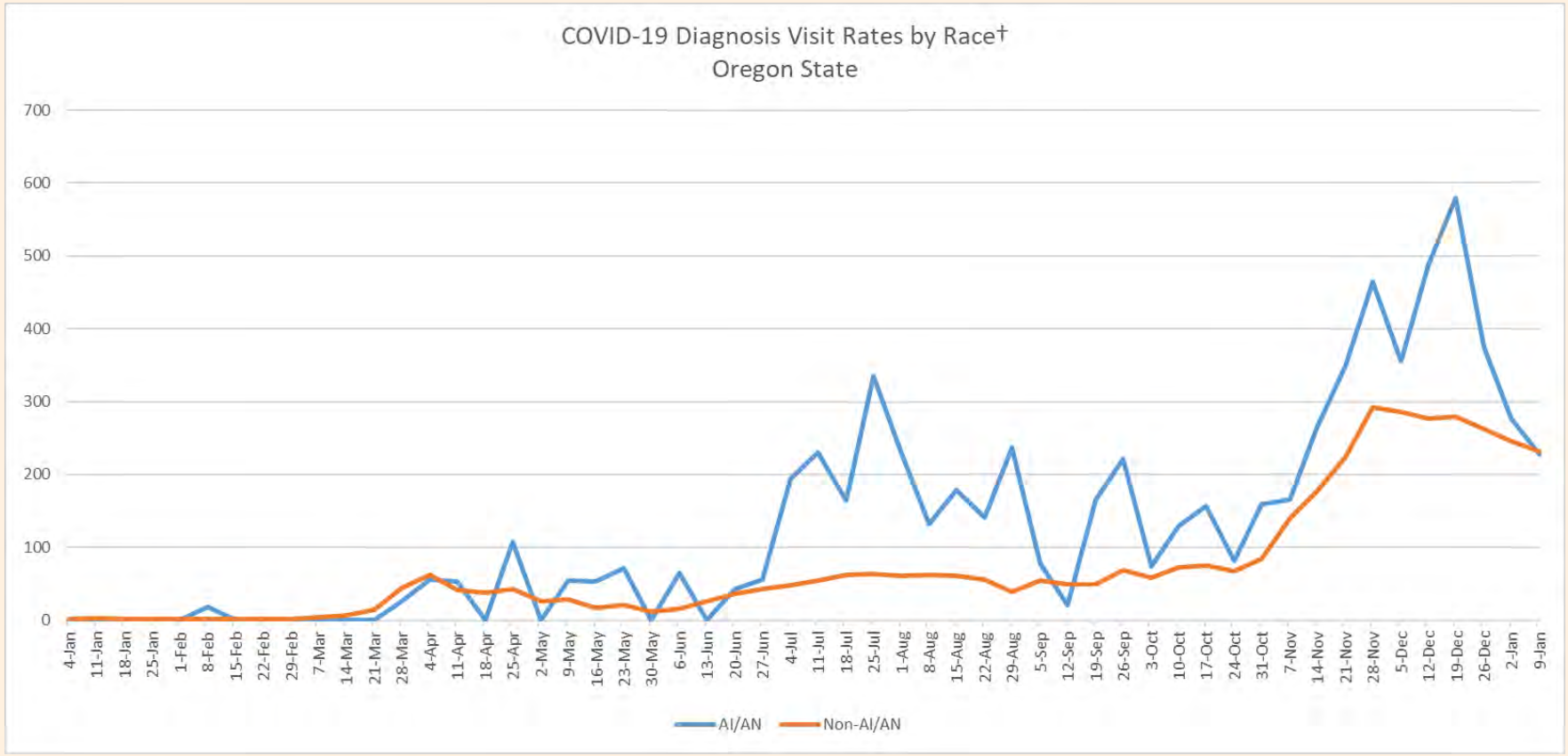
COVID-19 Diagnosis by Race (1 Year) ED Data- Oregon State



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Idaho Dashboard for ED Visits

- DPH Idaho COVID-19 Dashboard - Idaho Division of Public Health | Tableau Public

Questions or Comments

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2021 Policy Priorities

Presented by: Elizabeth J. Coronado and Candice Jimenez

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NPAIHB Health Policy Team

- *New* Staff Introduction

Elizabeth J. Coronado, JD

Chukchansi

Candice B. Jimenez, MPH

Confederated Tribes of Warm Springs

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Legislative and Policy Committee

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Indian Health Service

- Fully fund the IHS. This was requested to be at the top of any document and high priority.
- Establish a separate and indefinite discretionary appropriation for 105(l) lease funding. This request was accomplished, but needs to be mandatory.
- Provide mandatory funding for IHS
- Amend IHCIA to authorize advance appropriations for IHS. Huge Priority.
- For Purchased and Referred Care, move access to care factor from category 3 to category 2 in funding formula. This will increase PRC funding to Portland Area.
- Tribes need to advocate for COVID-19 Response and Relief 2021.

Health Care Facility Funding

- Request GAO to issue a report on IHS Health Care Facilities Construction Priority System.
- Create equitable health care facilities funding opportunities for all IHS areas.
- Fund Regional Referral Specialty Care Demonstration Project in the Portland Area.
- Increase funding for small ambulatory programs and joint venture projects.
- Bill HR 2 reintroduced in Congress with health care facility funding.
- Funding for long term care, assisted living, hospice care under IHCIA. NPAIHB needs to look at the IHCIA to determine if it includes facilities.

IHS IT Modernization

- For FY 2021, fund $25 million for planning and phased in maintenance of RPMS.
- Conduct tribal consultation in each IHS area on any efforts to modernize or replacement of RPMS.
- Provide ample transition period, training, and TA.
- Consider the many tribal facilities that have purchased commercial off the shelf systems. Consult with the tribes that have purchased COTS and are using tribal resources for upgrades, technical support and maintenance in order to guarantee interoperability. Reimbursement for the tribes who have purchased COTS and funding for maintenance, TA, replacement.
- 10 year transition period to a new EHR is unacceptable, tribes will have be forced to move away from RPMS to continue operations.
- All hospitals in NW are on EPIC.

Workforce Development

- Establish HRSA TAC in FY 2021.
- Expand Title 38 authorities to ensure that IHS and tribal facilities can be competitive in the current job market.
- Fund IHCIA 112, 132, and 134 for additional resources to address recruitment and training programs.
- Fully fund IHS Indian Health Professionals scholarships and support Loan Repayment Program. This is a priority that IHCP scholarships are fully funded to support AI/AN workforce. Need to look at expanding the type of professions that qualify for the scholarships. Recommendation to look at the needs in Indian County for health professionals (IT, administration, etc.).

SDPI

- Permanently authorize SDPI at $200 million per year with medical inflation rate increases annually. (NPAIHB Res. No. 19-04-12)
- Create options for tribes to receive SDPI funds through Title I or Title V compacts or contracts.
- Allow areas to reallocate data infrastructure funds to Tribal Epi Centers to assist tribes in managing their SDPI data.

Patient Protection and Affordable Care Act / IHCIA

- Congress must protect ACA and IHCIA.
- Fully fund IHCIA, including long term care, recruitment and retention, and behavioral health.
- Fund Tribal Epi Centers to fulfill their role as a Public Health Authority. (TA, capacity building, evaluation, public health surveillance)

Medicaid/CHIP

- Protect 100% FMAP.
- Protect FFS (not subject to managed care or value based payments).
- Support legislation that:
  - Extends Medicaid eligibility for all AI/AN with household income up to 138% of the federal poverty level.
  - Authorizes IHCPs in all states to receive Medicaid reimbursement for health care services delivered to AI/ANs
  - Extend full federal funding through 100% FMAP to states for Medicaid services furnished by urban Indian providers
  - Removes the limitation on billing by IHCPs for services provided outside the 4 walls of a tribal clinic

Elders Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Elders and Long Term Care

- Congress must fund long term care services, assisting living services, hospice care and home/community-based services (*all authorized under IHCIA for AI/AN people*)
- HHS/CMS/IHS must create an encounter rate (*or enhanced rate*) for tribal nursing homes
- Congress must increase funding to IHS or ACL for elder access to no-cost eyeglasses
- No changes at this time.

Behavioral Health Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Behavioral Health (Mental Health & Substance Use)

- Strengthen partnerships for integrated care between behavioral health and medical care teams (*top priority)*
- SAMHSA –
  - Accessible funding: prevention, training for mid-level SUD providers, data waiver trainings for SUD providers, training & development of peer counselors
- Support funding for the IHS *Fully* fund a *Behavioral Health Programs for Indians* with option for tribal shares and non-competitive funding for direct service tribes (NPAIHB Res. No. 19-04-09)
- Increase support for AI/AN youth inpatient and outpatient mental health and substance use services
- Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/Ans with Substance Use Disorder (SUD)

Behavioral Health (Mental Health & Substance Use)

- Fully fund IHCIA provisions for increases to Behavioral Health
  - Provide inpatient treatment, training for mental health techs, tele-mental health expansion and demonstration grants and *crisis intervention training*
- For IHS to ensure that all BH initiatives create option for tribes to receive funding through contracts and compacts
- For SAMSHA to *acknowledge and support* the development and implementation of Tribal Best Practices, traditional Indigenous knowledge and cultural practices in prevention and interventions
- Reduce restrictions of federal housing programs for tribal members in recovery; acknowledge houselessness as PH crisis and COVID-19
- Provide telehealth/telemedicine resources to increase accessibility

Community Health Aide & Oral Health Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Community Health Aide Program Nationalization & Dental Health Aide Therapists

- Support continued funding for Community Health Aide Program (CHAP) & Community Health Representative (CHR) program expansion in FY 2022
- Support unification of national CHAP program by removing state authorization requirements for the use of DHATs as part of a CHAP program
- Implement nationalization of CHAP in the Portland IHS Area (NPAIHB/CRIHB Joint Res No. 17-04-09)
- Support tribes to authorize/license/certify CHAP providers
- Creation of permanent series and classification of position descriptions CHA/Ps in federally-operated facilities ~~(*for DHA/Ts*)~~

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Public Health Committee

Note: Consideration that this section should include health factors that predispose community members to chronic and communicable disease – how can we uplift the multitude of needs, resources and challenges as voiced by NW tribal communities.

- Public Health –
  - Infrastructure development
  - Events of international importance incl. COVID-19
  - Capacity development
  - Emergency preparedness

Overall, a focus on Tribal practices that guide each of these areas.

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

COVID-19 (Vaccine)

COVID-19 Pandemic has laid bare the structural inequities that lead to health disparities, including inadequate public health infrastructure.

- Hold agencies accountable to conduct ongoing and meaningful tribal consultation on all COVID-19 vaccine policies and plans
  - Ensure access to all 3 options to receive vaccine: federal, state and local
  - Ensure that tribes have resources needed to receive and store vaccine
- Honor tribes' authority to determine service & priority populations
- HHS and IHS must provide funding and infrastructure support to tribes for vaccine reporting

HCV & HIV Treatment and Funding

- For HCV, ensure that all AI/AN patients with HCV at I/T/U facilities have access to treatment
- Ensure that Indian Country is included in *Ending the HIV Epidemic Funds*
- IHS to support creation of a funding mechanism to receive Minority AIDS Initiative (MAI) funding for distribution via the Office of Infectious Disease and HIV/AIDS Policy
- For State Medicaid Agencies, make HCV treatment a clinical priority and ensure access to medications to all persons with medical need
  - as determined per American Association for the Study of Liver Diseases (AASLD) guidelines (NPAIHB Res No. 18-02-03)
- Ensure Administration's National Plan for HIV Elimination is inclusive of tribes and AI/AN communities

Public Health

- Appropriate funding directly to tribes for tribal public health infrastructure; tribally-determined
- Develop Tribal Public Health capacity; equitable access to services & gradual capacity improvement; equity reflected in all areas, not just funding – an equity based framework
- Authorize Public Health Emergency Fund established through the Secretary of HHS that tribes can access for tribally-declared public health emergencies
  - analogous to tribal disaster declarations to access FEMA funding
- Fund Tribal EpiCenters to fulfill their role as a Public Health Authority
  - Outlined in IHCIA for activities such as technical assistance, capacity building, evaluation, public health surveillance, etc.
- Provide targeted funding through CDC for tribes to increase asthma treatment programs
  - Education and remediation of environmental triggers associated with poor asthma control and housing-related environmental hazards; a leading causes of illness and early mortality
- Support Good Health and Wellness in Indian Country (GHWIC) and Tribal Practices for Wellness in Indian Country (TPWIC) expansion
- Ensure equity in funding to address social and economic factors that impact health (SDoH)
  - Invest in Maternal Child Health (MCH) programs that address tribal priorities

Veterans Committee

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Veterans

- On Reimbursement agreements:
  - Pass legislation to preserve and strengthen VA reimbursement agreements
  - Ensure reimbursement at the OMB encounter rate & allow VA reimbursement of Purchased and Referred Care (PRC) dollars for specialist care to AI/AN veterans
- Streamline and improve process for establishing reimbursement agreements between the VA and tribal health programs
- Increase outreach & advocacy resources to ensure all AI/AN veterans are eligible for health care benefits available in their community including veterans' care coordination and mental health care needs
- Support and improved interoperability of the EHR for IHS, VA, and DOD
- ~~Pass legislation creating VA Tribal Advisory Committee~~ (NPAIHB Res No 19-04-11)
  - Passed! See HR 7105 (Sec. 7002) and HR 6237 (Amends IHCIA for Proper/Reimbursed care)

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Youth Committee

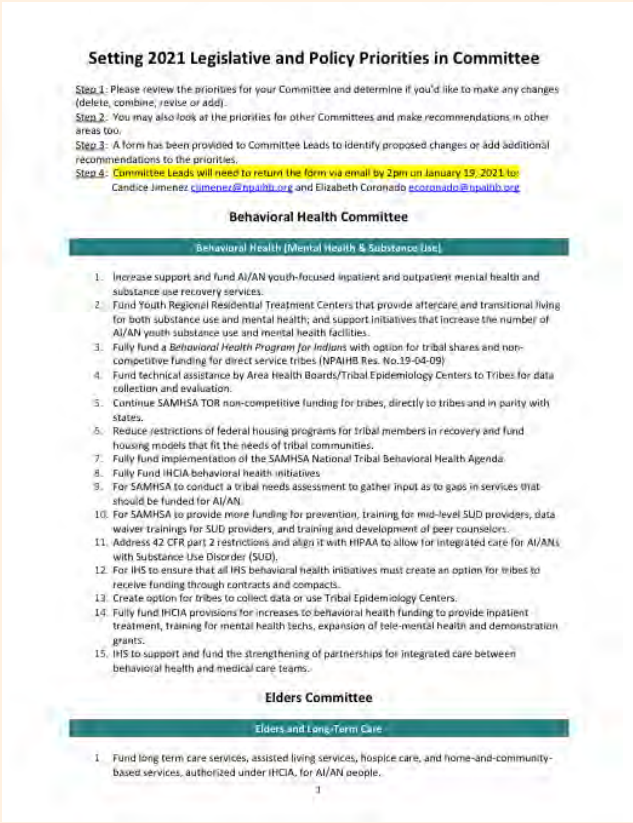
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Youth

- **Fund initiatives that provide for AI/AN adolescents & young adults:**
  - Fund tribes/IHS/Tribal Epi Centers to invest in safe and secure environments; places to live, learn and play; improve tribal capacity to support youth
    - *Brainstorm ways to continue supportive funding; sustainability w/o funding source*
- **Prepare AI/AN youth in taking active role in their health and wellbeing**
  - Engage youth, tribal youth councils – connect tribes to establish rapport and culture sharing across youth councils
  - Uplift youth delegates as future leaders; policy coordinators meet with youth and connect priority areas with adolescent youth action plan
  - Maintain opportunities for youth engagement/skill building alongside education

2021 Policy Priorities – *Moving Forward*

- **Policy Team Follow-up**
  - Review 2021 Leg & Policy requests and Biden transition priorities
  - Compile in draft form for tribal delegates; ‘this is not a ‘final draft’
  - Liz/Candice will follow-up for continuous feedback



Setting 2021 Legislative and Policy Priorities in Committee

Step 1: Please review the priorities for your Committee and determine if you'd like to make any changes (delete, combine, revise or add).
Step 2: You may also look at the priorities for other Committees and make recommendations in other areas too.
Step 3: A form has been provided to Committee Leads to identify proposed changes or add additional recommendations to the priorities.
Step 4: Committee Leads will need to return the form via email by 2pm on January 19, 2021 to: Candice Jimenez cjimenez@npaihb.org and Elizabeth Coronado ecoronado@npaihb.org

Behavioral Health Committee

Behavioral Health (Mental Health & Substance Use)

1. Increase support and fund AI/AN youth-focused inpatient and outpatient mental health and substance use recovery services.
2. Fund Youth Regional Residential Treatment Centers that provide aftercare and transitional living for both substance use and mental health; and support initiatives that increase the number of AI/AN youth substance use and mental health facilities.
3. Fully fund a *Behavioral Health Program for Indians* with option for tribal shares and non-competitive funding for direct service tribes (NPAIHB Res. No.19-04-09)
4. Fund technical assistance by Area Health Boards/Tribal Epidemiology Centers to Tribes for data collection and evaluation.
5. Continue SAMHSA TOR non-competitive funding for tribes, directly to tribes and in parity with states.
6. Reduce restrictions of federal housing programs for tribal members in recovery and fund housing models that fit the needs of tribal communities.
7. Fully fund implementation of the SAMHSA National Tribal Behavioral Health Agenda
8. Fully Fund IHCIA behavioral health initiatives
9. For SAMHSA to conduct a tribal needs assessment to gather input as to gaps in services that should be funded for AI/AN.
10. For SAMHSA to provide more funding for prevention, training for mid-level SUD providers, data waiver trainings for SUD providers, and training and development of peer counselors.
11. Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/ANs with Substance Use Disorder (SUD).
12. For IHS to ensure that all IHS behavioral health initiatives must create an option for tribes to receive funding through contracts and compacts.
13. Create option for tribes to collect data or use Tribal Epidemiology Centers.
14. Fully fund IHCIA provisions for increases to behavioral health funding to provide inpatient treatment, training for mental health techs, expansion of tele-mental health and demonstration grants.
15. IHS to support and fund the strengthening of partnerships for integrated care between behavioral health and medical care teams.

Elders Committee

Elders and Long-Term Care

1. Fund long term care services, assisted living services, hospice care, and home-and-community-based services, authorized under IHCIA, for AI/AN people.

1

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Mich gayis / Tai itukdi – Thank you!

ecoronado@npaihb.org
Elizabeth J. Coronado, JD
Chukchansi

cjimenez@npaihb.org
Candice B. Jimenez, MPH
Confederated Tribes of Warm Springs

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Cindy Darcy Presentation January 19, 2021,

to the NPAIHB Quarterly Board Meeting:

Considerations for Setting Priorities for the 117th Congress

New Administration's priorities

Continued COVID-19 relief (American Rescue Plan)
Cabinet nominations and other Administration appointments
Full and mandatory funding for Indian Health Service
Native health date collection and sharing
Infrastructure proposal (to be released in February)
Climate change

Roles of your members of Congress

NPAIHB members are in key positions – For example,

Senator Murray is expected to chair the Senate Health, Education, Labor and Pensions Committee, and will serve again on the Appropriations Committee.

Senator Merkley is an appropriator. In the House, Representatives Kilmer, Simpson, Newhouse and Herrera Beutler are all appropriators.

Senator Wyden will chair the Senate Finance Committee, and Senator Crapo will be the ranking member. Congressman Blumenauer serves on the House companion committee, Ways and Means.

Congresswoman McMorris Rodgers will be the ranking member of the House Energy and Commerce Committee. Representative Schrier is newly appointed to that Committee. With its jurisdiction over health care, energy, the environment and the Internet, the Committee is poised to play a major role in President-elect Biden's policy agenda. That committee and the House Ways and Means Committee will be working to enact President-elect Biden's plan for building on the 2010 health care law.

What are those members', those committees' priorities for the 117th Congress?

Senator Wyden recently outlined his Finance Committee priorities, with the COVID-19 pandemic response being the first, but also including drug pricing legislation, proposals to build on the 2010 Affordable Care Act, and racial disparities in health care (which focused a lot last year on the impact of the coronavirus in Indian Country).

House Natural Resources Committee Chairman Grijlava has indicated he will continue to focus on climate change and environmental justice issues this year.

Senator Schatz, who is expected to chair the Senate Indian Affairs Committee, led the Senate Democrats' Special Committee on the Climate Crisis in the 116th Congress. He would likely lead Committee action on addressing the impact of climate on Native American communities.

What broader, major, national legislation will be considered that should have an "Indian Country component"?

For example,

Reauthorization of and amendments to the Violence Against Women Act (VAWA) - House-passed 2019 bill included positive tribal provisions.

Infrastructure package – The House-passed INVEST Act in 2020 included significant new funding for Indian health program hospitals and outpatient health care facilities, and construction, modernization, improvement, and renovation of water, sewer, and solid waste sanitation facilities located on tribal land that are listed on the IHS Sanitation Facilities Deficiency List. Those should be included in 2021. The infrastructure package might be the legislative vehicle for the Regional Referral Specialty Care Centers proposal.

Family Violence Prevention and Services Act reauthorization

Child Abuse Prevention and Treatment Act reauthorization

Reauthorization of the Higher Education Act

What was enacted in the last Congress?

Special Diabetes Program for Indians reauthorized – Amendments? Reauthorize permanently?

Native veterans bills - Standalones and in the broader veterans' services package

Urban Indian Health Organizations - Amendment to authorize arrangements for the sharing of medical services and facilities, and to provide Federal Tort Claims Act coverage

What legislation was passed by the House or Senate during the 116th Congress, but not by the other chamber, and could be moved quickly in 2021?

Examples of bills passed by the House of Representatives but not by the Senate are:

the "Patient Protection and Affordable Care Enhancement Act" (H.R. 1425), which contains language extending full federal medical assistance percentage to Indian health care and Native Hawaiian health care providers

the Indian Child Protection and Family Violence Prevention Act (H.R. 4957)

the Tribal Health Data Improvement Act (H.R. 7948; no action on S. 4562)

reauthorization of the State Opioid Response grants program at SAMHSA (H.R. 2466)

several bills related to medical marijuana use

Examples of bills passed by the Senate but not by the House of Representatives are:

legislation to provide for the conveyance of certain property in Alaska to the Southeast Alaska Regional Health Consortium and the Alaska Native Tribal Health Consortium located in Sitka, AK (S. 3099 and S. 3100).

a bill to authorize the acquisition of private land to facilitate access to the Desert Sage Youth Wellness Center (S. 4556).

legislation to convey land in Anchorage, AK, to the (S. 3100).

Bills that were introduced in the 116th and prior Congresses:

Advance appropriations authority (S.229/H.R. 1128)

Two-fiscal-year budget authority for IHS (S. 2541/H.R. 1135)

Health Equity and Accountability Act (S. 4819/H.R. 6637)

Tribal Nutrition Improvement Act (H.R. 2494/S. 1307)

Improve behavioral health outcomes for American Indians and Alaska Natives (H.R. 4533/S. 3126)

Improve the public health system in tribal communities by increasing the number of American Indians and Alaska Natives who pursue careers in public health (H.R. 4534)

Fund the Indian Health Service for the next fiscal year in the event of a federal government shutdown (H.R. 195)

Cadence or tempo of 1st session of a new Congress

Organizing of and assignments to congressional committees

Nominations needing Senate confirmation

HELP will consider HHS Secretary

SCIA IHS Director, ANA Commissioner, and others

FY 2022 budget request

Oversight – or general – hearings

Burns Paiute Tribal Update

Twila Teeman, Tribal Health Director


Where are we located?
SAMISH
LUMMI
NOOKSACK
KOOTENAI
JAMESTOWN S'KLALLAM
UPPER SKAGIT
SWINOMISH
SAUK-SUIATTLE
COLVILLE
KALISPEL
MAKAH
LOWER ELWAH
STILLAGUAMISH
TULALIP
SPOKANE
QUILEUTE
HOH
PORT GAMBLE
SUQUAMISH
SKOKOMISH
SEATTLE
SPOKANE
QUINAULT
SQUAXIN ISLAND
PUYALLUP
COEUR D' ALENE
MUCKLESHOOT
Columbia River
WASHINGTON
OLYMPIA
TACOMA
NISQUALLY
SHOALWATER BAY
CHEHALIS
Snake River
LEWISTON
YAKAMA
NEZ PERCE
COWLITZ
Columbia River
UMATILLA
PORTLAND
PENDELTON
Salmon River
NPAIHB
GRAND RONDE
SALEM
IDAHO
SILETZ
NEWPORT
WARM SPRINGS
OREGON
EUGENE
COOS, LOWER UMPQUA,SIUSLAW
BOISE
IDAHO FALLS
NW SHOSHONI
COQUILLE
Snake River
ROSEBURG
COW CREEK UMPQUAS
SHOSHONE BANNOCK
MEDFORD
KLAMATH
KLAMATH FALLS

Burns Paiute Tribe (WaDa-Tika Band of Northern Paiute)

- Located in rural Eastern Oregon in Harney County
- 183 miles to Boise, ID (heading east)
- 300 miles to Portland, OR (heading west)
- We in the boonies, for real

BPT Background cont.

- Smallest tribe of the 9 federally recognized tribes in Oregon
- Governed by a 7 person Tribal Council
- Enrollment= 460
  - Around 160 tribal members reside in Harney County
- 55 Tribal employees
- Title 1 tribe

Services Include

- WaDa-Tika Health Center
  - Built in 1996
  - Staff include- Health Director, Registration clerk, Billing clerk, Tribal Nurse, CHR, National Certified Coder, Warehouse manager, Physical Activities Coor.
- Contract NP
- Most services are purchase referred care
- Clinic is held one day a week (every Wednesday)
- Specialty Care- provided in Bend, OR which is 130 miles one way (heading west)

Programs at Health Center

- Alcohol/drug outpatient
- Tobacco Prevention
- Child care
- General Assistance (GA)
- ICWA
- FDPIR

Updates

- Lost 8 elders this year
  - 2 via COVID-19
- Offices closed mid-March except essential staff
- Yearly training & meetings done via Zoom
- Highest purchase referred care services
  - 1st Dental
  - 2nd Prescriptions

Updates Continued

- Installed backup generator for water pumphouse (funding provided by the health board)
- Health Center renovations- building painted, new roofing/siding, and inside re-painted
- Tribe purchased National Guard Armory

COVID-19 Updates

- Harney County cases- 175 & 4 deaths (as of 1/18)
- Two drive-thru testing events in May and July
- Currently doing rapid testing's when requested
- Working w/ local health department to administer COVID-19 vaccinations (Moderna)
- Estimated 60 tribal community members received 1st dose on December 30th
- 2nd dose will be administered later this month

Quiz Time!

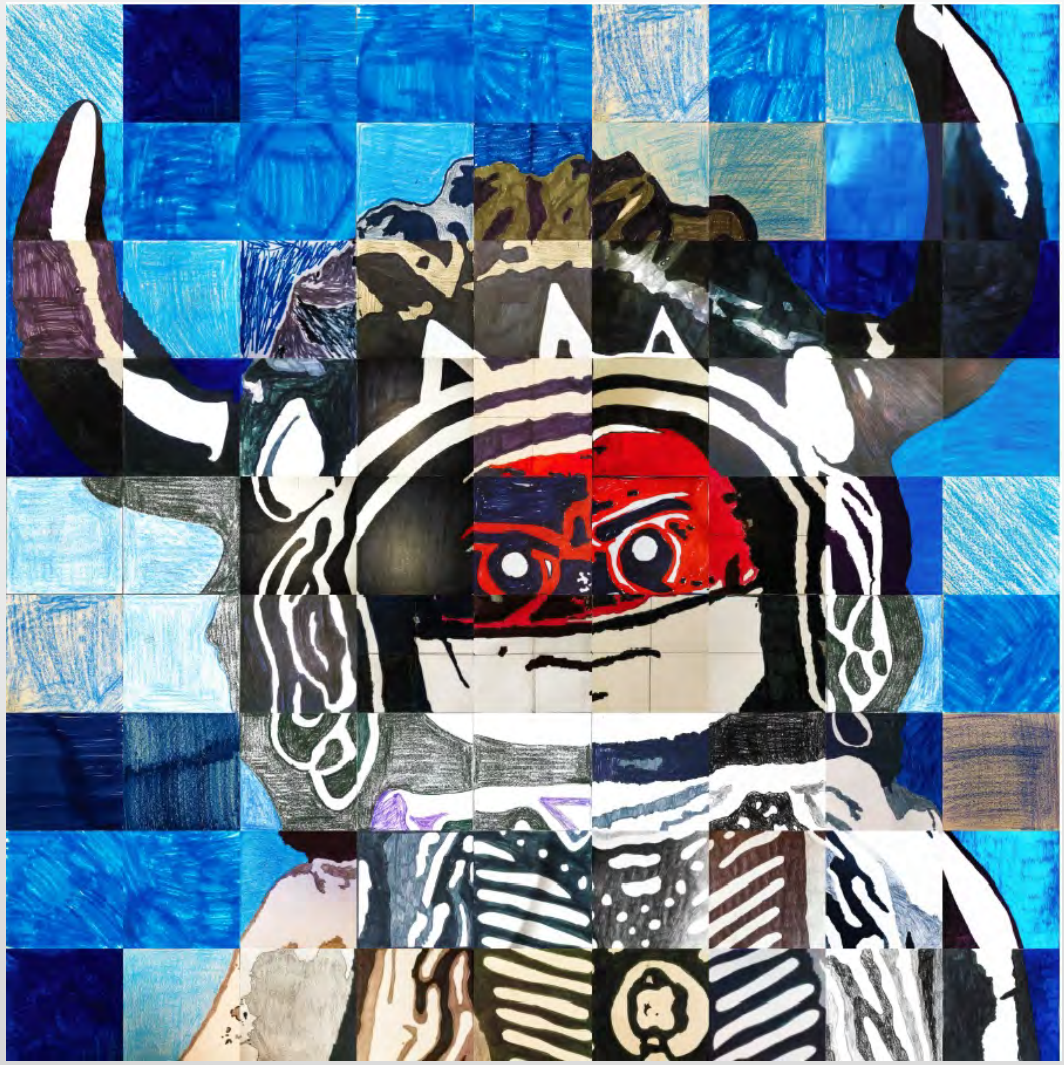
Winners will receive a We R Native facemask

How many enrolled tribal members does Burns have?

How many miles is Boise, ID from Burns, OR?

When was the health center built?

Thank you & Be Kind



_____Youth_____ COMMITTEE
2021 LEGISLATIVE AND POLICY REQUESTS

CHANGES OR ADDITIONAL REQUESTS FOR 2021
Return with updated 2021 Legislative and Policy Requests by
2:00pm on 1/19/21 to Liz Coronado and Candice Jimenez

Request (What is the ask?)	**Reason (Why?)**
E.g., Ensure that future SAMHSA opioid funding opportunities allow a tribe to address other substance use issues.	E.g., Opioid funding opportunities are too restrictive. AI/AN in many communities are dealing with other substance use issues, not just opioids.
Continue to engage other youth, tribal youth councils, and local efforts. Put our local tribal youth as priorities.	Connect with Tribes who are expanding their youth councils to establish better rapport and culture sharing.
Utilizing our Youth Delegates as future leaders. Continuing to strengthen platforms for them to engage and showcase what they are doing.	Our youth are important. Wanting us to be transparent and inclusive.
Brainstorm ways to continue supporting and funding our Youth Delegates.	Wanting to sustain this project without a funding source. Or identifying a new way to continue this important project.

New policy coordinators to meet with the youth and hear why they chose the priority areas, based off the adolescent youth action plan.	They can get more education around why/what the Youth delegates deem as priorities.
Create opportunities that encourage their educational growth alongside their ability to be Youth Delegates.	School is important. Our ability maintain a healthy balance is crucial to the tribes support.
Article around the Youth delegates Showcasing what they have accomplished over the last year.	

Behavioral Health Committee meeting at the NPAIHB QBM

January 19, 2021

Attendees: Danica Brown, NPAIHB; Colbie Caughlan, NPAIHB; Jeramie Martin, Confederated Tribes of Siletz; Marilyn Scott, Upper Skagit Tribe; Larissa Molina, NPAIHB; Candice Jimenez, NPAIHB; Katie Hunsberger, NPAIHB; Nick Lewis, Lummi; Lisa Guzman, CTUIR; Eric Vinson, NPAIHB

Agenda:

Quick introductions

Danica described projects that Behavioral Health program is working on including partnerships with SUD programs and THRIVE at the NPAIHB.

- CDC 1803 Supplemental funding in collaboration with THRIVE administered a survey in the late fall with the NW Tribes asking about COVID, suicide prevention, ACEs, intimate partner violence, etc. The survey results will help guide the work for the supplemental funding and THRIVE dollars from SAMHSA
- Opioid Response Network funding to organize a Behavioral Health ECHO primarily in regards to SUD but will include mental health too.
- Working with Katie H. to develop BHAP/C for students

Marilyn reminded everyone of the multiple issues happening, COVID, SUD, mental health and losses we are all experiencing due to these things right now.

Lisa Guzman let everyone know that they had their "soft opening" for the sober housing building!

Danica led discussion around the Policy and Leg. Priorities for 2021

- Track changes are written on the attached document. . .
- COVID-19 Impact:
    - Communities not having access to Tele-health
    - Rural communities not having the connections needed for Tele-health
    - Trying to increase # of patients to come in for services but restrictions made this difficult so had to do Tele-health for services that more successful if done in-person
    - People haven't had full crisis training – have only had SUD or Suicide
        - So concerned about staff working outside their scopes of work so discussed other models out there for suicide interventions i.e. QPR
        - Emphasized for referral from medical to SUD and mental health and behavioral health integration, CTUIR is up for an award for this integration
        - How do Tribes develop integration systems to meet suicide crises that are occurring
        - How do we help individuals who have mental health challenges and require psychiatric assistance but we cannot detain them to be on the proper medicine regiment to function. These folks are ending up in jails vs. being in a care system that can support their psychiatric needs.—**Danica is thinking about how to include this as a priority**

- Marilyn: Still not able to get recognition of cultural teachings by SAMHSA for dollars to be used on certain activities i.e. drumming or canoe pulling
    - CDC dollars and SMAHSA TOR dollars are less strict on these guidelines
- Jeramie: wants to see more engagement with youth. Mental health providers working very hard and have seen suicidality expressed more often. Trying to get vaccinations out and follow OHA guidelines to see more patients in person. Did upgrades for ropes course, other upkeep allowable with the COVID dollars too. Goal is integration.

Commented [CC1]: Add a priority of Federal entities and States recognizing TBP as EBP in Policy and Leg doc.

Elder Committee Meeting Minutes

Zoom Meeting
January 19-20, 2020
Portland, OR

Members: Patty Kinswa Gaiser – Cowlitz Tribe

NPAIHB Staff: Tanya Firemoon, Kerri Lopez, Chandra Wilson, Clarice Charging

- Elder Committee reviewed the 2021 policy and agreed there were no additions or changes. Thanks to Candice and Elizabeth for their work on this project.
- Presentation of the NW Tribal Elder's Project by Chandra Wilson
    - Update on BOLD (Building Our Largest Dementia) Infrastructure for Alzenheimers Act Grant Award to address Alzheimer's Disease and Related Dementia's (ADRD). This award is in part of the BOLD Infrastructure for Alzheimer Act that was recently passed
    - The grant will promote the implementation of the CDD Road Map and the healthy Brain initiative Road map for Indian Country
    - The BOLD infrastructure is deigned to:
        - Create a public health program infrastructure
        - Focus on increasing early detection and diagnosis of dementia
        - Dementia risk reduction
        - Prevention of avoidable hospitalizations
        - Supporting dementia patient caregivers

Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Notes

January 19, 2021

Start Time: 12:30 pm

Members Present: Cassandra Sellards-Reck

Staff Present: Andra Wagner

- Personnel update was reviewed.
    - _5___ new hires
    - _1___ promotion
    - _3___ transfers
    - _3___ departures
    - 3 Recognitions:
        - Jessica Leston – 10 years of service
        - David Stephens – 10 years of service
        - Amy Franco – Employee of the Year
    - 1 Open Position – Finance Director

Adjourned at 12:40 p.m.

NPAIHB Quarterly Board Meeting
Public Health Committee Meeting
January 19, 2021

Agenda

- Introductions
- Review of 2021 Policy Priorities
- Public Health Improvement Updates
- Data Access Update
- Other

Ali Desautel, Kalispel
Andrew Shogren, Digwalic/Swinomish
Ashley Hoover, NPAIHB
Bridget Canniff, NPAIHB
Celeste Davis, NPAIHB
Christina Diego, SIHB
Dawn Rae Bankson, CDC Foundation/NPAIHB
Karen Hanson, Kootenai
Lauren Sawyer, NPAIHB intern
Lona Johnson, Nooksack
Marilyn Scott, Upper Skagit
Nancy Bennett, NPAIHB
Nickolaus Lewis, Lummi
Obinna Oleribe, Klamath
Tam Lutz, NPAIHB
Tempest Dawson, North Sound Accountable Community of Health
Ticey Mason, NPAIHB
Tyanne Connor, CDC Foundation/NPAIHB
Victoria Warren-Mears, NPAIHB

Review of 2021 Policy Priorities – Public Health

For any corrections changes:

- COVID-19 Vaccine - none
- Public Health
    - Andrew Shogren: Add COVID-19 response – lack of PH infrastructure has hurt tribes in the response, underline that in addition to carrying the existing priorities forward. Example in #2 – where we didn't have the capacity and had to create it. But perhaps it should have its own number.
    - Obinna Oleribe – look at it as part of PH emergency response, as an example. Celeste Davis, suggested wording: "The COVID-19 pandemic has laid bare the

structural inequities that lead to health disparities. This includes inadequate public health infrastructure."
    - Victoria: Includes GHWIC support – important to expand that to include the TPWIC (Tribal Practices for Wellness in Indian Country) CDC funding?
    - #7 not just about funding, but inequity in general – in vaccine distribution, for example. (Ali)
    - For #5, update language "through CDC" rather than "to CDC"
    - Dr. Oleribe: Who defines what is appropriate in No 1? Victoria: each tribe defines what adequate PH infrastructure looks like for them (add tribal determination language)
    - Coordination between NPAIHB, states, tribes in determining needed public health infrastructure
    - Introductory sentence about current pandemic, enhance equity in PH response?
    - Victoria: Is this panel of topics what NPAIHB should put forward?
    - In #5, including other non-communicable disease, where asthma is specifically called out – bring up leading causes of morbidity/mortality, MV injury, for example, COVID-19, etc. (HCV and HIV called out specifically in next section, due to potential for loss of funding in previous cycles)
        - Unintentional injuries 3rd leading cause of death, all ages
        - For ages 1-44, number 1 leading cause of death
        - Specific to Motor Vehicle Injury: AI/AN aged 1-19 years, MV injury is the leading cause of unintentional injury death. Among infants less than one year of age, the motor vehicle traffic death rate among AI/AN is 8 times higher than that of non-Hispanic whites.
    - How can we strengthen public health infrastructure, especially for emergency purposes?
- HCV/HIV Treatment and Funding – no comments, may need some rewording for clarity

VWM general comments: Wordsmithing needed, broadening categories to take into account additional health conditions of public health concern. Not limiting ourselves to any one particular disease, although COVID-19 is all-encompassing right now.

Leg and policy team will incorporate out changes this evening, and present a more final document tomorrow. Will try to broaden some of this and capture concept of generic public health readiness.

Public Health Improvement Updates
Two upcoming initiatives/opportunities:

- Oregon Survey Modernization workgroup recruitment, to review how BRFSS and Oregon Health Teen survey data can be best used for decision making by the tribes and AI/AN communities, and identify and address limitations or gaps. Contact Bridget Canniff at bcanniff@npaihb.org or respond to our recruitment survey at https://www.surveymonkey.com/r/ORSurveyModRecruit
- Washington tribal data partners meeting: February 3, 10-1 PM, virtual meeting

- Agenda:
  - Introduction to the WA Tribal Public Health Improvement Program
  - Data Linkage presentation
  - Communicable Disease Data Briefs overview
  - Facilitated discussions
- Register at: https://www.surveymonkey.com/r/DataPartnersMtg

Data Access Update

The NWTEC has a data sharing MOU with the state of Idaho for COVID-19 data. This MOU is the broadest of any state and allows us to link the NW Tribal Registry with the State of Idaho COVID-19 data to correct for missing or incorrect AI/AN individuals. The state will then correct their records and provide them to CDC. This will make Idaho's AI/AN data very accurate. We feel that this MOU is a proof of concept and will be expanded to other data the state has that we can perform linkages with.

COVID-19 Discussion

- Ticey Mason: Concerns about mixing households, gatherings, parties, etc. where people are not social distancing, masking, or taking other precautions
- Chairman Lewis: high positivity, people who are positive out and about violating quarantine, but there is pushback at the tribe. Concerns about HIPAA as related to public health, where maybe our health team, under public health emergency declaration, could share more with law enforcement, casino, etc. – people aren't listening about COVID-19 risk, not just here at Lummi.
- Celeste Davis: The tribe, as public health authority, does have ability to make certain info known to public safety officials, or gaming commission probably as well, to share info about cases. This applies to public health authority in public health emergency. In different places, tribes have exercised this authority with non-compliant HIV patients, and in cases in the NW with TB patients not being compliant, which is highly infectious. Tribes made names and addresses, etc. available, not to the public, but other agencies and programs within the tribe to ensure quarantining and appropriate care, medication compliance, etc. Probably the best examples of laws/ordinances are from county health depts templates. Fines could also be implemented as a means to ensure compliance, even imposing fines after the fact.
- AIHC isolation and quarantine resources online:
  - COVID-19 model plans, policies, codes: https://aihc-wa.com/aihc-emergency-preparedness/incident-responses-and-other-news/covid-19-model-docs/
  - AIHC Model Communicable Disease Code is here: https://secureservercdn.net/50.62.172.232/tvl.3bf.myftpupload.com/wp-content/uploads/2020/03/AIHC-Model-Tribal-Communicable-Disease-Code-03-30-2020.doc
  - Communicable disease code example https://aihc-wa.com/covid-19-isolation-and-quarantine/
  - Involuntary Detention: https://secureservercdn.net/50.62.172.232/tvl.3bf.myftpupload.com/wp-

content/uploads/2020/03/Appendix-Q-Court-Order-Granting-Involuntary-Detention.doc

- Chairman Lewis: The tribe does have some control over employees who are deliberately going against policies, so what can we do for corrective action? There are policies in place, but a lot of people think they're not going to get it and when they do and have been out and about, and get COVID, they feel remorseful. But there are also concerns that people won't tell the truth in contact tracing if they risk reprimand or firing. Casinos/businesses staying open is another issue. When they initially closed, it leveled off COVID-19 spread, but with reopening, there are many challenges. There are also issues with what's happening on reservation vs. in Bellingham. Some tribes closed their borders early on, are there current or planned border closures?
- VWM example: Shoalwater Bay put in place, on the honor system, around the holidays, had employees agree to go into quarantine and be tested before going back to work if they might have been exposed in social settings. This is a little bit of a different approach that might work better in small clinic to ensure enough workforce would be available, but is an innovative solution. We encourage you to discuss with one another; there are some promising practices that allow people a break from COVID fatigue but also allow for a measure of control in the community.

Veteran's Committee Meeting notes, January 19, 2021

Debbie Jones, Samish Indian Nation
Stephanie Birdwell, VA – Office of Tribal Government Relations
Terry Bentley, VA – Office of Tribal Government Relations
Don Head, NPAIHB

The meeting began with a review of the priorities that were previously generated by the committee. It was noted that one of the priorities, the establishment of a Veterans Administration Tribal Advisory Committee, was accomplished through H.R. 7105, Section 7002, enacted as public law on January 5, 2021. The rest of the priorities were forwarded through, unchanged.

Stephanie Birdwell updated the committee on the recent changes in the Veterans Administration:

- H.R. 6237, concerning VA reimbursement to IHS for services to tribal veterans for Purchased/Referred Care (PRC)
- H.R. 7105:
    - section 3002, concerning AI/AN no longer subject to copayments for services
    - section 4206 concerns coordination of services under HUD-Veterans Affairs Supportive Housing
    - section 7002, establishes a new VA tribal advisory committee (TAC)
- VA/IHS Tribal Consultation on the VA/IHS MOU. A Dear Tribal Leader Letter was sent out on December 2, 2020 for a 90-day consultation notice and comment period. Two informational/listening sessions were completed on December 9, 2020 and January 8, 2021. Two more are scheduled for January 27, 2021 and February 17, 2021.
- The Tribal HUD-VASH expands program dollars by $3.2M, and allows for the current 26 tribes who have this grant to apply for additional funding in addition to allowing new tribes to apply for funding.

Stephanie Birdwell also commented on the priorities identified by the committee, and suggested a future WebEx meeting on the topic of EHR interoperability between the VA/IHS/DoD. She will reach out to the Veterans Health Administration about this priority.

Debbie Jones asked about the reimbursement of PRC to tribes that did not have clinics, but still provided services through PRC. Stephanie Birdwell replied that the nuts and bolts of the recently passed legislation will need to be worked out, because right now the entry point for PRC reimbursement is usually on the tribal side. There are also other factors, including a determination at VA to pay for community health care, and the benefits package that the veteran is eligible for.

The meeting was adjourned at 130p.

Legislative and Resolutions committee Minutes

July 14, 2020

Attendees: Nick Lewis (Lummi Nation), Kay Culbertson (Cowlitz), Mike Collins (Warm Springs), Cassia Katchia (Warm Springs), Tracey Rascon (Makah),

NPAIHB Staff: Christina Peters, Laura Platero, Sarah Sullivan

The Legislative and Resolutions Committee discussed five resolutions. The Committee suggested minor formatting edits to the Community Health Aide Program (CHAP) Portland Area Certification Board. No edits were proposed to the other four resolutions. Chairman Lewis requested a future resolution on homelessness as a public health issue and a resolution on racism/racial bias in health policies/health care for American Indians and Alaska Natives.

The Legislative and Resolutions Committee discussed the five following resolutions:

1. **Direct Tribal Access to the Strategic National Stockpile (SNS) During National or State Public Health Emergencies**

   The HHS Assistant Secretary for Preparedness and Response (ASPR) within HHS administers the Strategic National Stockpile (SNS) and is not statutorily required to deploy SNS personal protective equipment and medical supplies to IHS, tribes, tribal health organizations, or urban Indian organizations. Currently, only states have direct access to the SNS. Legislation is needed to guarantee that IHS, tribes, tribal organizations and urban Indian organizations have direct access to the SNS. Under this resolution, NPAIHB calls on Congress to enact legislation that amends Section 319F–2(a)(3)(G) of the Public Health Service Act requiring the HHS Secretary to directly deploy the appropriate drugs, vaccines and other biological products, medical devices, counter measures, personal protective equipment and other supplies from the strategic national stockpile, and qualified pandemic or epidemic products to health programs or facilities operated by the IHS, an Indian tribe, a tribal organization, an inter-tribal consortium, or through an urban Indian organization.

Action: Motion by Cowlitz; second by Lummi Nation (Nick Lewis); and unanimous vote to pass the resolution to the Board for consideration.

2. **Portland Area Community Health Aide Program (CHAP) Certification Board**

   Under this resolution, NPAIHB supports the creation of and implementation of the Portland area CHAP Certification Board (PACCB). Additionally, NPAIHB supports the development of the PACCB with federal baseline standards for consistency of services provided by any CHAP program. The NPAIHB CHAP Board Advisory Workgroup has spent

the previous two years laying the foundation for the PACCB. On July 2, HHS issued the IHS Circular No. 20-06 for the CHAP with the purpose of implementing, outlining, and defining a national CHAP policy for the contiguous 48 states. Portland Area Tribes have established and continue to implement CHAP within our member tribes. Our member tribes would benefit from the existence of a Portland Area CHAP Certification Board for certification of CHA/Ps, BHA/Ps, and DHA/Ts as outlined in the IHS Circular for CHAP expansion.

Action: Motion by Lummi Nation; second by Cowlitz; and unanimous vote to pass the resolution to the Board for consideration.

3. **Native Dental Therapy Initiative – Funding Offered by the National Indian Health Board for Education/Outreach to Enhance Policies Supportive of Dental Therapy**

The National Indian Health Board is offering a funding opportunity of up to $25,000 for work to enhance polices supportive of dental therapy programs. Under this resolution, NPAIHB endorses and supports efforts by staff of the Tribal Community Health Provider Project, under the guidance of the Executive Director to apply for funding from NIHB in the amount of $25,000 to support NDTI work toward a stronger online presence with improved sharing of information, including creation of a new website and more robust social media presence.

Action: Motion by Lummi Nation; second by Cowlitz; and unanimous vote to pass the resolution to the Board for consideration.

4. **Native Dental Therapy Initiative – Implementation of Dental Therapy Offered by the National Indian Health Board**

The National Indian Health Board is offering a funding opportunity of up to $25,000 for work to improve the implementation of dental therapy laws in Tribal communities. Under this resolution, NPAIHB endorses and supports efforts by the Tribal Community Health Provider Project, under the guidance of the Executive Director, to apply for funding from NIHB in the amount of $25,000 to support the creation of an online Supervising Dentist Training for dentists planning to supervise DHATs, and related support for this training.

Action: Motion by Makah; second by Lummi Nation; and unanimous vote to pass the resolution to the Board for consideration.

5. **Northwest Tribal Dental Preventive and Clinical Support Center HHS-2020-IHS-TDCP-0001**

WHEREAS the services provided by the Northwest Tribal Dental Preventive and Clinical Support Center help to increase the overall resources and capacity of the dental services available for each dental site in the Portland Area.

THEREFORE, BE IT RESOLVED that the NPAIHB endorses and supports an effort to apply for the continued funding of the Northwest Tribal Dental Preventive and Clinical Support Center in response to proposal announcement HHS-2020-IHS-TDCP-0001.

Action: Motion by Makah; second by Lummi Nation; and unanimous vote to pass the resolution to the Board for consideration.

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RESOLUTION #21-01-06

Community Catalyst Funding Opportunity to Support Native Dental Therapy Initiative

WHEREAS the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS the NPAIHB is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington ("member tribes"); and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member tribes; and

WHEREAS, NPAIHB's Native Dental Therapy Initiative was established to connect tribal communities with innovative approaches to address American Indian/Alaska (AI/AN) oral health disparities, to remove barriers impeding the creation of efficient, high quality, modern dental teams and to provide opportunities for AI/AN people to become oral health providers; and

WHEREAS, Community Catalyst is a national non-profit advocacy organization working to build the consumer and community leadership that is required to transform the American health system so it serves everyone; and

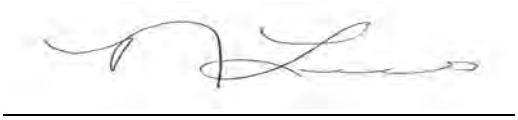
WHEREAS, Community Catalyst has invited NPAIHB to apply for funding to support grassroots organizing and story collection efforts for two coalitions of which we are members: The Washington Dental Access Campaigns and the Oregon Dental Access Campaign.

THEREFORE, BE IT RESOLVED, the Northwest Portland Area Indian Health Board (NPAIHB) approves the submission of the grant application in response to the invitation to apply by Community Catalyst for a grant of up to $50,000 to fund dental therapy consumer engagement, education and visibility in Washington and

Oregon for an anticipated project period extending from date-of-award through June 30th, 2021.

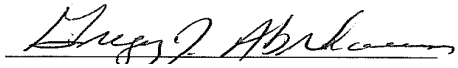
CERTIFICATION

The foregoing resolution was adopted by the NPAIHB Executive Committee at the weekly Executive Committee meeting, held November 13, 2020, with a quorum present.



Nickolaus D. Lewis
NPAIHB Chairman

ATTEST



Greg Abrahamson
Secretary

Ratified by the Board of Directors of the Northwest Portland Area Indian Health Board at the January 20, 2021 Quarterly Board Meeting. With a quorum being established.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Coquille Tribe
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RESOLUTION #21-01-07

Lead Testing in School and Child Care Program Drinking Water Tribal Grant

WHEREAS the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS the NPAIHB is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member tribes; and

WHEREAS, NPAIHB's Environmental Public Health Program provides direct environmental health services and support in order to identify and reduce environmental risks and hazards where people live, learn, work, and play; and

WHEREAS, NPAIHB's Environmental Public Health Program objective is to work in partnership with Tribes and other collaborators using environmental health data, identifying priorities, and developing action plans to address environmental health issues including in the area of safe drinking water and children's environments; and

WHEREAS, the Environmental Protection Agency allocated funding under the Water Infrastructure Improvements for the Nation (WIIN) Act for projects that benefit Tribal schools and child care facilities; and

WHEREAS, the Environmental Protection Agency has invited NPAIHB to apply for funding to support lead testing at tribally-operated child care centers, American Indian/Alaska Native (AI/AN) Head Start and Early Head Start centers, and tribally-operated schools; and

NOW, THEREFORE, BE IT RESOLVED, that the Northwest Portland Area Indian Health Board approves the submission of the grant application to the Environmental Protection Agency in response to the invitation to apply for a grant of up to $445,000 to fund lead testing in school and child care programs as part of the Water Infrastructure Improvements for the Nation (WIIN) Act for an anticipated project period of February 1st, 2021 through January 30th, 2023.

CERTIFICATION

NO. 21-01-07

The foregoing resolution was duly adopted the Executive Committee of the Northwest Portland Area Indian Health Board. A quorum being established; __5__ for, ____0__ against, __0___ abstain on December 16, 2020.

Nicolaus Lewis, Chairman

ATTEST:

Greg Abrahamson, Secretary

Ratified by the Board of Directors of the Northwest Portland Area Indian Health Board at the January 20, 2021 Quarterly Board Meeting. With a quorum being established.

Support for Legislation to Amend Lease Compensation Provisions of the Indian Self-Determination and Education Assistance Act
RESOLUTION # 21-02-01

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
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WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board"} was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the Indian health system has always been chronically underfunded, as documented by the U.S. Commission on Civil Rights, among others; and

WHEREAS, tribes and tribal organizations providing health care services through contracts and compacts with the Indian Health Service (IHS) under the Indian Self-Determination and Education Assistance Act (ISDEAA) have been able to supplement inadequate health care facilities funding by leasing tribal facilities to IHS under the authority of section 105(*l*) of the ISDEAA, 25 U.S.C. § 5324(*l*); and

WHEREAS, tribes also generate income by providing health care services for individuals who are not otherwise eligible for IHS under section 813 of the Indian Health Care Improvement Act, 25 U.S.C. § 1680c; and

WHEREAS, many tribal providers are the primary health care providers in their rural communities and the only ones that will take on Medicare and Medicaid patients; Section 813 helps these Tribes provide better services to their members, other Indians, and their non-Indian neighbors; and

WHEREAS, IHS leasing of tribal facilities providing health care services to eligible Indians and non-eligible individuals in the community served by the facility, as well as the third-party revenues generated by these services, enhance tribal health programs and benefit the communities served, which are in rural areas; and

WHEREAS, IHS has adopted a policy that will only pay 105(*l*) lease costs based on a "supportable space" formula that allows costs based on what is needed to serve eligible Indians; and

WHEREAS, the recent court decision of *Jamestown S'Klallam Tribe v. Azar,* No. 19-2665, 2020 WL 5505156 (D.D.C. Sept. 11, 2020), upheld the IHS decision restricting the compensation available for 105(*l*) leases by allowing IHS to deny compensation for space the agency decides is allocated to serving non-beneficiaries—even though such services are deemed by statute to be provided under the ISDEAA; and

WHEREAS, without legislative action to clarify the interplay of Sections 813 and 105(*l*), it is likely that future rulings will be made along the lines of *Jamestown*, thereby impacting health delivery for IHS beneficiaries and non-beneficiaries alike.

THEREFORE BE IT RESOLVED, that NPAIHB supports legislation to clarify the intent of Congress that space used to provide services within the scope of an ISDEAA agreement, to any patient, is compensable under 150(*l*).

CERTIFICATION

The foregoing resolution was duly adopted by the Board of Directors of the Northwest Portland Area Indian Health Board at the January 20, 2021 Quarterly Board Meeting. With a quorum being established.

Nicolaus Lewis, Chairman

ATTEST:

Greg Abrahamson, Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Environmental Protection Agency Region 10 General Assistance Program (GAP) Proposal
RESOLUTION # 21-02-02

WHEREAS the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS the NPAIHB is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member tribes; and

WHEREAS, NPAIHB's Environmental Public Health Program provides direct environmental health services and support in order to identify and reduce environmental risks and hazards where people live, learn, work, and play; and

WHEREAS NPAIHB's Environmental Public Health Program objective is to work in partnership with tribes and other collaborators using environmental health data, identifying priorities, and developing action plans to address environmental health issues; and

WHEREAS, the Environmental Protection Agency (EPA) has announced an opportunity to apply for General Assistance Program (GAP) funding for Federal Fiscal Year 2022 to support federally recognized tribes and intertribal consortia in environmental program capacity building activities; and

WHEREAS, the EPA allocates funding for intertribal consortia after it has funded individual tribes' proposals, and consortia work plans must meet the capacity-building needs of their member tribes without duplicating members' efforts; and

WHEREAS, the NPAIHB Environmental Public Health Program seeks permission to apply for EPA GAP funding to work with the 43-member tribes to support climate change preparation and resiliency planning including activities such as:

- a comprehensive assessment of what tribes have done and are doing to prepare for, mitigate, and build resiliency in response to climate change
- conducting a systematic review of all environmental threats and identifying the public health impacts associated with each
- researching and establishing regional health indicators for climate change, conducting a needs assessment, and working with tribes to integrate public health outcomes and resiliency activities into climate change plans where appropriate
- developing internal capacity and knowledge, collecting information about traditional ecological knowledge relevant to climate change, and developing partnerships with tribes and other intertribal consortia such as ATNI and ANTHC

NOW, THEREFORE, BE IT RESOLVED, that the Northwest Portland Area Indian Health Board authorizes the submission of a grant application to the Environmental Protection Agency as an intertribal consortia to be funded after individual tribes for up to $125,000 a year for four years to build capacity to support tribes in integrating public health indicators and outcomes in planning for, mitigating, and building resiliency to climate change for an anticipated project period of October 1, 2021 through September 30, 2025.

CERTIFICATION

The foregoing resolution was duly adopted by the Board of Directors of the Northwest Portland Area Indian Health Board at the January 20, 2021 Quarterly Board Meeting. With a quorum being established.

Nicolaus Lewis, Chairman

ATTEST:

Greg Abrahamson, Secretary

Tl- 21-007 Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Opioid Response (TOR) Grant
RESOLUTION # 21-02-03

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Chehalis Tribe
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Cowlitz Tribe
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WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board"} was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS §450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, since 1997, Northwest American Indian/Alaska Native (Al/AN) people have had consistently higher drug and opioid overdose mortality rates compared to non-Hispanic Whites (NHW) in the Northwest region; and

WHEREAS, from 2012-2016, the Al/AN age-adjusted death rate for drug overdose was more than twice the rate of non-AI/AN in the region, and the rate of opioid overdose was 2.7 times higher; and

WHEREAS, our member tribes are in need of additional resources directly from the federal government for funding to combat the multitude of problems related to opioid use through best practices for their tribal members; and

WHEREAS, the Department of Health and Human Services (HHS} Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Opioid Response (TOR), FOA No. Tl-21-007, provides up to 150 awards to tribes across Indian country, including 11 of our member tribes; and

WHEREAS the NPAIHB's Northwest Tribal Epidemiology Center (EpiCenter) is authorized to operate nationally to carry out the goals and objectives of SAMHSA's TOR grant and to coordinate a NPAIHB TOR Consortium on behalf of our interested member tribes; and

WHEREAS, the NPAIHB has deeply rooted partnerships with our member tribes, and has a successful track record of administering public health programs that are sensitive

to the concerns and needs of tribal communities, including prior iterations of TOR funding (H79TI081812, H79TI082598, and 1H79TI083243); and

WHEREAS, our member tribes have provided NPAIHB with the authority to apply for the SAMHSA TOR grant on their behalf as part of the NPAIHB TOR Consortium; and

WHEREAS, NPAIHB is not competing with member tribes applying for this funding directly, but rather, ensuring that those tribes that do not apply directly receive funding for grant activities through the NPAIHB TOR Consortium; and

WHEREAS, NPAIHB EpiCenter would provide leadership, coordination, data management and analytic support, and training and technical assistance to member tribes participating in the NPAIHB TOR Consortium to ensure successful completion of grant activities; and

WHEREAS, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the NW Tribal EpiCenter strategic plan; and

THEREFORE BE IT RESOLVED that the NPAIHB endorses and supports efforts by staff of the NPAIHB/NW Tribal EpiCenter, under the guidance of the Executive Director, to pursue funding through the Tl-21-007 SAMHSA TOR grant on behalf of member tribes who participate in the NPAIHB TOR Consortium

CERTIFICATION

The foregoing resolution was duly adopted by the Board of Directors of the Northwest Portland Area Indian Health Board at the January 20, 2021 Quarterly Board Meeting. With a quorum being established.

Nicolaus Lewis, Chairman

ATTEST:

Greg Abrahamson, Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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

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Portland, OR 97201
Phone: (503) 228-4185
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www.npaihb.org

Behavioral Health Aid Training and Support Project
RESOLUTION # 21-02-04

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington ("member tribes"); and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, American Indians and Alaska Natives (AI/AN) communities are disproportionately affected by physical health, behavioral health and oral health disparities and inadequate access to health services; and

WHEREAS, the Community Health Aide Program (CHAP), including Dental Health Aide Therapists (DHAT) and Behavioral Health Aides (BHAs) has been in existence in Alaska since 1968 and has proven to significantly improve health outcomes for communities served by these providers; and

WHEREAS, NPAIHB has established a Tribal Community Health Provider Program to bring CHAP providers to the Portland Area and member tribes would benefit from training members of tribal communities to become care providers for their own communities; and

WHEREAS, NPAIHB has a longstanding relationship with Washington Health Authority for BHA education and training; and

WHEREAS, NPAIHB is developing a BHA education program and is seeking funds to support BHA students who have been furloughed in their practicum field placement due to the Covid-19 pandemic; and

WHEREAS, this specific funding opportunity supports developing the behavioral health workforce for AI/AN people in the Pacific Northwest to deliver high quality, sustainable, culturally relevant behavioral services in AI/AN communities; and

WHEREAS, funding is available through the Tribal Behavioral Health Division of WA Health Care Authority in the amount of a $100,000 contract; and
WHEREAS, funding will be used to fund two Northwest Elders Knowledge Holders and Culture Keepers trainings in the Spring and Fall; and

WHEREAS, funding will be used to support the salary for a BHA student furloughed during the Covid-19 pandemic, allowing the student to complete required particum hours for certification.

NOW, THEREFORE BE IT RESOLVED that the NPAIHB endorses and supports efforts by staff of the Behavioral Health Aid Training and Support Project, under the guidance of the Executive Director, to accept funding from the Tribal Behavioral Health Division of WA Health Care Authority, to support the BHA education program.

CERTIFICATION

The foregoing resolution was duly adopted by the Board of Directors of the Northwest Portland Area Indian Health Board at the January 20, 2021 Quarterly Board Meeting. With a quorum being established.

Nicolaus Lewis, Chairman

ATTEST:

Greg Abrahamson, Secretary