MINUTES

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING

April 20 - 22, 2021

Via Zoom

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April 20 -22, 2021

MINUTES

Summary of Minutes

Issue	Summary	Action	Follow-Up
TUESDAY APRIL 20, 2021			
Call to Order:	at 8:39 AM and Welcome by Nick Lewis, NPAIHB Chairman		
Roll Call:	There were 27 delegates present, a quorum was established.		
Review and approve October's Quarterly Board minutes	• **Motion by Shawna Gavin, Confederated Tribes of Umatilla** • **Motion 2nd by Cheryl Rasar, Swinomish** • **Motion Carried**		
Chairman's Report, Nick Lewis	It is so good to be here with you today and glad that our IHS Acting Director Liz Fowler will be joining our meeting later this morning. Thank you to Chairwoman Kennedy, our NPAIHB Vice Chair, for chairing the meeting today. This is the last day of my eldest son's visit with me. He'll be heading back home later today. We have had beautiful weather up at Lummi lately, the trees that lost their leaves last fall are just starting to show their green, the sky is a bright blue, and the breeze that blows over the water gives me a feeling of hope. Even though we are together over Zoom again, I am so encouraged as I look back at all we have come through over the last year, and I see all we have accomplished, together. We know how to pull together, whether it is sharing vaccinations, passing on supplies and PPE, or working together in the federal-tribal consultations (and there sure have been a lot of consultations lately). Someday soon – and I look forward to that day – we will look back at the time that we fought the COVID-19 pandemic together. There is opportunity and hope on the other side of this pandemic. Since the last board meeting, we vaccinated many of our people in Idaho, Oregon, and Washington. Tribes are working with the IHS or their States to get vaccines into the arms of our people, and our tribal leaders and clinic staff are working to reduce vaccine hesitancy in our communities. While there may be a bit of setback with the Johnson & Johnson vaccine, we cannot stop addressing vaccine hesitancy. It's a big concern right now, especially with our younger tribal members.		

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	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 • We held National Tribal Budget Consultation in early April for Fiscal Year 2023. Shortly after the Budget Consultation, President Biden released his proposed budget for Fiscal Year 2022. President Biden has proposed a significant increase to the IHS budget, bringing it up from $6.2 billion to $8.5 billion. We continue to advocate with our representatives in Washington DC for the resources we need through virtual meetings and by submitting written testimony and appropriations requests. • I attended the National Indian Health Board quarterly Board meeting in late January, and was nominated to be their Vice-Chairman. Although the vote on that was delayed until March, I am honored to report that the NIHB made me their Vice-Chair. NIHB also recently asked me to represent them as their at-large representative with the CMS-TTAG and SAMHSA-TTAC. I am humbled by their confidence in me. I will do my best serving our people on these committees. I believe this is the right work at the right time – We are working in all our Tribal Advisory Committees with all the other Areas and tribes across the country to get tribal priorities in front of the Biden Administration. And I am pleased to say that senior Biden Administration leadership is showing up at the table in our Tribal Advisory Committee meetings. • I continue to actively participate in the NIHB weekly Board and Quarterly Board meetings. • I have recently been appointed as the Portland Area Representative to the IHS Information Systems Advisory Committee, and will work to advocate for tribes operating RPMS and operating commercial off-the-shelf-systems on this Committee. • I've participated in weekly Biden White House calls, and continue to remind the administration that Indian Country needs to see equity in action, not only to fight this pandemic, but also in all federal funding. • The Board's Executive Committee has been meeting weekly for over a year now. Each week, Executive Committee members get admin and finance updates, discuss policy concerns, and get COVID-19 and EPI updates.		

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	As we look forward to the changes that spring brings, we also look forward to bringing additional resources home to our communities so that we can repair the damage from COVID-19, and invest in the public health infrastructure that we need to sustain lasting change. The Portland Area is working alongside 29 other regional and national tribal organizations, actively promoting an Indian Country Infrastructure Plan. As the Biden administration looks at infrastructure investments, getting our priorities to the administration, and to our legislators is a priority. My commitment to you remains the same - I am here for you, you all should have my cell number by now, please always feel free to call or text, and let me know if there is anything you need Board support and resources for, we will try to make it happen. I hope you all have a productive meeting today and I will be with you tomorrow chairing the meeting.		
Executive Director Report, Laura Platero	***Please see attached PowerPoint***		
COVID-19 Response, Celeste Davis, Environmental Health Director	***Please see attached PowerPoint***		
Indian Health Service, Dean Seyler, Portland Area IHS Director	**<u>Community Health Aide Program (CHAP)</u>** **<u>Circular No. 20-06</u>** ❖ Policy was approved in FY2020 ❖ Requires establishment of Area and National Certification Board ❖ Responsible for certification of providers (Federal & Tribal) ❖ Review and recommendation of certification training programs **<u>Dear Tribal Leader Letter – Portland Area Certification Board</u>** ❖ Sent April 14, 2021 ❖ Seeking Consultation and comments until **<u>May 14, 2021</u>** ❖ Board make-up (seating plan) ❖ Board candidacy requirements ❖ Term limits ❖ Representation (T1, TV, DST)		

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CRRSAA - Pub. L. No. 116-260

- Overall purpose still needs to fall under COVID-19
  - Vaccine Funding – Sent unilaterally (DTLL 2/2/21)
  - Testing Funding – Bilateral amendments, (DTLL 1/15/21)

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 correct for 2016-Present
  - New Employee – Michael Mummey, ISDA Financial Specialist (CSC)
  - If we have not contacted you please provide us final pass-throughs or salary information.
- 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 the FY20 Recurring Base, which runs through 1/27/2021

FY20 Catastrophic Health Emergency Fund (CHEF)

Status as of April 7, 2021

- 67 Total Cases
- 41 Total Amendments
- $2,471,289.00 Reimbursed
- $40,202.78 Pending Reimbursements
- 92% Total Reimbursed

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- **FY20 CHEF Balance: $19,042,902**

Division of Health Facility Engineering

Regional Specialty Referral Center Network

- IHS Continues to Explore Avenues to Support a Demonstration Project

Combined Supportable Facility Engineering

- Responses were due February 15th
- One-week extension provided
- 12 Tribes responded (30 Tribes Last Year)
- Responding Tribes are eligible for FY21 BEMAR Funding Consideration
  - (Funds well be available, Amount Still being Determined)

Division of Sanitation Facilities Construction

- Positions Filled
  - Tribal Utilities Consultant, Olympic District Office: LCDR Sandra Redsteer P.E. sandy.redsteer@ihs.gov
  - Tribal Utilities Consultant, Portland Area Office: LCDR Jason Davis P.E. Jason.davis@ihs.gov
- Positions Pending
  - Environmental Engineers (2): 1 each at the Spokane District Office and Port Angeles Field Office
- Positions Vacant
  - (Coming soon): Senior Environmental Engineers (2)
    - – Port Angeles FO, Fort Hall FO
  - Engineering Technicians (2
- Contact: Alex Dailey, Portland Area DSFC Director, 503-414-7780 alexander.dailey@ihs.gov

- 2021 appropriation resulted in 5.4% increase in IHS construction funding over last year.

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	❖ With contributions, there was an 18.4% increase in funding for IHS projects. ❖ 34 Projects currently on the draft FY21 Funding Plan ❖ Currently gathering needs for FY22 funding (Regular and Housing Projects) ❖ CARES Act funding: $10M nationally in 2020 for SFC ❖ Resulted in $421,017 in funding for Portland Area ❖ IHS developed 8 projects benefitting 11 Tribes ❖ 4 of 8 projects complete, with funds disbursed to Tribes Example: $23,517 for Colville Tribes to upgrade their well service truck to allow maintenance of community		
Indian Health Service, Elizabeth Fowler, Acting IHS Director	**Cheryle Kennedy, Grand Ronde** – As you mentioned COVID-19 is a very serious problem we are very worried about the lingering effects that it has, some yet to be to be revealed. In addition to that, we face mental health and substance abuse issues due to the isolation, which are also part of what we are dealing with. Here in the Pacific Northwest you've probably heard about the raging fires that took out millions of acres here in the Northwest, the effect of that we are also dealing with. I just want you to know that our Area Director, Dean Seyler is very committed to the Tribes here. I want you to know his tireless work and efforts he made this past year. IHS is critical to our work and success. We look forward to working with you to improve the health and wellbeing of our people. We hope you will continue with your current roll in leadership, and join us at our Quarterly Board meetings. Our next Board meeting is going to be held July 27th – 29th. When you were talking about the President's budget we want to express the appreciation for the increases. Especially the historical request of Advance Appropriations for FY2023. You talked about the FY2023 budget, the amount you mentioned is way off from the Tribal Formulation workgroup recommendations. We want you to know we support the Tribal Formulation workgroups recommendations for full funding of $48B dollars for FY2023. We also support mandatory funding for CSC and Section 105(l) lease agreements. All of those elements are necessary for Tribes to continue to prepare to provide quality healthcare. The Indian Health Services budget has been lacking in its ability to provide quality health services because of funding limitations and insufficiencies in funding. This time, the time is right for the funding levels increase so that we can be fully fortified, fully enable, fully ready to meet challenges that are before us. One of the things the Northwest Portland Area Indian Health Board has been a leader in is SDPI, the		

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	diabetes funding. Now is the time for us to get permanent authorization at $250M per year with medical inflation increases annually. The programs have not received any increase in two decades and yet we see diabetes escalating. We are doing good work, and it's effective but it's not enough funds to support it. New grantees must be able to come into the program and current programs need increase funding for the support of our self-determination. All the various titles 638 contracts and compacts we have we request IHS work with Congress to make the necessary legislative change that would allow Tribes to receive funds normally received through the grant process. Through our compacts and contracts Portland Area Tribes have been making this request as to SDPI funds and all the Behavioral Health Initiatives we hope and are confident under your leadership this can happen. We've seen you be an advocate we know that you are able to affectively present the needs of Indian people are. When Tribes receive program dollars of course we need the indirect costs rates to provide all the supportive services to make those programs and services happen. We request an exclusion of all onetime non-reoccurring COVID-19 funds in the indirect cost rate calculations. It will significantly impact our indirect cost rates in the future. There have been many studies and I know you are aware of impact of the indirect rate and how they effect program and services of Indian people. That is a request the Portland Area has made for many, many years. **Ms. Fowler, Acting IHS Director** – thank you for going through that list. Tribal priorities and their budget requests was much higher than what came out in the President's budget requests and it's the fact that it's a $2B increase still have very significant indicator of this administrations support. With all my years at the Indian Health Service and all my years working in budget formulation I've not seen this level of support for IHS before. Even though it does fall short of that full funding amount that the Tribe's approved as their budget priorities for FY2022 I do think, and of course there is still time to advocate for additional funding. We've initiated the FY2023 budget cycle, there are more opportunities and we're hopeful that this funding level that is requested will be approved by Congress, and that we can fill the pot to actually reach that level of funding that the Tribe's have determined need priority and full funding level. I've heard you and taken down your comments and will take them the Special Diabetes Program for Indians funding. Certainly, the Indian Health Service believes that this program is a showcase		

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	program for Indian County. It shows what Indian county is able to do with a focus set of funding IHS definitely wants to see the funding continue and we know it needs a definitely needs permanent funding it's not helpful and it's not effective to have that uncertainty in that funding IHS supports those efforts as well. We do understand the need for new grantees to expand the program we hear you on that. I wanted to touch on one more item's, your comments on the indirect cost rate we've heard this in some prior meetings. I do think your making a great point bring that up I'm not sure exactly what IHS is going to do there in terms of the actual indirect cost rate negotiations because it's not handled by IHS but I think it's something IHS can have a discussion about it and how it applies to our ISDEAA agreements. I do want to mention we do plan to stand up our Contract Support Cost workgroup soon fairly soon in the next few months they plan or reestablishing that workgroup. That can be one of those items the workgroups pick up and works on how to mitigate the impact of COVID so on the application of the indirect cost rate for next year moving forward. I'll stop there for now. **Cheryle Kennedy, Grand Ronde** – The Portland Area does not have hospitals of course we are talking about PRC dollars. That's always been a discussion of what that all means for us. Then we have to look to our PRC dollars for any of our hospitalizations we're always lagging. I'm not saying that other Areas don't need these dollars or they have too much or anything. But what I'm saying is we don't have enough. We have to cover especially at these times with increased hospitalizations and more long-term care it just very staggering for us to deal with. We don't yet know about the long haulers and what that means in terms of additional funds that we have to expend and we were not there before. We're really asking for $1B increase in PRC which would meet the needs of the Portland Area Tribes and support Specialty care for long haulers, that's really a specific request in the budget for us. Would you like to comment on that? **Ms. Fowler, Acting IHS Director** – I completely understand your point as co-chair of the PRC workgroup a few years ago. I understand the differences in Areas who have hospital or inpatient services and your right, it's not that other Areas don't need PRC, but the hospitals that they do have are more like community hospitals. They are still transferring patients out for higher levels of care as		

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	well. But it's such a great point you make for more funding. I've heard similar concerns raised from the California Area; they have a particular interest in seeing the PRC allocation formula revisited, we are not sure if that's something we have the PRC workgroup to review and consider. As I'm aware they haven't quite come to that decision on that recommendation yet and it's something we are still working through. I know that this is a concern for both Portland and California Area, and understand the concerns and needs. . **Cheryle Kennedy, Grand Ronde** – the way I look at it I know that there are special provisions and still are for the Alaska Area because of the high cost of care there, the high cost of living there, everything there, so there is a factor of adjustment there. I get concerned about other Areas veto power over other Areas because they have a different need. I just put that out there for consideration that this probably needs to be looked at when there are unique extenuating circumstances, and that needs to be looked at through those eyes. **Andy Joseph, Colville -** As Co-Chair of the National IHS Budget we request a meeting with the White House and OMB. I would also request on the infrastructure bill staffing for all the Tribal clinics that haven't ever had an increase in staffing of Providers. **Ms. Fowler, Acting IHS Director –** if he's still on I would say Andy's been a great advocate for the budget the Indian Health Service with his work with the budget formulation, and he has raised this in different forums including with the Secretary and the Secretary's Tribal Budget consultation session and other forums as well. We are prepared to advocate for getting the meeting scheduled, I think that HHS has been supportive of facilitating getting the meeting scheduled, I think we are going to be able to do that. Regarding the infrastructure bill, that is something else we are keeping an eye on, and I know his note or focus is on staffing point and that is something that we have been sure to include whenever we have been asked to provide technical assistance. It's not just a project, not just funding for the project, it's self but it's for the staff that goes along with it, that it's a similar concept there it's noted that staffing is needed. He's also been advocating for that for a while now, Dr. Mike Pine at the Oklahoma City Area office, I can also say that I share that concern as well.		

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Cheryle Kennedy, Grand Ronde – I'd like to go over the Board priorities. Then we'll mix in some of the comments or questions. The other priority we wanted present to you is the Community Health Aide Program. The Board has worked hard to establish the framework for the CHAP expansion in the Portland Area. We have 12 DHATs working within our Tribes, we have seven Behavioral Health Aide students in the Alaska education program, and we have four more Behavioral Health Aide students who will start their education program in May of this year. After five years of preparations, we are ready to stand up our CHAP certification board to certify our Portland Area CHAP providers, to accredit education programs for DHATs, and the BHAs in the Portland Area. We have recommended seating for the Board, provided Standards and Procedures, and drafted by-laws to support the CHAP Certification Board. We're looking forward to partnering with IHS to support our Portland Area Certification Board. We also acknowledge the DTLL sent in by Portland Area Director Seyler and we look forward to working together. We look forward to hearing about IHS decision on the $5M in CHAP funds for FY2020. We'd like to know the processes used for the $5M in FY2021 funds. For FY2023 we request $60M for the continuation of the national expansion and $10M for the Portland Area to continue to expand CHAP. This is a new initiative but the Board has been working on it diligently our Tribes have come forward. Is this something you can get behind and move forward in your leadership role?

Ms. Fowler, Acting IHS Director – we are planning to announce the decision on CHAP consultation on the $5M regarding the allocation of the $5M planning on announcing that next week. I will say the focuses on the preparations and the planning the infrastructure that is needed to move forward with implementing a CHAP program. Portland is well positioned and I can't really share any for the details at this point in time. I think there is some good news coming.

Cheryle Kennedy, Grand Ronde – you talked a little about Regional Referral centers I know Andy was on earlier and we heard from Director Seyler there is a possibility of funding for three Regional Referral centers. We know that Portland Area was in the que for those funds and now learn that there is not a staffing package associated with those facilities. Andy articulated it very well, how successful can we be? We get construction planning dollars, we do the construction, get everything set up and

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	we see an empty building staring at us. I'm recalling back and I believe that the language for the Regional Referral center said for the first couple years, two or three years that Indian Health Service would staff that. That they would be employees of the Federal government and be the ones in there working and then it could be transferred over to Tribal leadership or operations. I see that as a serious problem for the Indian Health Service, do you have the staff ready to do this? The comment is that we need staffing dollars. **Ms. Fowler, Acting IHS Director –** I've been briefed on this project and I was a little surprised that it is still pending. I thought the project was underway actually. I'm going to make it a priority to settle on that question and determine what we are able to do, just so we know about moving forward with that project. I agree with you it's just ineffective and wasteful to put so many millions of dollars into construction of a place and not having the staff, not having it open and being able to provide the services that it was planned to deliver. We will work on determining what path is available to us to go forward with and I hope we can move on this discussion, and settle on an answer as soon as possible. **Cheryle Kennedy, Grand Ronde –** The mental health and substance use issue, there are national statics that say increases of suicide are happening especially among adolescents and young adults. The Board has set up many programs to combat that, but during this pandemic it's just having a double whammy on the Tribes and our people. There are unfunded mental health initiatives in the Indian Health Care Improvement Act that should be funded to increase prevention and treatment services including mental health providers and support behavioral research. The National Tribal Formulation Budget workgroup said the increases should be for mental health $6M in alcohol and substance Abuse by $527M then will move into the behavioral health facilities. We have to regional treatment centers in the Portland Area the Healing Lodge of the Seven Nations in Spokane and NARA NW in Portland we need much more than that. The States we live in really don't have these types of facilities either so we are looking to you to see this problem resolved. Our children and youth are without a future unless we can assist them, it's a heartbreaking situation, what a loss for our communities, our Tribes, our population. We bring that to you for you to support and to find other ways to getting funds out or services. I have concerns about sending our youth to non-cultured		

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	facilities. **Ms. Fowler, Acting IHS Director –** it is a concern for me as well. I've heard of stories and it's really heartbreaking especially what's been highlighted with the pandemic we're going backwards it seems like the isolation the need to at some reservations with the lockdowns that was needed measure to prevent the spread of COVID at the same time it added to those factors that lead to depression, and I've heard and briefed on some suicides that have been happening in parts of Indian country and it really is heartbreaking to hear that. Behavioral health, we know continues to be one of the very top priorities for the Tribal Budget Formulation workgroup and that means it's a top priority for the Indian Health Services as well. Whatever opportunity we have to advocate for additional funding, additional services, additional programs to help in the behavioral health area we take that opportunity to do so and will continue to do that. **Cheryle Kennedy, Grand Ronde –** the Board seeks to eliminate Hepatitis C among Indian people we know and looked at the statistics and we know healing. The elimination of it but vaccines have been very costly and we rely on PRC payments and we believe at least $600M is need for Indian Health Service to provide this lifesaving treatment to those effected, those who are served by IHS. The VA was able to do this and IHS must follow. This is a cure. **Ms. Fowler, Acting IHS Director –** Thank you for raising that and I don't know very many of the specifics of that, and this something I will have to get back to you on. It sounds to me like an investment that would produce the outcomes that we want to see healthier American Indians/Alaska Natives. I'll take that back and find out more about that and see what we can do about that. **Cheryle Kennedy, Grand Ronde –** The Board Chairman who is Nick Lewis he sent a letter to you expressing concerns that arose during the March 21 SDPI meeting. We're wondering if you could clarify how IHS intends to use the $30M in unused allocated carryover funding over which Tribal consultation was held August 2020? The second concern we have is use of offset funds in grant with unallocated balances it appears that the IHS uses both funding streams either without following recommendations from Tribal consultation or without Tribal input. We are wondering if you have		

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	had time to review our letter and if you can address our concerns? **Ms. Fowler, Acting IHS Director –** I do have your letter and its currently being reviewed. We will send you a specific response in writing to the letter just a general a broad response the decisions that were made about the offsets the funding that resulted in from the offset and use were provided or recommendations were provided from the Tribal Leaders Diabetes Committee which the Indian Health Services accepted as determined to approve those recommendations. But, we will put that in writing to you so you have a clear response to those questions. **Elizabeth Jim, Shoshone-Bannock -** My concern is Providers and healthcare workers are at an all-time low and much burn out due to COVID. How are we going to address these problems? How do we sustain the workforce? **Ms. Fowler, Acting IHS Director –** Sometimes you hear that question what keeps you up at night and I think for me similar for me it's how do we answer the recruitment and retention issue that we face in Indian country. I think our team and our IHS and our I/T/U programs are amazing I think their dedications is just awesome but your right and understanding what it is going to take to ensure we have a steady pipeline of providers its critical for our programs and that is one area for me that is every time I hear about the issues facing our hospitals and clinics there is always a common thread and that common thread is how do we ensure that we have the staff we need and think about COVID we needed deployment in order to respond to COVID. I apricate your comment so much I like your idea of centralized recruitment place and I will say we are able to advertise on the IHS website for jobs not just for our federal sites but for our Tribal sites as well. That's one avenue that is open to Tribal site that you may not beware of but its something we can think about. I don't have any answers for you or what it's going to take to ensure that we have the nurses we need especially with the shortages not just for Indian Health Services but nationwide. I will say that one of our four strategic aims for COVID include the recovery phase its just not at the end of the pandemic but throughout the pandemic ensure our staff are getting some periods of rest so that they are able to get some rest and feel refreshed and keep going and keep the fight up against COVID. Those are all strategies, we have multiple resources on our website about from a behavioral health through our		

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	center of excellent regarding how to improve resiliency and that type of things we can provide those links to those resources. Its not the answer to take care of everything but I assure you that it's a concern IHS has. **Sharon Stanphill, Cow Creek -** SDPI and $30 M "unallocated" funding which was consulted on in August 2020. Can you speak to our letter we sent you April 8, 2021 to clarify the "grant supplements" decision by the IHS please? **Ms. Fowler, Acting IHS Director -** the broad response I gave regarding and give some assurance we did rely Tribal Diabetes Committee to provide recommendations and we approved their recommendations and we were responsive to those. We will explain that in the written response exactly what the recommendations were and what the plan is for that $30M. **Nate Tyler, Makah Tribe** – I want to agree to what the Chairwoman has said and to what Andy Joseph had to say and I apricate the time spent here today. A couple items I'd like to bring up you mentioned the roll out of the CHAP should be coming down the pipeline next week? Just thinking about President's Biden Executive Order #13175 following the footsteps of President Clinton and President Bush as far as consultation and CHAP in general and DHAT I don't think we talk enough in general dental and I'm hoping we can get some support from IHS on the DHAT program in the sense of scholarships training and the general roll out and backing on the DHAT program dental in Indian country is not talked about enough. More and more Tribes have been compacting and when we see infrastructure bills and we see. It doesn't really reflect monies coming down the pipeline we can look at the IT that came out IHS took a major chunk of that. It's a need that all Tribes face and the equitable cuts towards IT, towards construction, toward infrastructure all these things coming down the pipeline are going to reflect fair and equitable shares towards Tribes. For me DHAT and if we can focus on dental more I'd apricate that. **Ms. Fowler, Acting IHS Director –** I think the good thing about the CHAP program, the national program really covers all of the health aides not just the community health but the behavioral health and the dental health aide. The funding that's been appropriated and will be allocated to the community health program and does cover the dental health aide program as well. I was looking at		

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	the Tribal budget priorities and dental is usually in the top five of those funding priorities. I hope the funding that is coming down for CHAP I hope you find it helpful to start addressing the DHAT needs. The comment on the scholarships is something we can consider whether or not it has potential for that and it depends on what kind of training is required and I'll take that back for consideration. **Cheryle Kennedy, Grand Ronde –** IT modernization the pandemic has highlighted the deficiencies with the current IHS electronic health records system and the critical importance of having a robust health information exchange Indian Health Service delivery system. IT health modernization would be a priority for IHS with an expedite implementation over the next three to five years. Tribes using RPMS cannot wait ten years for an update they need fixes, technical assistance and support now. During any transition period the National Tribal Budget Formulation workgroup estimates full implementation of a new EHR system will cost $3B based on the 25% of the VA cost estimate for FY2022. For FY2023 we recommend $100M for planning and phased in replacement of RPMS. We also recommend that IHS provide funding to reimburse and provide ongoing financial support for Tribal facilities that have purchased and implemented off the shelve systems. There is a very real need and deficiencies and we are aware that the IHS budget is often predicated from the uses and delivery of services provided on the field and reported through those systems. We need the fix and we need to be able to do it now rather than later. **Ms. Fowler, Acting IHS Director –** IHS feels the same way its outdated and it would be very costly to string it out over many years. We would rather have the funding to move forward with that project all at once. We also have heard from Tribes that have purchased their own systems using whatever funding they identify to do that. Worthwhile noting the House subcommittee on Interior Appropriations did ask us to compile the amount of funding the Tribes have spent purchasing their own systems. That some piece of request coming out so we will be working on gathering that information. Having a sense of how much funding has already been spent to replacing and putting into place electronic health care system.		
LUNCH			
Committee Meetings Breakout Rooms			

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Legislative Update, Cindy Darcy Policy Consultant	***Please see attached PowerPoint***		
Regulatory/Administration Update, Liz Coronado, Health Policy Specialist	***Please see attached PowerPoint***		
	Recess for the day at 4:30 PM		
WEDNESDAY APRIL 21, 2021			
Call to Order:	by Cheryle Kennedy at 9:59AM		
Finance Report & 2020 Audit Report, Eugene Mostofi, Fund Accounting Manager & Chris Tyhurst, REDW			
Portland Area Tribal Advisory Committee Updates, Sue Steward NPAIHB Deputy Director	***Please see attached PowerPoint***		
LUNCH			
EpiCenter Update, Victoria Warren-Mears, NW EpiCenter Director	***Please see attached PowerPoint***		
By-Laws Discussion, Laura Platero, NPAIHB Executive Director	Constitution and By-Laws Background • Purpose: Governs the Board relating to development and implementation of Indian Health legislation, regulations, policies, and programs • Adopted in July 1996, and last revised in October 1999 • Changes are needed to better align the vision and purpose of the Board and to authorize use of remote meetings during this virtual environment Bylaws Communications with Delegates • 10/21/20: Proposed changes to By-Laws discussed at QBM		

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- 11/13/20: Proposed changes to By-Laws circulated via email for comment
- 12/18/20: First deadline for comments
- 1/21/21: Proposed changes to By-Laws discussed at QBM
- 2/4/21: Proposed Special Board Meeting to discuss By-Laws- no quorum; discussion occurred
- 4/12/21: Circulated updated version of By-Laws via email that included input from Delegates who expressed concerned about certain provisions; created new language options to replace originally drafted provisions
- 4/21/21: Review of 4/12/21 By-Laws circulated

Preamble

- Option 1 – original language
  - "the NPAIHB, with the health and guidance of Almighty God, adopt these constitution and by-laws guide the representatives of the Board to secure an organized voice and participation in decisions relating to the development and implementation of Indian health legislation, regulations, policies, and programs."
- Option 2- closely aligned with original wording with slight revisions
  - "the NPAIHB, a tribal organization under ISDEAA, adopt these constitution and by-laws guide the representatives of the Board to secure an organized voice and participation in decisions relating to the development and implementation of Indian health legislation, regulations, policies, and programs."
- Option 3- wellness of the seventh generation
  - "the elders 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 Northwest Tribal Leaders to form the NPAIHB, a tribal organization under ISDEAA to advocate and realize the wellness of our seventh generation . . . "

NEW Article II, Sec. 7 Code of Conduct

- Option 1- original language presented at the January QBM

Summary of Minutes

- Establishes a code of conduct including, regularly attending meetings, conduct all functions with due care, not share confidential information outside of official duties and responsibilities, work respectfully, identify any actual or potential conflicts.
- Option 2- Revised Option 1 that more closely aligns with the mission and values of the Board
  - Work respectfully with other Board members, employees, agents, and others in a spirit of cooperation, giving individuals courteous consideration of their options
  - Regularly attend meetings, not use his or her position for private gain, not make any statements that purport to represent NPAIHB or act on behalf of the Board unless authorized
  - Conduct all functions with due care and in a confidential manner, if required.

NEW Article II, Sec. 8 – Discipline or Removal

- Option 1- failing to abide by the code of conduct in previous slide Board member may be asked to meet with Executive Committee.
  - Any discipline or removal shall be by unanimous action of the Board in an Executive Session and confidential
  - Option 2 - no language

NEW Article IX, Sec. 4 Remote Meetings

- Section 4 is a NEW section to authorize use of remote meetings
  - NPAIHB meetings are held in-person.
  - Board may use other meeting methods for emergency health and safety related concerns of in-person meetings.
  - If any single Board member may not attend an in-person meeting due to emergency reasons and if the meeting location can support remote attendance, the Executive Committee may allow the Member to attend remotely.

Next Steps:

- After all changes are received, final review of Bylaws by lawyer.
- Article X (Amendments) requires the Board to agree to provide 30 days notice prior to a vote

Summary of Minutes

	on any amendments or changes.
	• NPAIHB Resolution Article X (Amendments) of the NPAIHB Constitution and By-Laws—30 Days-Notice will be presented to the Board tomorrow. If approved, the NPAIHB will:
	  • agree to provide the 30 days notice; and
	  • direct the Executive Director to send out such notice.
	• If Board plans to approve revised by laws at July QBM (July 27-28), then resolution would require me to send out the final version of By-Laws by June 27.		

	Recess for the day 3:09 p.m.		
THURSDAY APRIL 22, 2021			
Call to Order	at 9:05 a.m. by Nick Lewis, NPAIHB Chairman		
Veteran's Update, Terry Bentley, & Stephanie Birdwell, Director, Office of Tribal Government Relations	***Please see attached PowerPoint***		
Red Lodge Transition Service, Trish Jordan, Executive Director	***Please see attached PowerPoint***		
Tribal Opioid Response Funding, Colbie Caughlan & Eric Vinson, ECHO Project	***Please see attached PowerPoint***		
Strategic Plan Review, Nora Frank-Buckner & Stephanie Craig-Rushing	• Motion by Cheryle Kennedy, Grand Ronde • Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla • **Motion Carried**		
Trans & Gender Care Strategic Vision and Action Plan	***Please see attached PowerPoint***		

Summary of Minutes

Committee Reports	**Elders Committee – Chandra Wilson, NPAIHB staff** (A copy of the report is attached) **Veterans – Debra Jones, Samish Tribe –** (A copy of the report is attached) **Public Health – Bridget Canniff, NPAIHB staff** (A copy of the report is attached) **Behavioral Health – Birdie Wermy, NPAIHB staff** (A copy of the report is attached) **Personnel – Cassie Sellards-Reck, Cowlitz** (A copy of the report is attached) **Youth – Paige Smith, NPAIHB staff –** (A copy of the report is attached) **Legislative Report – Cheryle Kennedy, Grand Ronde & Sue Steward, NPAIHB Deputy Director** (A copy of the report is attached)		
Resolutions:	21-0-01 ***Strengthening Indigenous Health and Science Research: NW NARCH Program*** • Motion by Andy Joseph, Jr., Colville • Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla • **Motion Carried** 21-03-02 ***NW Tribal Food Sovereignty Coalition (NTFSC) and Food Sovereignty Initiatives Project 2021 RFA- Native American Agriculture Fund (NAAF)*** *SETTLEMENT FUNDING: KEEPSEAGLE v. VILSACK LITIGATION* Motion by Libby Wantanbe, Snoqualmie with edits • Motion 2nd by Andy Joseph, Jr. Colville • **Motion Carried** 21-03-03 ***Native Dental Therapy Initiative – Funding Offered by the National Indian Health Board for Education/Outreach to Enhance Polices Supportive of Dental Therapy*** • Motion by Marilyn Scott, Upper Skagit		

Summary of Minutes

- Motion 2nd by Libby Wantanbe, Snoqualmie
- **Motion Carried**

21-03-04 ***Native Dental Therapy Initiative – Implementation of Dental Therapy Offered by the National Indian Health Board***

- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-05 ***Indian Health Service Minority HIV/AIDS Fund Clinical Program Support***

- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-06 ***Indian Health Service Minority HIV/AIDS Fund to Support Ending the HIV Epidemic in Indian County***

- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-07 ***Action by Unanimous Consent of the Governing Board – Restatement of 403(b) Retirement Plan***

- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-08 ***Call on Congress to Support Full Funding for FY 2022 Indian Health Service Budget***

- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

Summary of Minutes

	21-03-09 ***Article X (Amendments) of the NPAIHB Constitution and By-Laws --- 30 Days' Notice*** • Motion by Andy Joseph, Jr., Colville • Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla • **Motion Carried** 21-03-10 ***Portland Area CHAP Certification Board (PACCB)*** • Motion by Andy Joseph, Jr., Colville • Motion by 2nd by Libby Wantanbe, Snoqualmie • **Motion Carried** 21-03-11 ***Support for Trans and Gender-Affirming Care in IHS, Tribal, and Urban Indian Health Facilities – 2021 Strategic Vision and Action Plan*** • Motion by Andy Joseph, Jr., Colville • Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla • **Motion Carried** 21-03-12 ***Option to Exclude All One-Time, Non-Recurring COVID-19 Funds from Direct Cost Base When Negotiating New Indirect Cost Rate*** • Motion by Andy Joseph, Jr., Colville • Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla • **Motion Carried**		
	Adjourn at 3:35 PM • Motion by Andy Joseph, Jr., Colville • Motion 2nd by Cheryl Rasar, Swinomish • **Meeting Adjourned**		

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

APRIL 2021
QUARTERLY BOARD
Zoom Meeting

April 20 – 22, 2021

MINUTES

TUESDAY APRIL 20, 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**

CHAIRMAN'S REPORT, NICK LEWIS, NPAIHB CHAIRMAN

It is so good to be here with you today and glad that our IHS Acting Director Liz Fowler will be joining our meeting later this morning. Thank you to Chairwoman Kennedy, our NPAIHB Vice Chair, for chairing the meeting today. This is the last day of my eldest son's visit with me. He'll be heading back home later today.

We have had beautiful weather up at Lummi lately, the trees that lost their leaves last fall are just starting to show their green, the sky is a bright blue, and the breeze that blows over the water gives me a feeling of hope. Even though we are together over Zoom again, I am so encouraged as I look back at all we have come through over the last year, and I see all we have accomplished, together. We know how to pull together, whether it is sharing vaccinations, passing on supplies and PPE, or working together in the federal-tribal consultations (and there sure have been a lot of consultations lately). Someday soon – and I look forward to that day – we will look back at the time that we fought the COVID-19 pandemic together. There is opportunity and hope on the other side of this pandemic.

Since the last board meeting, we vaccinated many of our people in Idaho, Oregon, and Washington. Tribes are working with the IHS or their States to get vaccines into the arms of our people, and our tribal leaders and clinic staff are working to reduce vaccine hesitancy in our communities. While there may be a bit of setback with the Johnson & Johnson vaccine, we cannot stop addressing vaccine hesitancy. It's a big concern right now, especially with our younger tribal members.

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
- We held National Tribal Budget Consultation in early April for Fiscal Year 2023. Shortly after the Budget Consultation, President Biden released his proposed budget for Fiscal Year 2022. President Biden has proposed a significant increase to the IHS budget, bringing it up from $6.2 billion to $8.5 billion. We continue to advocate with our representatives in Washington DC for the resources we need through virtual meetings and by submitting written testimony and appropriations requests.
- I attended the National Indian Health Board quarterly Board meeting in Late January, and was nominated to be their Vice-Chairman. Although the vote on that was delayed until March, I am honored to report that the NIHB made me their Vice-Chair. NIHB also recently asked me to represent them as their at-large representative with the CMS-TTAG and SAMHSA-TTAC. I am humbled by their confidence in me. I will do my best serving our people on these committees. I believe this is the right work at the right time – We are

working in all our Tribal Advisory Committees with all the other Areas and tribes across the country to get tribal priorities in front of the Biden Administration. And I am pleased to say that senior Biden Administration leadership is showing up at the table in our Tribal Advisory Committee meetings.

- I continue to actively participate in the NIHB weekly Board and Quarterly Board meetings.
- I have recently been appointed as the Portland Area Representative to the IHS Information Systems Advisory Committee, and will work to advocate for tribes operating RPMS and operating commercial off-the-shelf-systems on this Committee.
- I've participated in weekly Biden White House calls, and continue to remind the administration that Indian Country needs to see equity in action, not only to fight this pandemic, but also in all federal funding.
- The Board's Executive Committee has been meeting weekly for over a year now. Each week, Executive Committee members get admin and finance updates, discuss policy concerns, and get COVID-19 and EPI updates.

As we look forward to the changes that spring brings, we also look forward to bringing additional resources home to our communities so that we can repair the damage from COVID-19, and invest in the public health infrastructure that we need to sustain lasting change. The Portland Area is working alongside 29 other regional and national tribal organizations, actively promoting an Indian Country Infrastructure Plan. As the Biden administration looks at infrastructure investments, getting our priorities to the administration, and to our legislators is a priority.

My commitment to you remains the same - I am here for you, you all should have my cell number by now, please always feel free to call or text, and let me know if there is anything you need Board support and resources for, we will try to make it happen. I hope you all have a productive meeting today and I will be with you tomorrow chairing the meeting.

EXECUTIVE DIRECTOR REPORT, LAURA PLATERO

QBM Highlights

- IHS Acting Director Liz Fowler (Today)
- Leg Update - Cindy Darcy, DC Policy Strategist (Today)
- Alzheimer's and HIV/HCV Consultation (Wednesday)
- REDW Presentation – FY 2020 Audit Report (Wednesday)
- Bylaws Review/Discussion (Wednesday)
- Strategic Plan 2020 to 2025 (Thursday)
- Tribal Reports (Thursday)

Administration & Finance

- Office Closed – Multnomah County Back to "High Risk" on April 9
    - Teleworking recommended at "High Risk" and" Moderate Risk" levels
- Administration
    - Developing policies for
        - Return to "Limited office work" when County is at "Lower Risk" level
        - Required staff travel under grants or projects
    - Most staff vaccinated
    - Virtual Staff Retreat in May
- Finance
    - FY 2020 Audit completed – Clean audit

New Employees

- Asia Brown, Sexual Health Communications Specialist
- Jane Manthei, Health Native Youth Outreach Specialist
- Dawn Bankson, Oregon Tribal and Urban Testing Liaison
- Tammy Cranmore, Finance Director
- Holly Thompson Duffy, Environmental Health Science Manager

Recognition – 25 years of Service
Jim Fry - a member of the Colville Tribe and our IT Director, has been a steadfast figure at our board for 25 years. Today we honor his 25 years of service. For his service, Jim will receive a blanket and a gift card

Other Personnel Updates

- Celena McCray, Promoted to WYHS Project Manager
- Morgan Thomas, Promoted to Paths (re) Member Program Co-manager

New Awards, supplements, and proposal submitted

Looking forward

- **Admin**: Phased in Return to Work/Travel Policies (dependent on variants)
- **Finance**: New Finance Director, updating Accounting Manual and implementing subrecipient monitoring for FY 2021
- **Communications**: Streamline and continue branding efforts
- **Leg and Policy**: Hill visits, continued submission of appropriations and policy requests, and House and Senate appropriations testimony
- **Fundraising**: Oregon DHAT Legislation
- Advocacy Funds Needed for Oregon Dental Therapy Legislation
- Our pilot project in Oregon has been successful for the last 5 years, but it is not a permanent solution, our pilot project expires in May of 2022.
- Due to language in the Indian Health Care Improvement Act, we need dental therapists to be authorized in state law in order for our Oregon Tribes to continue utilizing their DHATs.

- No other CHAP providers need state authorization – just DHATs - due to federal lobbying by the American Dental Association.
- The Oregon Dental Therapy Bill passed out of the House Healthcare Committee on Tuesday in Salem. We need to keep up the pressure to get the bill passed off the House floor and over to the Senate.
- We need additional funds to pass the dental therapy bill during the 2021 legislative session. Our goal is to raise at least $15,000 of unrestricted funds. This would enable us to keep our current legislative consultant working on this through the legislative session.
- This is necessary because most of our grant funding cannot be used for this type of advocacy. We did receive a small grant for this work in Oregon and have used up most of those funds.

COVID-19 RESPONSE, CELESTE DAVIS, ENVIRONMENTAL HEALTH DIRECTOR

Public Health Operations

- Clinical Education and Support: COVID-19 ECHOs
  - NWTEC/NPAIHB has hosted 78 COVID-19 ECHO clinics
  - 9,512 participants, and
  - Answered 1,152 questions
- Mental Health Education and Support
  - Receive data when persons of concern use the words “Native” or “Indigenous” and text to communicate with a Crisis Text Line (CTL) counselor at 741741
  - Behavioral Health Needs Assessment - Plans to conduct 10 key informant interviews with behavioral health, chemical dependency and MAT providers.
- 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
- Environmental/Occupation Health & Safety:
  - Over 80 Facility Reviews/Inspections, Risk Assessments
  - Collaborated with CDC to conduct virtual Clinical Infection Control consults
  - 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

Planning & Information Support

- Surge Staffing & Resources
  - Management of Emergency CDC Funds Distribution to Tribes
  - CDC Foundation Surge Staffing – ended 3/31, 2 short extensions

- Logistics & PPE
  - Respiratory Fit Test Kits for Clinics
  - Diabetes Patients' Health Promotion Kits
  - PPE & Medical Supplies: 9200 nitrile gloves, 102 containers of hospital-grade disinfecting wipes, 3550 disposable surgical masks, 2180 N95 respirators, 2 air purifiers, 1 Temperature Scan Kiosk and Extension Kit and more
- Data Collection & Analysis
  - Bi-weekly regional data reports
  - Technical Assistance in Data Analysis for Tribes
- Medical Counter Measure Planning – VACCINES!
  - Coordinating with IHS and States
  - NW only - created and support 42 VAMS clinic portals to facilitate vaccine reporting to CDC
  - National - provided training: COVID 19 Vaccine Data Management – part of a team that delivered 34 classes (6,066 participants) in November and December, with twice weekly office hours ongoing
  - National - part of a team that developed telemedicine documentation guidance documents and training for IHS

Review Regional Data

Leadership & Guidance

- Engaging with Tribal Health Leadership
  - Zoom Meeting Every Tuesday at 10, Forum for Information Exchange & Sharing
- Technical Guidance & Support for Tribal Leader's Decision-Making
  - "Vaccine Comparison Chart
  - "Scientific & Technical Guidance on Achieving Community Immunity"
  - Policy Advocacy
  - Legislation & Funding
  - Vaccine Distribution

One Year Later…
Successes

- Adaptability & Innovation – developing case investigation and contact tracing from scratch
- Wrap around services and supports – quarantine & isolation
- Partnerships with IHS and the States

Challenges

- Still have mixed messages, Politicization of Public Health
- Structural and systemic inequities of course lead to health disparities
- Indian Health remains woefully underfunded

The Road Ahead

- Anticipate Operating under Public Health Emergency Declaration through 2021

- Vaccinations will be what wins the Battle
- How to integrating efforts into new Pandemic/COVID-19 Plans
- Given the Resources, Tribes Can Excel – will it continue?
- Focus on Improving Health Disparities
    - Demand for Resources to Strengthen PH Infrastructure
    - Addressing Social Determinants of Health
    - Research on COVID-19, Health Services & Policy Research

INDIAN HEALTH SERVICE, DEAN SEYLER, PORTLAND AREA IHS DIRECTOR

Community Health Aide Program (CHAP)
Circular No. 20-06

- Policy was approved in FY2020
- Requires establishment of Area and National Certification Board
    - Responsible for certification of providers (Federal & Tribal)
    - Review and recommendation of certification training programs

Dear Tribal Leader Letter – Portland Area Certification Board

- Sent April 14, 2021
- Seeking Consultation and comments until **May 14, 2021**
    - Board make-up (seating plan)
    - Board candidacy requirements
    - Term limits
    - Representation (T1, TV, DST)

CRRSAA - Pub. L. No. 116-260

- Overall purpose still needs to fall under COVID-19
    - Vaccine Funding – Sent unilaterally (DTLL 2/2/21)
    - Testing Funding – Bilateral amendments, (DTLL 1/15/21)

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 correct for 2016-Present
    - New Employee – Michael Mummey, ISDA Financial Specialist (CSC)
    - If we have not contacted you please provide us final Passthroughs or salary information.
- 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 the FY20 Recurring Base, which runs through 1/27/2021

FY20 Catastrophic Health Emergency Fund (CHEF)
Status as of April 7, 2021

- 67 Total Cases
- 41 Total Amendments
- $2,471,289.00 Reimbursed
- $40,202.78 Pending Reimbursements
- 92% Total Reimbursed
- **FY20 CHEF Balance: $19,042,902**

Division of Health Facility Engineering
Regional Specialty Referral Center Network

- IHS Continues to Explore Avenues to Support a Demonstration Project

Combinated Supportable Facility Engineering

- Responses were due February 15th
- One-week extension provided
- 12 Tribes responded (30 Tribes Last Year)
- Responding Tribes are eligible for FY21 BEMAR Funding Consideration
  - (Funds well be available, Amount Still being Determined)

Division of Sanitation Facilities Construction

- ❖ Positions Filled
  - ❖ Tribal Utilities Consultant, Olympic District Office: LCDR Sandra Redsteer P.E. sandy.redsteer@ihs.gov
  - ❖ Tribal Utilities Consultant, Portland Area Office: LCDR Jason Davis P.E. Jason.davis@ihs.gov
- ❖ Positions Pending
  - ❖ Environmental Engineers (2): 1 each at the Spokane District Office and Port Angeles Field Office
- ❖ Positions Vacant
  - ❖ (Coming soon): Senior Environmental Engineers (2)
    - ❖ – Port Angeles FO, Fort Hall FO
  - ❖ Engineering Technicians (2
- ❖ Contact: Alex Dailey, Portland Area DSFC Director, 503-414-7780 alexander.dailey@ihs.gov

- ❖ 2021 appropriation resulted in 5.4% increase in IHS construction funding over last year.
- ❖ With contributions, there was an 18.4% increase in funding for IHS projects.
- ❖ 34 Projects currently on the draft FY21 Funding Plan

- Currently gathering needs for FY22 funding (Regular and Housing Projects)
- CARES Act funding: $10M nationally in 2020 for SFC
  - Resulted in $421,017 in funding for Portland Area
  - IHS developed 8 projects benefitting 11 Tribes
  - 4 of 8 projects complete, with funds disbursed to Tribes

Example: $23,517 for Colville Tribes to upgrade their well service truck to allow maintenance of community and individual wells, and to repair their existing sewer vacuum truck

INDIAN HEALTH SERVICE, ELIZABETH FOWLER, ACTING IHS DIRECTOR

Cheryle Kennedy, Grand Ronde – As you mentioned COVID-19 is a very serious problem we are very worried about the lingering effects that it has some yet to be to be revealed.
In addition to the we face the mental health and substance abuse issues due to the isolation also part of what we are dealing with. Here in the Pacific Northwest you've probably heard about the raging fires that took out millions of acres here in the Northwest the effect of that we are also dealing with. I just want you to know that our Area Director Dean Seyler are very committed to the Tribes here and want you to know their tireless work and efforts they made this past year. IHS is critical to our work and success. We look forward to working with you to improve the health and wellbeing of our people. We hope you will continue with your current roll in leadership and join us at our Quarterly Board meetings. Our next Board meeting is going to be held July 27th – 29th. When you were talking about the Presidents budget we want to express the appreciation for the increases. Especially the historical request of Advance Appropriations for FY2023. You talked about the FY2023 budget the amount you mentioned is a way off from the Tribal Formulation workgroup recommends. We want you to know we support the Tribal Formulation workgroups recommendations for full funding of $48B dollars for 2023. We also support mandatory funding CSC and Section 105(l) leases agreements. All of those elements are necessary for Tribes to continue to prepare to provide quality healthcare. The Indian Health Services budget has been lacking in its ability to provide quality health services because of funding limitations and insufficiencies in funding. This time, the time is right for the funding levels increase so that we can be fully fortified, fully enable, fully ready to meet challenges that are before us.
One of the things the Northwest Portland Area Indian Health Board has been a leader in is SDPI the diabetes funding, now is the time for us to get permanent authorization at $250M per year with medical inflation increases annually. The programs have not received any increase in two decades and yet we see diabetes escalating. We are doing good work and it's effective but it's not enough funds to support it. New grantees must be able to come into the program and current programs need increase funding for the support of our self-determination. All the various titles 638 contracts and compacts we have we request IHS work with Congress to make the necessary legislative change that would allow Tribes to receive funds normally received through the grant process. Through our compacts and contracts Portland Area Tribes have been making this request as to SDPI funds and all the Behavioral Health Initiatives we hope and are confident under your leadership this can happen. We've seen you be an advocate we know that you are able to affectively present the needs of Indian people are.

When Tribes receive program dollars of course we need the indirect costs rates to provide all the supportive services to make those programs and services happen. We request an exclusion of all onetime non-reoccurring COVID-19 funds in the indirect cost rate calculations. It will significantly impact our indirect cost rates in the future. There have been many studies and I know you are aware of impact of the indirect rate and how they effect program and services of Indian people. That is a request the Portland Area has made for many, many years.

Ms. Fowler, Acting IHS Director – thank you for going through that list. Tribal priorities and their budget requests was much higher than what came out in the Presidents budget requests and it's the fact that it's a $2B increase still have very significant indicator of this administrations support. With all my years at the Indian Health Service and all my years working in budget formulation I've not seen this level of support for IHS before. Even though it dose fall short of that full funding amount that the Tribes approved as their budget priorities for FY2022 I do think and of course there is still time to advocate for additional funding. We've initiated the FY2023 budget cycle there are more opportunities and we're hopeful that this funding level that is request will be approved by Congress that we can fill the pot and actually reach that level of funding that the Tribes have determined need priority and full funding level.
I've heard you and taken down your comments and will take them the Special Diabetes Program for Indians funding. Certainly, the Indian Health Service believes that this program is a showcase program for Indian County. It shows what Indian county is able to do with a focus set of funding IHS definitely wants to see the funding continue and we know it needs a definitely needs permanent funding it's not helpful and it's not effective to have that uncertainty in that funding IHS supports those efforts as well. We do understand the need for new grantees to expand the program we hear you on that.
I wanted to touch on one more item's, your comments on the indirect cost rate we've heard this in some prior meetings. I do think your making a great point bring that up I'm not sure exactly what IHS is going to do there in terms of the actual indirect cost rate negotiations because it's not handled by IHS but I think it's something IHS can have a discussion about it and how it applies to our ISDEAA agreements.
I do want to mention we do plan to stand up our Contract Support Cost workgroup soon fairly soon in the next few months they plan or reestablishing that workgroup. That can be one of those items the workgroups pick up and works on how to mitigate the impact of COVID so on the application of the indirect cost rate for next year moving forward. I'll stop there for now.

Cheryle Kennedy, Grand Ronde – The Portland Area does not have hospitals of course we are talking about PRC dollars. That's always been a discussion of what that all means for us. Then we have to look to our PRC dollars for any of our hospitalizations we're always lagging. I'm not saying that other Areas don't need these dollars or they have too much or anything. But what I'm saying is we don't have enough. We have to cover especially at these times with increased hospitalizations and more long-term care it just very staggering for us to deal with. We don't yet about the long haulers and what that means in terms of additional funds that we have to expend and were not there before. We're really asking for $1B increase in PRC which would meet the

needs of the Portland Area Tribes and support Specialty care for long haulers that's really a specific request in the budget for us. Would you like to comment on that?

Ms. Fowler, Acting IHS Director – I completely understand your point as co-chair of the PRC workgroup a few years ago. I understand the differences in Areas who have hospital or inpatient services and your right it's not that other Areas don't need PRC the hospitals that they do have are more like community hospitals. They are still transferring patients out for higher levels of care as well. But it's such a great point you make for more I've heard similar concerns raised from the California Area they have a particular interest in seeing the PRC allocation formula revisited we are not sure if that's something we have the PRC workgroup to review and consider. As I'm aware they haven't quite come to that decision on that recommendation yet and it's something we are still working through. I know that this is a concern for both Portland and California Area and understand the concerns and needs.
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Cheryle Kennedy, Grand Ronde – the way I look at it I know that there are special provisions and still are for the Alaska Area because of the high cost of care there, the high cost of living there, everything there so there is a factor of adjustment there. I get concerned about other Areas veto power over other Areas because they have a different need. I just put that out there for consideration that this probably needs to be looked at when there are unique extenuating circumstances and that needs to be looked at through those eyes.

Andy Joseph, Colville - As Co-Chair of the National IHS Budget we request a meeting with the White House and OMB. I would also request on the infrastructure bill staffing for all the Tribal clinics that haven't ever had an increase in staffing of Providers

Ms. Fowler, Acting IHS Director – if he's still on I would say Andy's been a great advocate for the budget the Indian Health Service with his work with the budget formulation and he has raised this in different forums including with the Secretary and the Secretary's Tribal Budget consultation session and other forums as well. We are prepared to advocate for getting the meeting scheduled I think that HHS has been supportive of facilitating getting the meeting scheduled I think we are going to be able to do that.
Regarding the infrastructure bill that is something else we are keeping an eye on and I know his note or focus is on staffing point and that is something that we have been sure to include when ever we have been asked to provide technical assistance. It's not just a project, not just funding for the project it's self but it's for the staff that goes along with it, that it's a similar concept there it's noted that staffing is needed. He's also been advocating for that for awhile now Dr. Mike Pine at the Oklahoma City Area office I can also say that I share that concern as well.

Cheryle Kennedy, Grand Ronde – I'd like to go over the Board priorities. Then we'll mix in some of the comments or questions. The other priority we wanted present to you is the Community Health Aide Program the Board has worked hard to establish the framework the CHAP expansion in the Portland Area. We have 12 DHATs working within our Tribes, we have seven Behavioral Health Aide students in the Alaska education program, and we have four more

Behavioral Health Aide students who will start their education program in May of this year. After five years of preparations we are ready to stand up our CHAP certification board to certify our Portland Area CHAP providers to accredit education programs for DHAT and the BHA in the Portland Area. We have recommended seating for the Board provided Standards and Procedures and drafted by-laws to support the CHAP Certification Board. We're looking further to partner with IHS to support our Portland Area Certification Board. We also acknowledge the DTLL sent in by Portland Area Director Seyler and we look forward to working together. We look forward to hearing about IHS decision on the $5M in CHAP funds for FY2020. We'd like to know the processes used for the $5M in FY2021 funds. For FY2023 we request $60M for the continuation of the national expansion and $10M for the Portland Area to continue to expand CHAP. This is a new initiative but the Board has been working on it diligently our Tribes have come forward. Is this something you can get behind and move forward in your leadership role?

Ms. Fowler, Acting IHS Director – we are planning to announce the decision on CHAP consultation on the $5M regarding the allocation of the $5M planning on announcing that next week. I will say the focuses on the preparations and the planning the infrastructure that is needed to move forward with implementing a CHAP program. Portland is well positioned and I can't really share any for the details at this point in time. I think there is some good news coming.

Cheryle Kennedy, Grand Ronde – you talked a little about Regional Referral centers I know Andy was on earlier and we heard from Director Seyler there is a possibility of funding for three Regional Referral centers. We know that we were in the que the Portland Area was in the que for those funds and now learn that there is not a staffing package associated with those facilities. Andy articulated it very well how successful can we be? We get construction planning dollars, we do the construction, get everything set up and we see an empty building staring at us. I'm recalling back and I believe that the language for the Regional Referral center said for the first couple years, two or three years that Indian Health Service would staff that. That they would be employees of the Federal government and be the ones in there working and then it could be transferred over to Tribal leadership or operations. I see that as a serious problem for the Indian Health Service do you have the staff ready to do this? The comment is that we need staffing dollars.

Ms. Fowler, Acting IHS Director – I've been briefed on this project and I was a little surprised that is still pending and I thought the project was underway actually. I'm going to make it a priority to settle on that question and determine what we are able to do just so we know about moving forward with that project. I agree with you it's just ineffective and wasteful to put so many millions of dollars into construction of a place and not having the staff, not having it open and being able to provide the services that it was planned to deliver. We will work on determining what path is available to us to go forward with and I hope we can move on this discussion and settle on an answer as soon as possible.

Cheryle Kennedy, Grand Ronde – The mental health and substance use issue there are national statics that say increases of suicide are happening especially among adolescents and young

adults. The Board has set up many programs to combat that but during this pandemic it's just having a double whammy on the Tribes and our people. There are unfunded mental health initiatives in the Indian Health Care Improvement Act that should be funded to increase prevention and treatment services including mental health providers and support behavioral research. The National Tribal Formulation Budget workgroup said the increases should be for mental health $6M in alcohol and substance Abuse by $527M then will move into the behavioral health facilities. We have to regional treatment centers in the Portland Area the Healing Lodge of the Seven Nations in Spokane and NARA NW in Portland we need much more than that. The States we live in really don't have these types of facilities either so we are looking to you to see this problem resolved. Our children and youth are future unless we can assist them it's a heartbreaking situation, what a loss for our communities, our Tribes, our population. We bring that to you for you to support and to find other ways to getting funds out or services. I have concerns about sending our youth to non-cultured facilities.

Ms. Fowler, Acting IHS Director – it is a concern for me as well. I've heard of stories and it's really heartbreaking especially what's been highlighted with the pandemic we're going backwards it seems like the isolation the need to at some reservations with the lockdowns that was needed measure to prevent the spread of COVID at the same time it added to those factors that lead to depression and I've heard and briefed on some suicides that have been happening in parts of Indian country and it really is heartbreaking to hear that. Behavioral health we know continues to be one of the very top priorities for the Tribal Budget Formulation workgroup and that means it's a top priority for the Indian Health Services as well. Whatever opportunity we have to advocate for additional funding, additional services, additional programs to help in the behavioral health area we take that opportunity to do so and will continue to do that.

Cheryle Kennedy, Grand Ronde – the Board seeks to eliminate Hepatitis C among Indian people we know and looked at the statistics and we know healing. The elimination of it but vaccines have been very costly and we rely on PRC payments and we believe at least $600M is need for Indian Health Service to provide this lifesaving treatment to those effected, those who are served by IHS. The VA was able to do this and IHS must follow. This is a cure.

Ms. Fowler, Acting IHS Director – Thank you for raising that and I don't know very many of the specifics of that and this something I will have to get back to you on. It sounds to me like an investment that would produce the outcomes that we want to see healthier American Indians/Alaska Natives. I'll take that back and find out more about that and see what we can do about that.

Cheryle Kennedy, Grand Ronde – The Board Chairman who is Nick Lewis he sent a letter to you expressing concerns that arose during the March 21 SDPI meeting. We're wondering if you could clarify how IHS intents to use the $30M in unused allocated carryover funding over which Tribal consultation was held August 2020? The second concern we have is use of offset funds in grant with unallocated balances it appears that the IHS uses both funding streams either without

following recommendations from Tribal consultation or without Tribal input. We are wondering if you have had time to review our letter and if you can address our concerns?

Ms. Fowler, Acting IHS Director – I do have your letter and its currently being reviewed and we will send you a specific response in writing to the letter just a general a broad response the decisions that were made about the offsets the funding that resulted in from the offset and use were provided or recommendations were provided from the Tribal Leaders Diabetes Committee which the Indian Health Services accepted as determined to approve those recommendations. But, we will put that in writing to you so you have a clear response to those questions.

Elizabeth Jim, Shoshone-Bannock - My concern is Providers and healthcare workers are at an all-time low and much burn out due to COVID. How are we going to address these problems? How do we sustain the workforce?

Ms. Fowler, Acting IHS Director – Sometimes you hear that question what keeps you up at night and I think for me similar for me it's how do we answer the recruitment and retention issue that we face in Indian country. I think our team and our IHS and our I/T/U programs are amazing I think their dedications is just awesome but your right and understanding what it is going to take to ensure we have a steady pipeline of providers its critical for our programs and that is one area for me that is every time I hear about the issues facing our hospitals and clinics there is always a common thread and that common thread is how do we ensure that we have the staff we need and think about COVID we needed deployment in order to respond to COVID. I apricate your comment so much I like your idea of centralized recruitment place and I will say we are able to advertise on the IHS website for jobs not just for our federal sites but for our Tribal sites as well. That's one avenue that is open to Tribal site that you may not beware of but its something we can think about. I don't have any answers for you or what it's going to take to ensure that we have the nurses we need especially with the shortages not just for Indian Health Services but nationwide. I will say that one of our four strategic aims for COVID include the recovery phase its just not at the end of the pandemic but throughout the pandemic ensure our staff are getting some periods of rest so that they are able to get some rest and feel refreshed and keep going and keep the fight up against COVID. Those are all strategies, we have multiple resources on our website about from a behavioral health through our center of excellent regarding how to improve resiliency and that type of things we can provide those links to those resources. Its not the answer to take care of everything but I assure you that it's a concern IHS has.

Sharon Stanphill, Cow Creek - SDPI and $30 M "unallocated" funding which was consulted on in August 2020. Can you speak to our letter we sent you April 8, 2021 to clarify the "grant supplements" decision by the IHS please?

Ms. Fowler, Acting IHS Director - the broad response I gave regarding and give some assurance we did rely Tribal Diabetes Committee to provide recommendations and we approved their recommendations and we were responsive to those. We will explain that in the written response exactly what the recommendations were and what the plan is for that $30M.

Nate Tyler, Makah Tribe – I want to agree to what the Chairwoman has said and to what Andy Joseph had to say and I apricate the time spent here today. A couple items I'd like to bring up you mentioned the roll out of the CHAP should be coming down the pipeline next week? Just thinking about President's Biden Executive Order #13175 following the footsteps of President Clinton and President Bush as far as consultation and CHAP in general and DHAT I don't think we talk enough in general dental and I'm hoping we can get some support from IHS on the DHAT program in the sense of scholarships training and the general roll out and backing on the DHAT program dental in Indian country is not talked about enough. More and more Tribes have been compacting and when we see infrastructure bills and we see. It doesn't really reflect monies coming down the pipeline we can look at the IT that came out IHS took a major chunk of that. It's a need that all Tribes face and the equitable cuts towards IT, towards construction, toward infrastructure all these things coming down the pipeline are going to reflect fair and equitable shares towards Tribes. For me DHAT and if we can focus on dental more I'd apricate that.

Ms. Fowler, Acting IHS Director – I think the good thing about the CHAP program, the national program really covers all of the health aides not just the community health but the behavioral health and the dental health aide. The funding that's been appropriated and will be allocated to the community health program and does cover the dental health aide program as well. I was looking at the Tribal budget priorities and dental is usually in the top five of those funding priorities. I hope the funding that is coming down for CHAP I hope you find it helpful to start addressing the DHAT needs. The comment on the scholarships is something we can consider whether or not it has potential for that and it depends on what kind of training is required and I'll take that back for consideration.

Cheryle Kennedy, Grand Ronde – IT modernization the pandemic has highlighted the deficiencies with the current IHS electronic health records system and the critical importance of having a robust health information exchange Indian Health Service delivery system. IT health modernization would be a priority for IHS with an expedite implementation over the next three to five years. Tribes using RPMS cannot wait ten years for an update they need fixes, technical assistance and support now. During any transition period the National Tribal Budget Formulation workgroup estimates full implementation of a new EHR system will cost $3B based on the 25% of the VA cost estimate for FY2022. For FY2023 we recommend $100M for planning and phased in replacement of RPMS. We also recommend that IHS provide funding to reimburse and provide ongoing financial support for Tribal facilities that have purchased and implemented off the shelve systems. There is a very real need and deficiencies and we are aware that the IHS budget is often predicated from the uses and delivery of services provided on the field and reported through those systems. We need the fix and we need to be able to do it now rather than later.

Ms. Fowler, Acting IHS Director – IHS feels the same way its outdated and it would be very costly to string it out over many years. We would rather have the funding to move forward with that project all at once. We also have heard from Tribes that have purchased their own systems using what ever funding they identify to do that. Worth whiled noting the House subcommittee

on Interior Appropriations did ask us to compile the amount of funding the Tribes have spent purchasing their own systems. That some piece of request coming out so we will be working on gathering that information. Having a sense of how much funding has already been spent to replacing and putting into place electronic health care system.

12:35 PM – LUNCH BREAK

12:45 PM – COMMITTEE BREAKOUT ROOMS

LEGISLATIVE UPDATE, CINDY DARCY POLICY CONSULTANT

Spring congressional agenda includes

- Gender discrimination in the workplace
- Expedited review of COVID–19 hate crimes
- Statehood for the District of Columbia
- Security supplemental appropriations bill
- Additional nominations – HHS, CMS, DOI
- Unaccompanied children at the U.S.-Mexico border, immigration
- Continuing response to the COVID-19 pandemic
- Voting rights
- Gun control, background checks
- Climate change
- Racial injustice and environmental justice
- Infrastructure
- Additional hearings on Administration's FY 2022 budget request

FY 2022 budget request

- The Administration's FY 2022 budget request puts the emphasis on discretionary spending for domestic programs like education, health care and environmental protection, while essentially maintaining funding for defense spending.
- The discretionary request proposes $769 billion for non-defense discretionary (NDD) funding in FY 2022, which is a 16% increase over the FY 2021 enacted level.
- The discretionary request proposes $753 billion for national defense programs, which is a 1.7% increase over the FY 2021 enacted level.
- Mandatory funding, tax proposals and details of discretionary spending to be released later.
- Not parity between NDD and defense spending = > Rs not happy
- House Appropriations Subcommittees have actively been holding both oversight hearings on federal agencies and hearings on the FY 2022 budget request.
- Tribal requests and the President's campaign promise to fully funding IHS have resulted in a $2.2 billion proposed increase to IHS, plus advance appropriations for IHS in FY 2023.

New for FY 2022 appropriations bills

- Spending caps are gone.
- Expect earmarks, after a ten-year absence, in the FY 2022 appropriations bills.

- Can make up a maximum of 1% of the $1.4 trillion in annual discretionary spending.
- A House member is limited to submit 10 "congressionally-directed spending" requests per fiscal cycle to the Appropriations Committee, without guarantee of their inclusion; is required to show community support for the request; and must publicly disclose the request.

Infrastructure proposal – Administration's American Jobs Plan

- Multiple House and Senate committees
- Roads and bridges now, health care, child care later
- Republican alternative?
- Senate Appropriations Committee hearing 4/20, SCIP hearing 4/21

Movement on tribal health-related bills

REGULATORY/ADMINISTRATION UPDATE, LIZ CORONADO, HEALTH POLICY SPECIALIST

Litigation-Contract Support Cost

- **Swinomish update**
  - April 13, 2021: DC Circuit affirmed the district court holding and concluded that ISDEAA or Swinomish's contract do not require IHS to pay the Community contract support costs for health care services funded by third-party revenues.
  - Potential next steps in this case: request for a rehearing by the panel or a rehearing by the full court en banc; or petition SCOUTS for a writ of certiorari
  - Only one court has ruled in favor of tribal contractors on CSC claims in the 2016 Sage Memorial case (New Mexico)
  - Tribes continue to litigate CSC claims across the U.S.—including in AK, SD, and WY.

- **Brackeen v. Haaland (formerly Brackeen v. Bernhardt)**
  - 5th Circuit Case that challenges the constitutionality of the Indian Child Welfare Act (ICWA)
  - April 6, 2021, 5th Circuit published its en banc decision upholds that ICWA is constitutional. Congress has the plenary authority to enact ICWA! (good news)
  - However, the decision is 325 pages long with a number of concerning parts of the opinion that misunderstands the unique relationship between the U.S. and Tribal Nations.

- Chart on whether Brackeen applies to your case: https://turtletalk.files.wordpress.com/2021/04/brackeen-v-haaland-decision-tree_april2021_pdf.pdf

Allocation Decision of American Recovery Plan Act (ARPA) IHS Funds

- $6 billion for Indian Health Service
  - $2 billion for lost reimbursements
    - $1.92 billion to I/T facilities (CSC does not apply)
    - $80 million to UIOs
  - $500 million for additional health services/PRC
    - $480 million to I/T facilities H&C and PRC
    - $20 million to UIOs
  - $140 million for IT, telehealth infrastructure, and EHR modernization
    - $67 million to I/T facilities (CSC eligible)
    - $70 million for IHS for EHR modernization
  - $600 million for COVID-19 vaccination related activities
    - $526 million for I/T facilities (CSC eligible)
    - $50 million maintained by IHS for system improvements
  - $1 billion to detect, diagnose, trace, monitor and mitigate COVID-19
    - $960 million for I/T facilities (CSC eligible)

Federal Policy Updates

- HCA submitted 1115 Waiver Amendment to CMS
  - Public comments due 5/2/2021
- Biden Administration Resumes the White House Council on Native American Affairs
  - Secretary Haaland will serve as Chair.
  - First meeting scheduled for 4/23/2021
- NPAIHB joins 29 Regional and Tribal Organizations in proposing infrastructure investments in Indian Country

NPAIHB Policy Resources

- Weekly COVID-19 Call Lists (Mondays)
- Weekly Legislative and Policy Updates (Tuesdays)
  - Legislation Tracker
  - DTLL/Regulations Tracker
- NEW Monthly Tribal Advisory Committee updates

Portland Area Chap Certification Board (PACCB) Next Steps

- DTLL from Dean Seyler, April 14, 2021
- Packet prepared by NPAIHB
  - Copy of resolutions
  - Template letter for Tribes to respond
    - 4 Critical Component areas addressed:

- Seating Plan
- Board Candidacy Requirements
- Term Limits
- Representation of Tribes across the Portland Area

- Save the Date: Tribal Caucus
  April 27, 2021 at 3pm

Portland Area CHAP and Certification Board Response

- 4 Critical Components that will determine PACCB makeup
  - Seating Plan
  - Board Candidacy Requirements
  - Term Limits
  - Representation of Tribes Across the Portland Area
- Plus, one more critical component:
  - Adopting the Standards and Procedures

Seating Plan Recommendations:

- Adopt the attached Portland Area CHAP Certification Board Seating Chart as recommended by the PACCB Workgroup.
- Adopt the nomination recommendations of the PACCB Workgroup incorporated in the Board Seating Chart.
- House PACCB at NPAIHB and staffed by the NPAIHB Tribal Community Health Provider Project.

Board Candidacy Requirements Recommendations:

- Adopt the attached Portland Area CHAP Certification Board Seating Chart as recommended by the NPAIHB PACCB Workgroup
- Adopt the following process for seating the first board as recommended by the NPAIHB PACCB Workgroup

Term Limits Recommendations:

- The PACCB itself create a process through its bylaws for nominating each position of the PACCB to the Portland Area IHS Area Director.
- The PACCB, through its bylaws determine any term limits and other issues such as nominations, removals, meeting frequency, quorum requirements, technical advisors, executive sessions, rules of order to follow, notice of general and special meetings, codes of conduct, fiscal years, how to deal with vacancies, planned or unexpected, officers, executive committees, what the PACCB will and will not pay for (per diem, travel, etc.….) and more**.**

Representation of Tribes Recommendations

- Do not tie specific tribal or geographic representation to specific seats.

- Use the attached Portland Area CHAP Certification Board Representation Checklist for the PACCB be used in tandem with the attached PACCB seating chart to ensure diverse tribal representation on the PACCB.

Standards and Procedures Recommendations

- Adopt a process that directs the PACCB to accept (or reject) the draft Portland Area S&P as a basis for the CHAP in the Portland Area at their first meeting.
- The PACCB itself create a process through its bylaws for amending the Portland Area S&P as necessary.

Recess for the day at 4:30 PM

April 20 – 22, 2021

MINUTES

WESDAY JANUARY 20, 2021

Call to Order by Cheryle Kennedy at 9:59AM

Invocation: Michael Ray Johnson, CTUIR Council

FINANCE REPORT & 2020 AUDIT REPORT, EUGENE MOSTOFI, FUND ACCOUNTING MANAGER & CHRIS TYHURST, REDW

Eugene Mostofi, Finance report – Reviewed the balance sheet from 11/30.2020 through present

- Reviewed the FY2020 Budget versus the actual from 10/1/2019 through 9/30/2020
- Reviewed the statement of revenues and expenditures the organization budget as of October 2020 versus the current year actual budget and the prior year FY2019 actual.
- Review of the FY2021 budget summary by each cost center. Total budget versus the actual or remaining budget for the year.
- *a copy of the Board's FY2020 audit report can be provide upon request to the Executive Director

PORTLAND AREA TRIBAL ADVISORY COMMITTEE UPDATES, SUE STEWARD NPAIHB DEPUTY DIRECTOR AND AREA REPRESENTATIVES

Health and Human Services, Secretary's Tribal Advisory Committee (STAC)

- All federal agencies that participated in STAC indicated that they have a renewed commitment to working with Tribal leaders and improving the government to government relationship
- The Biden Administration issued an executive order in January, requiring all agencies to review their tribal consultation policies by April 26th, and submit a written plan of action to the Office of Management and Budget.
- CDC Director Rochelle Walensky, and Acting HHS Administrator Norris Cochran both attended STAC
- STAC recommended that SAMHSA update its Tribal Behavioral Health Agenda in consultation with tribal leaders,
- STAC also encouraged SAMHSA to use its Tribal Advisory Committee more frequently, and reduce administrative requirements tied to grants.

Portland Area Representative:

- Ron Allen, Jamestown S'Klallam Tribe (Primary)
- Andy Joseph, Confederated Tribes of the Colville Reservation (Alternate)

Technical Advisor:

- Laura Platero, lplatero@npaihb.org

Last Meeting Feb 26 – 27, 2021 Next Meeting May 5 – 6, 2021 *virtual*

Centers for Disease Control and Prevention Tribal Advisory Committee (CDC TAC)

- CDC Director Wolensky attended the meeting

- During the February meeting, a subcommittee was formed to review the Committee's charter
- An additional $50,000/tribe or tribal organization that is currently a grantee under the Supporting Tribal Public Health Capacity in Coronavirus Preparedness and Response was announced at the meeting.
- Tribal delegates were asked to review the National Institute for Occupational Health and Safety Strategic Plan
- The majority of the meeting focused on COVID-19 response and disease mitigation
- Portland Area Representative:
    - Steve Kutz, Cowlitz Indian Tribe (Primary)
    - Sharon Stanphill, Cow Creek Band of Umpqua Tribe of Indians (Alternate)
- Technical Advisor:
    - Candice Jimenez, cjimenez@npaihb.org
- Last Meeting Feb 06, 2021 Next Meeting Aug or Oct, 2021

Center for Medicare and Medicaid Services Tribal Technical Advisory Group (CMS-TTAG)

- Actively engaged in reviewing HHS consultation policy; developing specific recommendations based on previous (2015) review
- Addressed current TTAG priorities for Medicare and Medicaid with agency leadership
- Promoting solutions to inconsistencies in state operated Medicaid programs
- Seeking a true solution to the 4-walls issue, TTAG requested that CMS re-visit the decision made in 2016
- On-going monthly calls to move agenda items forward
- Upcoming MCO Roundtable on May 19th that will hi-light the work done in Washington by AIHC and innovations in OR around the development of an Indian Managed Care Entity, and also feature challenges and successes in Medicaid managed care impacting tribes in CA, NC, and Mississippi
- Taking a look at the long-term services and supports program Money Follows the Person, in the May LTSS Subcommittee meeting. We know that a number of tribes in Washington State have seen success with this program.
- Portland Area Representative:
    - John Stephens, Swinomish Indian Tribe (Primary)
- Technical Advisors:
    - Veronica Smith, vsmith-contractor@npaihb.org; and Liz Coronado, ecoronado@npaihb.org.
- Last Meeting Mar 10 – 11, 2021 Next Meeting Jul 21 - 22, 2021 *virtual*

Medicare, Medicaid, and Health Reform Policy Committee (MMPC)

- MMPC has a workgroup focused on revising Chapter 19 of the Medicare billing manual
- The regulations workgroup maintains regulations tracking tools, and is drafting and submitting comment letters on regulatory changes that impact the I/T/U system

- And the IHS/Tribal workgroup is addressing challenges that tribal and IHS facilities have getting paid by pharmacy benefit management companies, and tracking the 340b challenges that many tribal clinics are experiencing.
- MMPC is focused on preparation for the July TTAG meeting right now, and is working for more tribal leader involvement in agenda-setting.

IHS Direct Service Tribal Advisory Committee (DSTAC)
During the February meeting, DSTAC

- heard from Acting Director Fowler, who addressed the allocation of the $1b in funding for testing, contact tracing, and COVID-19 mitigation.
- We also heard from the IHS Chief Medical Officer who provided an overview of the current COVID-19 variants impacting Indian Country
- Jillian Curtis, the Director of Finance at IHS, provided an overview of the FY 2021 budget
- Reviewed Area reports
- Portland Area Representative:
    - Greg Abrahamson, Spokane Tribe of Indians (Representative)
- Technical Advisor: Liz Coronado, ecoronado@npaihb.org

IHS Federal Appropriations Advisory Board (FAAB)

- Developing or determining a method or system for new construction - outside of the priority system; especially in anticipation of funding coming from the proposed White House infrastructure bill
    - Role of master plans is big - need to set-aside funds for each area to conduct or update master plans
    - Also need to discuss the FNAW report and issues with the current priority system
    - Need to discuss how Area priority systems fit
- Consider adjustments to the supportable space formula that determines M&I funding - current formula doesn't include parking lots and other structures, is there a way to update this
- Definitions of medical equipment do not include IT, but much of modern medicine and biomedical equipment is directly related to IT and IT infrastructure - there is a need to have more discussion on this
- Portland Area Representative
    - Eric Metcalf, Coquille Indian Tribe (Primary)
    - Pending (Alternate)
- Technical Advisor: Celeste Davis, cdavis@npaihb.org
- Last Meeting Apr 12, 2021 Next Meeting TBD

Andy Joseph would like to be alternate

IHS Information Systems Advisory Committee (ISAC)

- ISAC heard a presentation on the IHS IT Modernization Project, which led to a lot of questions about how the funds allocated to Health IT Modernization are going to be used,

tribal leaders attending the meeting have asked for transparency and accountability for how the funds are used, and have repeatedly asked for tribal leadership in the Project Management Office tasked with this project.

- The recommendation was made that Health IT Summits be held specific to this project, and the concern for the lack of funding for tribes operating commercial off the shelf systems was also brought up
- Portland Area Representative
    - Nickolaus Lewis, Lummi Nation (Primary)
    - Nate Tyler, Makah Tribe (Alternate)
- Technical Advisor: Veronica Smith, vsmith-contractor@npaihb.org
- Last Meeting Mar 31 – Apr 01, 2021 Next Meeting: TBD

IHS National Budget Formulation Workgroup

Tribal Leaders on the National Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met virtually on February 11-12, 2021 to develop the national Indian Health Service budget recommendations for the FY 2023 budget year.

- The first ask is to urge the Administration to take immediate steps to address unfulfilled Trust and Treaty obligations with Tribal Nations by putting in place a strategy to finally end unacceptable health disparities and urgent life safety issues at IHS and Tribal Health facilities by implementing a budget which fully funds IHS at $48 billion.
- Top 10 priorities to fund are: 1) Hospital & Clinics; 2) Purchased/Referred Care; 3) Health Care Facilities Construction/Other Authorities; 4) Mental Health; 5) Alcohol and Substance Abuse; 6) Indian Health Care Improvement Fund; 7) Maintenance & Improvement; 8) Dental Services; 9) Sanitation Facilities Construction; and 10) Community Health Representatives
    - PRC made it to #2 due to the large amount that we recommended for PRC.
- Protect, Preserve and expand health care services in Indian Country, through the Medicare and Medicaid Programs, as well as the Indian Health Care Improvement Act.
- Take immediate action on repeated requests to allow the IHS to fully fund critical infrastructure investments which directly impact patient care and safety, similar to that afforded to the VA and DoD, specific to:
    - Health IT for full implementation of interoperable EHR systems & tele-health capacity at ~$3 Billion over 10 years; a phased in estimate of $95.22 million for FY 2023
    - Funds should be provided outside of the discretionary budget, sequestered from the operating budget of health services.
    - Health Facilities Construction Funding & Equipment (~$21 Billion over 10 years)
- Advocate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions
- Support Advance Appropriations for the Indian Health Service
- Allow federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level

- Request mandatory funding for Contract Support Costs (CSC) and 105(l) lease agreements, separate from the IHS annual operating discretionary budget.

Recommend that the Special Diabetes Program for Indians be permanently reauthorized and increase funding to $250 million per year, plus annual inflationary increases and authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 contracts and compacts.

- Portland Area Representatives
  - Steve Kutz, Cowlitz Tribe (Primary)
  - Andy Joseph, Confederated Tribes of the Colville Reservation (Alternate)
- Tribal Technical Advisors:
  - Liz Coronado, ecoronado@npaihb.org and Laura Platero, lplatero@npaihb.org
- Last Meeting February 11-12 *virtual* Next Meeting *virtual*

IHS Purchased and Referred Care (PRC) Workgroup

- Reviewed CHEF expenses by Area from 2013 – 2020
- Discussed changing the PRC distribution formula to improve equity for the tribes without IHS/Tribal hospitals
- Several members of the PRC workgroup have joined an IHS/VA workgroup to look at implementation of recent legislation requiring the VA to reimburse IHS/Tribal programs for PRC expenses for AI/AN veterans
- Portland Area Representatives
  - Eric Metcalf, Coquille Indian Tribe (Primary)
  - Elizabeth "Ann" Jim, Shoshone-Bannock Tribes (Alternate)
- Technical Advisor:
  - Veronica Smith, vsmith-contractor@npaihb.org
- Last Meeting Mar 16 – 18, 2021 Next Meeting Oct 20-21, 2021 *in Denver CO*

IHS Tribal Leader Diabetes Committee (TLDC)

- NPAIHB submitted a letter to IHS Director Fowler because of concerns that arose at the March meeting.
- It appears that the IHS made a unilateral decision to change how the $30m in unallocated funding from FY 2020 should be handled, and
- It appears that the IHS has changed how it handles carryover funding.
  - Both of these changes were made without tribal consultation, so we recommended a letter be sent to clarify these changes.
- Portland Area Representative:
  - Cassandra Sellards-Reck, Cowlitz Tribe (Primary)
  - Sharon Stanphill, Cow Creek Band of Umpqua Tribe of Indians (Alternate)
- Technical Advisor:
  - Veronica Smith, vsmith-contractor@npaihb.org
  - Last Meeting Mar 09, 2021 Next Meeting Jun 15, 2021 *virtual*

IHS Tribal Self Governance Advisory Committee (TSGAC)

- TSGAC submitted recommendations to the Biden Administration in February, 2020, these recommendations include
    - The Secretary of Interior, Secretary of Health and Human Services and the Director of the Office and Management and Budget, and other Departments with a high degree of programs that serve tribes, should develop funding formulas through consultation because direct funding is preferable to grant funding
    - That the Secretary of Health and Human Services and the Secretary of Interior should support advance appropriations
    - That the Director of the Office of management and Budget should quantify the appropriations intended for Indian Country, and identify how much of those funds are actually received by tribal governments. (Past estimates incorrectly identified funds that went to states as funding for Indian Country).
    - If you are interested in the full list of TSGAC recommendations, please let us know and we will make sure you get a copy.
    - At the February meeting,
    - TSGAC recommended that a separate Health IT Summit should be scheduled to discuss the IHS Health IT Modernization Project as there are a number of outstanding questions about Project Management Office governance, transparency, and lack of funding for tribes that have purchased commercial off-the-shelf systems.
    - And A Section 105(l) lease budget workgroup is forming – more information to be available this spring
- Portland Area Representative:
    - Ron Allen, Jamestown S'Klallam Tribe (Primary)
    - Tyson Johnston, Quinault Indian Nation (Alternate)
- Technical Support:
    - Liz Coronado, ecoronado@npaihb.org and Veronica Smith, vsmith-contractor@npaihb.org
- Last Meeting Feb 17, 2021 Next Meeting Summer, 2021

National Institute of Health Tribal Advisory Committee (NIH-TAC)

- Portland Area Representatives
    - Steve Kutz, Cowlitz Indian Tribe (Primary)
    - Jeromy Sullivan, Port Gamble S'Klallam Tribe (Alternate)
- Technical Advisor: Tam Lutz, tlutz@npaihb.org
- Last Meeting Mar 16, 2021 **Next Meeting** Apr 20, 2021

Substance Abuse Mental Health Administration Tribal Technical Advisory Committee (SAMHSA TTAC)

The SAMHSA TTAC had a virtual planning meeting on April 6 for the upcoming May meeting. Kim Beniquez, Acting Director of the Office of Tribal Affairs and Policy, at SAMHSA will replace Alec Thundercloud.

- Portland Area Representatives:
  - Marilyn Scott, Upper Skagit (Primary)
  - Nate Tyler, Makah Tribe (Alternate) - *Pending*
- Technical Advisor: Candice Jimenez, cjimenez@npaihb.org
- Last Meeting Jun 15-16, 2020 Next Meeting May 12 – 13, 2021

No Meetings Since Last QBM

- HRSA Tribal Advisory Group (HRSA-TAG)
- IHS Catastrophic Health Emergency Fund (CHEF)
- IHS Community Health Aide Program Technical Advisory Group (CHAP-TAG)
- IHS National Tribal Advisory Committee on Behavioral Health (NTAC)
- Portland Area Fund Distribution Workgroup (FDWG)
- Portland Area Facilities Advisory Council (PAFAC)

Committee Vacancies

- Portland Area Facilities Advisory Committee *(PAFAC)*
  - *Direct Service – three vacancies*
  - *Title I – two vacancies*
  - *Federal – one vacancy*

12:00 PM - LUNCH

12:56PM EPICENTER UPDATE, VICTORIA WARREN-MEARS, NWTEC DIRECTOR

Overview for TEC 11/2020 - present

- Public Health Improvement
- New Data Reports and Dash Boards
  - Alzheimer's Data
    - BOLD Project
  - Communicable Disease Data
    - HIV/AIDS and Hepatitis C
- Tribal Food Sovereignty Survey Update
- Northwest NARCH
- Trans and Gender Affirming Care Project Update
- Youth Sexual Health

Public Health Improvement & Training (PHIT)

- OR Tribal Public Health Improvement
  - 8 tribal capacity/expertise assessments completed with 9th scheduled for April 2021, final reports by June 2021, Action Plans by end of 2021
  - Survey modernization workgroup: BRFSS & Oregon Healthy Teens
- WA Tribal Public Health Improvement
  - Data Partners Meeting held February 2021, release and review of data briefs

- Identification of tribal assets for prevention and control of communicable disease (survey)
- Other PHIT Activities
  - Survey on communicable disease, public health training needs, and health priorities
    ID, OR, WA THDs/Clinic Directors/Delegates:
    www.surveymonkey.com/r/NPAIHB-PHIT2021
  - CDC Data Modernization project, 2020-2022: NPAIHB data systems, staff training

Linkage with Idaho COVID-19 case data

- NWTEC signed a data sharing agreement to improve identification of AI/AN COVID-19 cases in Idaho through linkages with the Northwest Tribal Registry
- Our first linkage earlier this month found:
  - **992 misclassified AI/AN COVID-19 case** since the beginning of the pandemic
  - **58%** of these misclassified AI/AN cases had missing or unknown race information, while **29%** were misclassified as White
  - Correcting race information for these 992 cases would increase the number of AI/AN COVID-19 cases in Idaho from **2,121** to **3,113**, a **47%** increase
- We plan to repeat these linkages on a quarterly basis and will use the corrected data to provide a more accurate picture of COVID-19 burden among AI/AN communities in Idaho

Cognitive Decline among American Indian/Alaska Native people

- Nationally, about 1 in 6 AI/AN adults aged 45 years and older reported experiencing Subjective Cognitive Decline
  - 63% of these people had to give up day-to-day activities
  - The majority (88%) of these people had at least one chronic condition
  - 50% of people with Subjective Cognitive Decline said it interfered with social activities, work, or volunteering
- Source:
  Centers for Disease Control and Prevention. Subjective Cognitive Decline among American Indian/Alaska Native Adults. April 2019. Available at: https://www.cdc.gov/aging/data/pdf/2015-2017-american-Indian-alaska-native-cognitive-decline-h.pdf.

Northwest Tribal Elders Project Building our Largest Dementia Infrastructure (BOLD

- 3 Year Funding Cycle: Capacity Building – CDC funding
- Year 1 Focus
  - Establish Tribal Advisory Committee (Elder Committee)
  - Capacity Building in NPAIHB tribal programs
  - Needs Assessment with Tribal Communities/health programs
  - Develop a strategic plan addressing ADRD

- Using first-ever public health guide focused on dementia in AI/AN (CDC Road Map for Indian Country)
- Year 2 – awareness campaign, provide resources and training (community, provider, and caregiver)

Project staff:
Kerri Lopez, Project Director Klopez@npaihb.org
Chandra Wilson, Project Coordinator cwilson@npaihb.org

Washington HIV

- As of 2016, there were 13,312 people living with HIV in Washington, 504 (nearly four percent) of whom were American Indian/Alaska Native.
- Diagnosis rates among AI/AN vary between 1990 and 2016, with an overall decline in diagnoses over the last ten years.
    - In 2016, there was an increase in both the number and rate of new HIV diagnoses.
- Overall, AI/AN HIV diagnosis rates in Washington have been lower than the US diagnosis rate.
- With the exception of 2013 and 2016, Washington AI/AN HIV diagnosis rates have been either the same or slightly lower than the US AI/AN diagnosis rate.
- The AI/AN HIV diagnosis rate for both males and females between 2007 and 2016 in Washington was 1.6 times higher than their Non-AI/AN counterparts.
- The male AI/AN diagnosis rate was 1.4 times higher than the male Non-AI/AN diagnosis rate and the female AI/AN diagnosis rate was two times higher than the female Non-AI/AN diagnosis rate.
- Most HIV diagnoses among AI/AN in Washington occurred between the ages of 25 and 44 and is highest among those between the ages of 25 and 34.
- The overall age distribution of HIV diagnoses in Washington is similar between AI/AN and Non-AI/AN.
    - However, the rate of diagnosis is double in almost every age category.
- While HIV-related deaths have fallen since the early to mid-nineties for all persons living with HIV, AI/AN HIV death rates are still disproportionately higher than their Non-AI/AN counterparts, with an average rate double the death rate of Non-AI/AN in 2014-2016

Washington HIV-Related Deaths

- Between 2007 and 2016, overall death rates for AI/AN in Washington were double those of their counterparts.
- When examining rates specific to sex at birth, the death rate for AI/AN males is 1.6 times higher than Non-AI/AN and females have a death rate **nearly seven times** that of Non-AI/AN females.

Washington Acute Hepatitis B

- A total of 22 cases of acute HBV were reported among AI/ANs in Washington between 2007-2016, which was approximately four percent of all acute HBV diagnoses during the ten-year period.
- On average, the AI/AN diagnoses rate for new infections was nearly three times higher than their Non-AI/AN counterparts.
    - These increased rates, particularly between 2012 and 2014, mirror the increase in injection drug use across the nation, a key risk factor associated with acute HBV infections.
- While the overall diagnosis rate of acute HBV among AI/AN in Washington are only slightly higher than the national rate, AI/ANs had nearly three times the rate of acute HBV diagnoses than those of their Non-AI/AN peers in Washington.
- When explored by sex at birth, AI/AN males experience a diagnosis rate 2.6 times that of Non-AI/AN males and AI/AN females had 3.7 times higher diagnosis rate than their Non-AI/AN female counterparts.

Washington Chronic Hepatitis B

- There were a total of 150 chronic hepatitis B diagnoses among AI/ANs in Washington during the 2007-2016 period, which accounted for approximately one percent of all chronic HBV diagnoses.
- Overall chronic HBV diagnoses for AI/ANs in Washington were 1.5 times higher than their Non-AI/AN counterparts.
    - When explored by sex at birth, AI/AN males experience a diagnosis rate 1.8 times that of Non-AI/AN males and AI/AN females had 1.2 times higher diagnosis rate than their Non-AI/AN female counterparts.
- AI/AN adults aged 45 and older had the largest disparity in HBV diagnoses compared to their Non-AI/AN counterparts, with adults aged 55-64 having a diagnosis rate three times the rate of Non-AI/AN persons in Washington.

Washington Acute Hepatitis C

- A total of 30 cases of acute HCV were reported among AI/ANs in Washington between 2007-2016, which was nearly six percent of all acute HCV diagnoses during the ten-year period.
- New HCV infection diagnoses fluctuated during this time, with a low between 2009-2011 and a peak in 2012-2014, mirroring the peak in new acute HBV diagnoses among AI/AN in Washington during the same period.
- Between 2007 and 2016, the diagnosis rate of acute HCV for AI/ANs in Washington was four times higher than the national rate of acute HCV diagnoses and over three times that of Non-AI/ANs in Washington.
- AI/AN males had a diagnosis rate 2.3 times higher than their Non-AI/AN peers and AI/AN females had a diagnosis rate five times that of Non-AI/AN females.

Washington Chronic Hepatitis C

- There were a total of 2,835 chronic HCV diagnoses among AI/ANs in Washington during the 2007-2016 period, which accounted for nearly five percent of all chronic HCV diagnoses.
- Chronic HCV diagnoses were 6.7 times higher for AI/ANs in Washington than Non-AI/ANs between 2007-2016.
    - While the rate for AI/AN males was 5.6 times higher than Non-AI/AN males, the greatest disparity was between AI/AN females and their Non-AI/AN peers: **AI/AN females had a diagnosis rate nearly nine times that of Non-AI/AN females.**
- All age groups for AI/AN chronic HCV diagnoses were at least seven times higher than Non-AI/AN persons in Washington.
- The greatest disparities were between the ages of 35-44 and 45-54, with diagnosis rates for AI/AN persons 8.4 and 8.2 times higher than Non-AI/AN persons, respectively.

Washington Hepatitis C-Related Deaths

- The overall death rate for AI/ANs in Washington between 2007 and 2016 was about two times higher than the death rate of their Non-AI/AN counterparts.
- When examining death rates by sex at birth, AI/AN males had a death rate 1.7 times higher than that of Non-AI/AN males and women had the greatest disparity, with a death rate three times higher than Non-AI/AN females.
- While every age group for AI/AN persons in Washington had a death rate at least twice as high as Non-AI/AN persons, adults aged 35-44 and 65 and older had a death rate four times that of Non-AI/AN persons.

Oregon Acute Hepatitis B

- A total of 12 cases of acute HBV were reported among AI/ANs in Oregon between 2007-2018, which was approximately three percent of all acute HBV diagnoses during the twelve-year period.
- The overall AI/AN diagnosis rate for new HBV infections was 1.3 times higher than their Non-AI/AN counterparts.
    - The male AI/AN diagnosis rate was lower than the male Non-AI/AN diagnosis rate both in Oregon and in the US.
    - However, the female AI/AN diagnosis rate was 2.4 times higher than the female Non-AI/AN diagnosis rate and 1.5 times higher than the US rate for females.

Oregon Chronic Hepatitis B

- A total of 164 cases of chronic HBV were reported among AI/ANs in Oregon between 2007-2018, which was approximately three percent of all chronic HBV diagnoses during the twelve-year period.
- Overall, the AI/AN diagnoses rate for HBV was approximately 1.4 times higher than their Non-AI/AN counterparts.

- Most HBV diagnoses among AI/AN persons in Oregon occurred between the ages of 25 and 44.
- While diagnosis rates were greater for AI/AN persons across all age groups, the greatest disparity is seen for those aged 55 and older, with a diagnosis rate for AI/AN persons 1.7 times higher than Non-AI/AN persons between the ages of 55 and 64, and 2.6 times higher for those 65 and older.

Oregon Acute Hepatitis C

- A total of 14 cases of acute HCV were reported among AI/AN persons in Oregon between 2007-2018, which was nearly five percent of all acute HCV diagnoses during the twelve-year period.
- The diagnosis rate for new HCV infections for AI/AN persons in Oregon was over two times that of Non-AI/AN persons in Oregon and of the total national rate.

Male AI/AN persons had a rate 2.7 times higher than Non-AI/AN persons

Oregon Chronic Hepatitis C

- There were a total of 2,187 hepatitis C diagnoses for AI/AN persons between 2007 and 2018 in Oregon, which accounted for three percent of all HCV diagnoses within that time period.
- Between 2007 and 2018, the diagnosis rate of chronic HCV for AI/ANs in Oregon was 1.5 times higher than that of their Non-AI/AN peers.
    - AI/AN males had a diagnosis rate 1.4 times higher than their Non-AI/AN peers and AI/AN females had a diagnosis rate nearly two times that of Non-AI/AN females.
- While diagnosis rates were greater for AI/AN persons across all age groups, the rate for those aged 25 and older was nearly two times that of Non-AI/AN persons

Oregon Hepatitis C-Related Deaths

- The rate of HCV-related deaths in Oregon among AI/AN persons fluctuated over the last twenty years, with a low of 3.0 deaths per 100,000 between 1998 and 2000 and a high of 10.7 deaths per 100,000 between 2011-2013.
- While the death rate for AI/ANs in Oregon between 2015 and 2017 was below the national AI/AN death rate for HCV-related deaths in 2017 (10.24 deaths per 100,000), the trend shows a slight increase from the previous three years.
- The overall death rate for AI/ANs in Oregon between 2007 and 2017 was nearly two times higher than the death rate of their Non-AI/AN peers.
- When examining death rates by sex at birth, AI/AN males had a death rate 1.6 times higher than that of Non-AI/AN males and women had the greatest disparity, with a death rate two times higher than Non-AI/AN females.
- While the HCV-related death rate for AI/AN persons was higher than Non-AI/AN persons across the age groups examined, the disparity was greatest among those between the ages of 45 and 64, with a death rate 2.6 times higher than Non-AI/AN persons.

About the Data

- Counts less than five have been suppressed.
- Crude rates are used for both diagnoses rates and death rates for all data briefs.
- HIV Deaths includes records with the following ICD codes for HIV as the underlying cause of death: ICD-9 (042, 043, 044), ICD-10 (B20, B21, B22, B23, B24).
- HCV Deaths includes records with the following ICD codes for HCV as the underlying cause of death: ICD-10 (B17.1, B18.2).

Data Sources:

- **Washington Data Sources**:
  - Department of Health Office of Infectious Disease HIV Surveillance
  - Washington Department of Health STD Program
  - Washington Department of Health Viral Hepatitis Program
  - Washington state death certificates
  - Washington Department of Health Tuberculosis Program
- **Oregon Data Sources:**
  - Oregon Health Authority
- **National Data Sources**:
  - Centers for Disease Control and Prevention (CDC) WONDER
  - National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) AtlasPlus

Tribal Food Sovereignty

- Surveys and Assessments have launched!
  - UW Food Security during COVID-19 in WA State
- Regional Food Sovereignty Assessment (ID, OR, WA)
- Scholarship opportunities will be available soon:
  - Funds up to $500/scholarship to support Native Agriculture-related business (including farmers, ranchers, fishers, and community gardens) for training and education purposes. Up to 16 awards will be available.
- NW Tribal Food Sovereignty Coalition Annual Gathering 2021 goes virtual!
  - A series of virtual gathering events will begin in June and will include community spotlight presentations, cooking demonstrations, and other trainings/activities focused on food sovereignty/food systems work in our region

NW Native American Research Center for Health (NARCH)

- Key participants: Warren-Mears, Weiser, Thomas, Cunningham, Davis, Livingston, Blackshear, Becker
- Current projects:

Improving asthma management
Cancer prevention and control fellowships
Graduate school fellowships

Pending: Three additional training grants in sciences (? Summer start)

Preparing now: Undergraduate and high school science enrichment (with the blessing of the delegates; our Advisory group has approved)

Trans & Gender-Affirming Care Strategic Plan
The Northwest Portland Area Indian Health Board, together with the Native Advocacy Workgroup for Trans Health, has recently published the *Trans & Gender-Affirming Care in I/T/U Facilities Strategic Vision and Action Plan*. This plan includes information designed to ensure clinical environments serving Indigenous people are affirming for all clients, especially those who identify as trans or gender-diverse. The plan includes sample policies and strategies to make clinical environments more affirming.
Access the strategic plan: bit.ly/2slgbtqstrategicplan

NPAIHB telehealth/Indian Country ECHO opportunities

- PrEP
- Pharmacy Led SUD Care
- Hep C/SUD
- Diabetes
- Trans & Gender-Affirming Care
- Peer Recovery
- COVID-19
- HIV/AIDS
- Tuberculosis
- Community Health
- Maternal and Child Health
- Harm Reduction
- Community Health Aide Program
- Behavioral Health

Affirming Environments Self-Assessment
We've already worked with five PNW tribes to enhance affirming environments. Individual clinical consultations are available to determine current level of affirmation and strategies for improvement.

- Contact Morgan at mthomas@npaihb.org

Two Spirit & LGBTQ Affirming Environments Clinical Self-Assessment:

- Visit bit.ly/2slgbtqaffirming.
- Text ASSESS to 97779

Funding Still Available for Youth Sexual Health Project

- 4-6 WA Tribal Sub recipients, Youth Access to and Experience with Sexual Health Care
- Applications Due:
  - April 26, 2021
  - May 24, 2021
- Applications are reviewed on a rolling basis, the last week of each month. Applicants will be notified by the NPAIHB within two weeks
- Open office hours: Tuesday's and Thursday's via Zoom
- Contact, Celena McCray cmccray@npaihb.org

Q & A with State Representatives

By-Laws Discussion, Laura Platero, NPAIHB Executive Director

Constitution and By-Laws Background

- Purpose: Governs the Board relating to development and implementation of Indian Health legislation, regulations, policies, and programs
- Adopted in July 1996, and last revised in October 1999
- Changes are needed to better align the vision and purpose of the Board and to authorize use of remote meetings during this virtual environment

Bylaws Communications with Delegates

- 10/21/20: Proposed changes to By-Laws discussed at QBM
- 11/13/20: Proposed changes to By-Laws circulated via email for comment
- 12/18/20: First deadline for comments
- 1/21/21: Proposed changes to By-Laws discussed at QBM
- 2/4/21: Proposed Special Board Meeting to discuss By-Laws- no quorum; discussion occurred
- 4/12/21: Circulated updated version of By-Laws via email that included input from Delegates who expressed concerned about certain provisions; created new language options to replace originally drafted provisions
- 4/21/21: Review of 4/12/21 By-Laws circulated

Preamble

- Option 1 – original language
    - "the NPAIHB, with the health and guidance of Almighty God, adopt these constitution and by-laws guide the representatives of the Board to secure an organized voice and participation in decisions relating to the development and implementation of Indian health legislation, regulations, policies, and programs."
- Option 2- closely aligned with original wording with slight revisions
    - "the NPAIHB, a tribal organization under ISDEAA, adopt these constitution and by-laws guide the representatives of the Board to secure an organized voice and participation in decisions relating to the development and implementation of Indian health legislation, regulations, policies, and programs."
- Option 3- wellness of the seventh generation
    - "the elders 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 Northwest Tribal Leaders to form the NPAIHB, a tribal organization under ISDEAA to advocate and realize the wellness of our seventh generation . . . "

NEW Article II, Sec. 7 Code of Conduct

- Option 1- original language presented at the January QBM

- Establishes a code of conduct including, regularly attending meetings, conduct all functions with due care, not share confidential information outside of official duties and responsibilities, work respectfully, identify any actual or potential conflicts.

- Option 2- Revised Option 1 that more closely aligns with the mission and values of the Board
  - Work respectfully with other Board members, employees, agents, and others in a spirit of cooperation, giving individuals courteous consideration of their options
  - Regularly attend meetings, not use his or her position for private gain, not make any statements that purport to represent NPAIHB or act on behalf of the Board unless authorized
  - Conduct all functions with due care and in a confidential manner, if required.

NEW Article II, Sec. 8 – Discipline or Removal

- Option 1- failing to abide by the code of conduct in previous slide Board member may be asked to meet with Executive Committee.
  - Any discipline or removal shall be by unanimous action of the Board in an Executive Session and confidential
  - Option 2 - no language

NEW Article IX, Sec. 4 Remote Meetings

- Section 4 is a NEW section to authorize use of remote meetings
  - NPAIHB meetings are held in-person.
  - Board may use other meeting methods for emergency health and safety related concerns of in-person meetings.
  - If any single Board member may not attend an in-person meeting due to emergency reasons and if the meeting location can support remote attendance, the Executive Committee may allow the Member to attend remotely.

Next Steps:

- After all changes are received, final review of Bylaws by lawyer.
- Article X (Amendments) requires the Board to agree to provide 30 days notice prior to a vote on any amendments or changes.
- NPAIHB Resolution Article X (Amendments) of the NPAIHB Constitution and By-Laws—30 Days-Notice will be presented to the Board tomorrow. If approved, the NPAIHB will:
  - agree to provide the 30 day's notice; and
  - direct the Executive Director to send out such notice.
- If Board plans to approve revised by laws at July QBM (July 27-28), then resolution would require me to send out the final version of By-Laws by June 27.

Recess for the day 3:09 p.m.

April 20 – 22, 2021

MINUTES

THURSDAY APRIL 22, 2021

Call to Order at 9:05 a.m. by Nick Lewis, NPAIHB Chairman

Invocation: Cassie Sellards-Reck, Cowlitz

VETERAN'S UPDATE, TERRY BENTLEY, TRIBAL RELATIONS SPECIALIST PACIFIC DISTRICT & STEPHANIE BIRDWELL, DIRECTOR, OFFICE OF TRIBAL GOVERNMENT RELATION

Recent Enactments of the 116th Congress: Native Veterans legislation Updates

- Reimbursements to Indian Health Service and PRC (HR 6237)- Status: A series of informational calls were held between VHA, IHS and members from IHS's PRC workgroup to gain an understanding of the PRC program. VA and IHS office of general councils are working together on details of the legislation.
- Co-pay prohibitions for Native American Veterans (HR 7105 section 3002) – Status: March 29 DTLL for consultation, virtual session April 29 and written comments due by May 29, 2021
- State Veterans Homes Grants (HR 7105 section 3004) – Status: Listening sessions held March 3, 2021 – DTLL forthcoming for consultation
- HUD-VASH (section 4206) – Status: Secured and increased funding
- VA Tribal Advisory Committee (HR 7105 section 7002) – Status: Nominations and first committee meeting to occur by Sept 2021
- Urban Indian Health Programs and Reimbursement Agreements with VHA (HR 6237) – Status: VHA is working National Council of Urban Indian Health and IHS Office of Urban Indian Programs to understand scope of services, clinic locations, and anticipated Veteran volume. Listening session was held March 23 with NCUIH.

Current VA Consultation

- Joint Agency Tribal Consultation with Department of Veterans Affairs, U.S. Department of Treasury, Social Security Administration; U.S. Small Business Administration on the Presidential Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships (seeking input on how we can improve Departments and Agency's Tribal Consultation Policy. DTLL sent March 8, virtual consultation sessions April 6, April 7, and April 8 with written consultation due April 9, 2021
- Co-pay prohibitions for Native American Veterans (HR 7105 section 3002) – Status: March 29 DTLL for consultation, virtual session April 29 and written comments due by May 29, 2021
- VA / IHS MOU update – Consultation Report being drafted

April 20 – 22, 2021

MINUTES

Virtual Outreach - OTGR Webex Wednesdays

4/7/21	**Native American Veterans: Federal Employment**	Kelly Woodall, Steven Juneau, Courtney Bernal, Allison Phillips
4/21/21	**VA Education 101**	Terry Warren, Stakeholder, Engagement, Education Office
4/28/21	**VA vaccinations in Tribal Communities**	Dr. Jane Kim

Regional Updates

- Regional Webex trainings offered
  - March 25, 2021 – Complex PTSD & Whole Health (55 attended)
  - June 8, 2021 – Behavioral Health Series, Part 2 – Dr. Sarah Sunigah
- Virtual Claims events with tribes
  - Confederated Tribes of Grand Ronde
  - Viejas Tribe
  - Rincon Tribe
- Tribal Veteran Representative (TVR) Virtual Training will be held on April 28-29, 2021 in collaboration with ODVA hosted by Confederated Tribes of the Umatilla Indian Reservation

Regional Updates

VA-IHS/THP Reimbursement Agreements Through February 2021

Executive Summary

	Jan 2021	Feb 2021	Difference	FY21	Program Inception to
Disbursed	$1,620,603.35	$2,211,951.56	$591,348	$8,283,709	$131,558,647
Unique Veterans	1,581	2,313	732	4,361	12,198
Inpatient Claims	493	406	-87	1,898	7,349
Outpatient Claims	3,610	5,526	1,916	18,819	368,691
Total Claims	4,103	5,932	N/A	20,717	376,040

	IHS/THP Feb 2021	
	IHS	THP
Claims	2423	3509
Unique Veterans	911	1435
Disbursed	$664,515.71	$1,547,435.85

OTGR Team and Contact Information
StephanieElaine.Birdwell@va.gov – Director
Terry.Bentley@va.gov
Mary.Culley@va.gov
Lorae.Pawiki@va.gov
Peter.Vicaire@va.gov
David.Ward@va.gov
www.va.gov/tribalgovernment - Main website
Tribal.agreements@va.gov – VA-IHS-THP Reimbursement Agreements
Tribal.Consultation@va.gov – email for tribal leaders to submit inquiries directly to VA

RED LODGE TRANSITION SERVICES TRISH JORDAN, EXECUTIVE DIRECTOR

COVID-19 BEHIND THE IRON DOORS
The Impact on Native American Religious Services & Cultural Programming within Oregon State Prisons During a Pandemic
Trish Jordan, RN, BSN
RED LODGE TRANSITION SERVICES

The Road to Incarceration
- Under-educated
- Mental health issues
- School to Prison Pipeline
- Dysfunctional family dynamics
- One or both parents have been incarcerated
- Wrong place at the wrong time…
- Intimate partner initiated
- No boundaries/PTSD
- Human trafficking victim

WHAT IS NATIVE AMERICAN RELIGIOUS SERVICES?
- Cultural and spiritual programming
- Talking Circle
- Drum Practice
- Smudge
- Sweatlodge
- Pipe Ceremony
- Wellbriety
- Parenting Classes
- Behavioral health classes
- Pipe Ceremony
- Hair Cutting Ceremony
- Medicine bags and medicines
- Giveaway
- Sacred Foods Ceremony
- Pow Wow
- Spirit Run
- Winter Solstice Sweat
- Art projects
- Flutes
- Special guests
- Native American Heritage Month

Programming is dependent on volunteers' space being provided. Each Prison is its own island

WHY IS NATIVE AMERICAN RELIGIOUS SERVICES NEEDED?

- Connection to Spirit
- Behavioral Health
- Holistic values
- Sense of belonging
- Personal identity
- Foundation upon which to rebuild
- Healing the Wounded Spirit
- Adult mentoring
- Respect for all life
- Maintain cultural and tribal sovereignty
- Lifeline to community
- Native Americans are incarcerated at a rate of 38% higher than the national average
- Native Americans are 3X more likely to be killed by police than any other racial group
- and religious freedom for an almost invisible population
- 70% of youth taken into federal custody are Native American (1)
- Native Americans experience violence at 2 X the national average (2)
- Native people need to connect with one another
- Reentry begins upon incarceration

COVID-19: Infections Among U.S. Prisoners Have Been Triple Those of Other Americans

- Over 1,400 new Adult in Custody infections and seven deaths, on average, have been reported daily
- Social distancing is not an option
- Testing was not a priority early in the pandemic
- One in three AIC in state prisons have had the virus
- 2,700 inmates have died according to the New York Times research tracking
- More than 525,000 reported infections nationwide in our prisons
- Deaths could have been prevented according to public health officials and Criminal Justice experts
- Disorganized response to virus in most prisons
- Over 138,00 prison and jail correctional officers and other workers were sickened and 261 died
- Oregon Dept of Corrections taken to Court and ordered to vaccinate ALL inmates who request immunization
- New strains of the virus are a real concern!
- https://www.nytimes.com/live/2021/04/10/world/covid-vaccine-coronavirus-cases

April 20 – 22, 2021

MINUTES

TRIBAL REPORTS (A COPY OF THE REPORTS IS ATTACHED)

- Coeur d'Alene, Helo Hancock Chief Executive Officer of Marimn Health
- Colville, Dr. Dan Barbara, Director, Health and Human Services Colville Confederated Tribes and Andy Joseph, Jr., Council
- Coos, Lower Umpqua and Siuslaw, Iliana Montiel, Interim Director of Health & Family Support Services

TRIBAL OPIOID RESPONSE FUNDING, COLBIE M. CAUGHLAN, MPH, PROJECT DIRECTOR - THRIVE & RESPONSE CIRCLES & ERIC VINSON, ECHO Project

Options for spending funds:
A: Provide SUD provider for the area

- Help with telehealth
- Provider can mentor local clinical providers (if interested/available)

B. Clinical Supervisor

- Available to tribes to use for supervision in their Behavioral Health Programs

If these licensures aren't available we'll spend funds for regional media creation and dissemination

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

- Motion by Cheryle Kennedy, Grand Ronde
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

TRANS & GENDER-AFFIRMING CARE STRATEGIC VISION AND ACTION PLAN
TRANS & GENDER-AFFIRMING CARE STRATEGIC VISION AND ACTION PLAN

Paths (Re)Membered Project

- Research and Data
- Community Engagement
- Advocacy

See the PowerPoint for additional graphic information

LUNCH BREAK

Committee Reports

Elders Committee – Chandra Wilson, 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 – Bridget Caniff, NPAIHB Staff (A copy of the report is attached)

Behavioral Health – Birdie Wermy, NPAIHB Staff (A copy of the report is attached)

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

Youth – Paige Smith, NPAIHB Staff (A copy of the report is attached)

Legislative – Cheryle Kennedy, Grand Ronde & Sue Steward, NPAIHB Deputy Director (A copy of the report is attached)

Resolutions

21-0-01 ***Strengthening Indigenous Health and Science Research: NW NARCH Program***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-02 ***NW Tribal Food Sovereignty Coalition (NTFSC) and Food Sovereignty Initiatives Project 2021 RFA- Native American Agriculture Fund (NAAF)*** *SETTLEMENT FUNDING: KEEPSEAGLE v. VILSACK LITIGATION*
Motion by Libby Wantabe, Snoqualmie with edits
- Motion 2nd by Andy Joseph, Jr. Colville
- **Motion Carried**

21-03-03 ***Native Dental Therapy Initiative – Funding Offered by the National Indian Health Board for Education/Outreach to Enhance Polices Supportive of Dental Therapy***
- Motion by Marilyn Scott, Upper Skagit
- Motion 2nd by Libby Wantabe, Snoqualmie
- **Motion Carried**

21-03-04 ***Native Dental Therapy Initiative – Implementation of Dental Therapy Offered by the National Indian Health Board***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-05 ***Indian Health Service Minority HIV/AIDS Fund Clinical Program Support***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla

- **Motion Carried**

21-03-06 ***Indian Health Service Minority HIV/AIDS Fund to Support Ending the HIV Epidemic in Indian County***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-07 ***Action by Unanimous Consent of the Governing Board – Restatement of 403(b) Retirement Plan***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-08 ***Call on Congress to Support Full Funding for FY 2022 Indian Health Service Budget***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-09 ***Article X (Amendments) of the NPAIHB Constitution and By-Laws --- 30 Days' Notice***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-10 ***Portland Area CHAP Certification Board (PACCB)***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Libby Wantabe, Snoqualmie
- **Motion Carried**

21-03-11 ***Support for Trans and Gender-Affirming Care in IHS, Tribal, and Urban Indian Health Facilities – 2021 Strategic Vision and Action Plan***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

21-03-12 ***Option to Exclude All One-Time, Non-Recurring COVID-19 Funds from Direct Cost Base When Negotiating New Indirect Cost Rate***
- Motion by Andy Joseph, Jr., Colville
- Motion by 2nd by Shawn Gavin, Confederated Tribes of Umatilla
- **Motion Carried**

April 20 – 22, 2021

MINUTES

Adjourn at 3:35 PM

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

_____ _____

Prepared by Lisa Griggs,
Executive Coordinator **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

April 20-22, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/99978452048?pwd=RWNUZUwzemlEd0ZXMFh2anlqTEd1UT09&from=addon
Meeting ID: **999 7845 2048** Passcode: **625249** Or by phone +1 253 215 8782 US (Tacoma)
Dropbox link to QBM material:
https://www.dropbox.com/sh/nk0dztibbf9bjf3/AAD3KZOybEfpopGW3XVHX8U-a?dl=0

TUESDAY APRIL 20, 2021

7:30 AM	Executive Committee Meeting (separate Zoom log in)	Executive Committee Members
9:00 AM	Call to Order Invocation Welcome Roll Call	Cheryle Kennedy, NPAIHB Vice-Chair Andy Joseph, Colville Tribal Council Greg Abrahamson, NPAIHB Secretary
9:15 AM	1. Approve Agenda 2. Future Board Meeting Dates/Sites • July 27 - 29, 2021 TBD • October 19 – 21, 2021 TBD • January 18 – 20, 2022 TBD • April 19 – 21, 2022 TBD 3. Review and Approve January QBM Minutes	
9:30 AM	Chairman's Report **(1)**	Nick Lewis, NPAIHB Chair
9:45 AM	Executive Director Report **(2)**	Laura Platero, NPAIHB Executive Director
10:00 AM	COVID-19 Response **(3)**	Celeste Davis, Environmental Health Director
10:20 AM	IHS Area Director Report **(4)**	Dean Seyler, Portland Area IHS Director
10:35 AM	**BREAK**	
10:40 AM	Indian Health Service *(confirmed)*	Elizabeth Fowler, Acting IHS Director

April 20-22, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/99978452048?pwd=RWNUZUwzemlEd0ZXMFh2anlqTEd1UT09&from=addon
Meeting ID: **999 7845 2048** Passcode: **625249** Or by phone +1 253 215 8782 US (Tacoma)
Dropbox link to QBM material:
https://www.dropbox.com/sh/nk0dztibbf9bjf3/AAD3KZOybEfpopGW3XVHX8U-a?dl=0

11:30 AM	**Committee Meetings** 1. Elders 2. Veterans 3. Public Health 4. Personnel	Virtual Rooms: Staff: Clarice Charging Staff: Don Head Staff: Bridget Caniff Staff: Andra Wagner
12:30 PM	**LUNCH BREAK**	
1:00 PM	**Committee Meetings** 5. Behavioral Health 6. Youth 7. Resolutions/Legislation	Virtual Rooms: Staff: Danica Brown Staff: Paige Smith Staff: Sue Steward
2:00 PM	Legislative Update **(5)**	Cindy Darcy, D.C. Policy Consultant
2:30 PM	Regulatory/Admin Update **(6)**	Liz Coronado, NPAIHB Health Policy Consultant
3:00 PM	Recess for Day	

April 20-22, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/99978452048?pwd=RWNUZUwzemlEd0ZXMFh2anlqTEd1UT09&from=addon
Meeting ID: **999 7845 2048** Passcode: **625249** Or by phone +1 253 215 8782 US (Tacoma)
Dropbox link to QBM material:
https://www.dropbox.com/sh/nk0dztibbf9bjf3/AAD3KZOybEfpopGW3XVHX8U-a?dl=0

WEDNESDAY APRIL 21, 2021

9:00 AM	IHS Listening Session on HIV/HCV & Alzheimer's Initiatives **(7)**	Marcy Ronyak, Division of Clinical & Community Services IHS Headquarters
9:50 AM	Call to Order Invocation	Nick Lewis, NPAIHB Chairman Michael Ray Johnson, CTUIR Council
10:00 AM	Finance Report & 2020 Audit Report	Eugene Mostofi, Fund Accounting Manager & Chris Tyhurst, REDW
10:50 AM	Portland Area Tribal Advisory Committee Updates **(8)**	Sue Steward with Portland Area TAC Representatives and Technical Advisors
12:00 PM	**LUNCH BREAK**	
12:30 PM	Epi Center Update **(9)**	Victoria Warren-Mears, NWTEC Director
1:00 PM	Q&A with State Representatives	David Bell, Deputy Administrator IDHW; Julie Johnson, OHA; Tamara Fife, DOH; Jessie Dean, HCA
1:30 PM	Bylaws Discussion **(10)**	Nick Lewis, Chairman
3:00 PM	Recess for the Day	

April 20-22, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/99978452048?pwd=RWNUZUwzemlEd0ZXMFh2anlqTEd1UT09&from=addon
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Dropbox link to QBM material:
https://www.dropbox.com/sh/nk0dztibbf9bjf3/AAD3KZOybEfpopGW3XVHX8U-a?dl=0

THURSDAY APRIL 22, 2021

9:00 AM	Invocation Call to Order	Nick Lewis, NPAIHB Chairman
9:15 AM	Veterans Update **(11)**	Terry Bentley, Tribal Relations Specialist Pacific District & Stephanie Birdwell, Director, Office of Tribal Government Relation
9:45 AM	Red Lodge Transition Services **(12)**	Trish Jordan, Executive Director
10:15 AM	Tribal Report • Coeur d'Alene	Tribal Reports in July • Cow Creek • Cowlitz • Grand Ronde
10:35 AM	**BREAK**	
10:50 AM	Tribal Reports – Cont'd • Colville • Coos, Lower Umpqua and Siuslaw	
11:30 AM	Tribal Opioid Response Funding **(13)**	Colbie M. Caughlan, MPH, Project Director - THRIVE & Response Circles & Eric Vinson, ECHO Project
11:40 AM	Strategic Plan Review **(14)**	Nora Frank-Buckner, Food Sovereignty Initiatives Director & Stephanie Craig-Rushing, Project Director
12:00 PM	Trans & Gender-Affirming Care Strategic Vision and Action Plan	Itai Jeffries, Morgan Thomas, and Jessica Leston
12:20 PM	**LUNCH BREAK**	

April 20-22, 2021

AGENDA

Join Zoom Meeting
https://zoom.us/j/99978452048?pwd=RWNUZUwzemlEd0ZXMFh2anlqTEd1UT09&from=addon
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Dropbox link to QBM material:
https://www.dropbox.com/sh/nk0dztibbf9bjf3/AAD3KZOybEfpopGW3XVHX8U-a?dl=0

1:00 PM	Committee Reports	Committee Members or Staff
2:00 PM	Resolutions	Nick Lewis, Chairman
3:00 PM	Adjourn	
3:00 PM	***Optional Tribal Caucus***- VA Tribal Consultation April 29	Veronica Smith, NPAIHB Policy Consultant

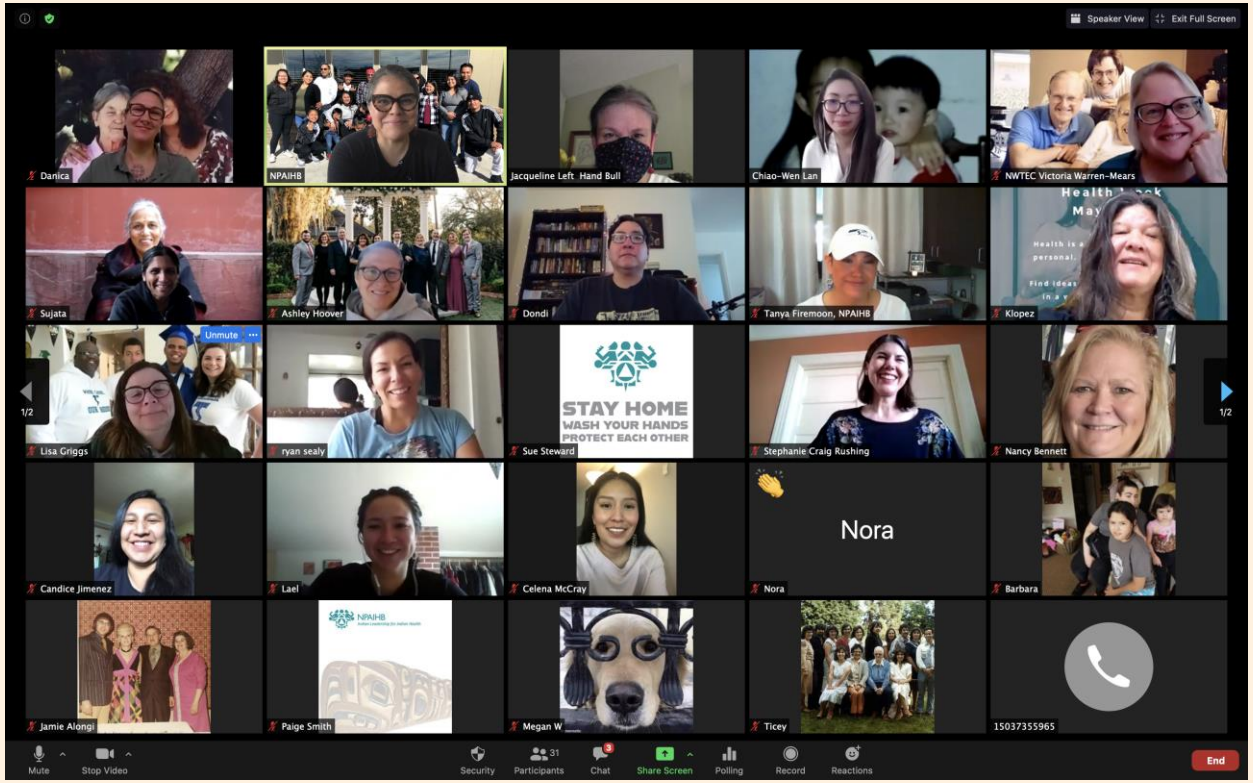
EXECUTIVE DIRECTOR REPORT
Virtual Quarterly Board Meeting
April 20, 2021

Laura Platero, JD

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Report Topics

1. QBM Highlights
2. Admin & Finance
3. HR/Personnel Updates
4. Grants/Awards Update
5. Looking Forward
6. Questions



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

QBM Highlights

- IHS Acting Director Liz Fowler (Today)
- Leg Update - Cindy Darcy, DC Policy Strategist (Today)
- Alzheimer's and HIV/HCV Consultation (Wednesday)
- REDW Presentation – FY 2020 Audit Report (Wednesday)
- Bylaws Review/Discussion (Wednesday)
- Strategic Plan 2020 to 2025 (Thursday)
- Tribal Reports (Thursday)

Administration & Finance

- Office Closed – Multnomah County Back to "High Risk" on April 9
  - Teleworking recommended at "High Risk" and "Moderate Risk" levels
- Administration
  - Developing policies for
    - Return to "Limited office work" when County is at "Lower Risk" level
    - Required staff travel under grants or projects
  - Most staff vaccinated
  - Virtual Staff Retreat in May
- Finance
  - FY 2020 Audit completed – Clean audit

New Full-Time Employees

Asia Brown
Sexual Health
Communications
Specialist

Jane Manthei
Health Native
Youth Outreach
Specialist

Dawn Bankson
Oregon Tribal and Urban
Testing Liaison (4/26)

Tammy Cranmore
Finance Director
(4/26)

Holly Thompson Duffy
Environmental Health
Science Manager
(4/26)

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Other Personnel Updates

OTHER INTERNAL PROMOTIONS/TRANSFERS	
Celena McCray	Promoted to WYSH Project Manager
Morgan Thomas	Promoted to Paths (Re)Member Program Co-Manager

OPEN POSITION
Compliance Manager

Recognitions – 25 years of Service

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Jim Fry

New Awards and Supplements - January–March 2021

Sponsor	Award Amount	Title and Purpose
CDC	$1,299,998	**Tribal Epidemiology Center Consortium to Increase Vaccination Coverage Across American Indian and Alaska Native (AI/AN) Adult Populations Currently Experiencing Disparities (TEC-IAVC):** This project will cover the United States AI/AN population through a national partnership among Tribal Epicenters (TEC) to build TEC public heath infrastructure and capacity for flu and COVID-19 vaccination-related activities
First Nations Development Institute	$10,000	**Emergency Relief Grant**: Flexible resource for general operating support to respond to CV19
IHS	$124,994	**Northwest Tribal Injury Prevention Program (NWIPP):** This 5-year project addresses child passenger and pedestrian safety in NW Tribal communities
Oregon Health Authority/CDC	$373,523	**COVID-19 Response and Recovery**: This subaward from OHA will support CV19 testing and coordination
Oregon Health Authority/CDC	$20,000	**Immunization Communications**: This subaward from OHA will support communications and media content related to influenza and CV19 immunizations
Seattle Foundation	$25,000	**COVID-19 Response Fund Phase 3 Supplement**: Flexible resource to community-based organizations working on CV19; these funds will continue to support culturally-relevant CV19 vaccine messaging
TOTAL	$1,853,515	

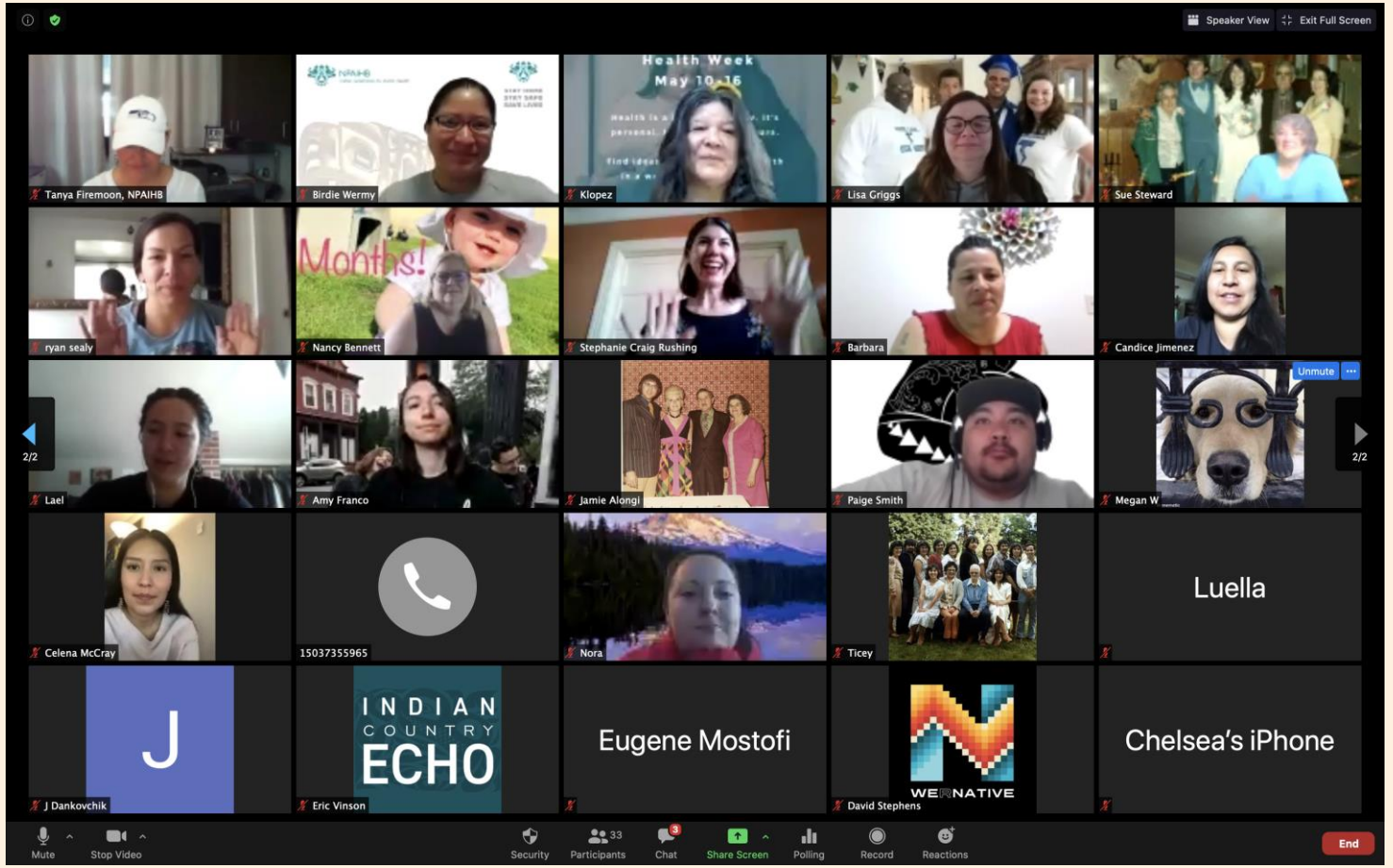
Proposals Submitted - January–March 2021

- First quarter of 2021: 5 proposals submitted
- Two proposals as prime applicant:
  - EPA Region 10 General Assistance Program
  - SAMHSA Tribal Opioid Response Consortium Phase 4
- Three proposals as subrecipient/subcontractor:
  - WA Health Care Authority Behavioral Health Aide Training
  - USDA/Food Research Action Center Food Security Survey
  - DOJ/OR Sexual Assault Task Force Tribal Advocacy and Training

Looking Forward

- **Admin**: Phased in Return to Work/Travel Policies (dependent on variants)
- **Finance**: New Finance Director, updating Accounting Manual and implementing subrecipient monitoring for FY 2021
- **Communications**: Streamline and continue branding efforts
- **Leg and Policy**: Hill visits, continued submission of appropriations and policy requests, and House and Senate appropriations testimony
- **Fundraising**: Oregon DHAT Legislation

Questions…?



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Indian Leadership for Indian Health

COVID-19 Pandemic Public Health Emergency Response

Celeste L. Davis, REHS, MPH (Chickasaw Nation)

Environmental Public Health Program Director

Incident Commander

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

The Incident Command System Team

ICS ROLE	NPAIHB ICS TITLE	NPAIHB STAFF
Incident Commander	Incident Commander	Celeste Davis
Assistant to IC	IC Coordinator	Holly Duffy
Liaison Officers	Oregon Liaison Officer	Sue Steward
	Washington/AIHC Liaison Officer	Tam Lutz
	Idaho Liaison Officer	Jessica Leston
	Policy Liaison Officer (ID, OR, & WA)	Veronica Smith, Liz Coronado, Candice Jimenez
Planning Section Chief	Planning & Information Coordinator	Victoria Warren-Mears
Data Analysis	Data Specialist	Sujata Joshi
Data Collection/Entry	Data Assistant	Bridget Canniff
Community Planning	Food Security Specialist	Nora Frank-Buckner
MCM Planning	MCM Planner	Katie Johnson
Operations Section Chief	Public Health Officer	Tom Weiser
Clinical Education & Support Unit Lead	COVID-19 ECHO Manager	David Stephens
Mental Health Education & Support Unit Lead	BH Program Manager	Danica Brown
Environmental Public Health/Occupational Safety & Health Unit Lead	EH Specialist/Occupational Safety & Health Specialist	Shawn Blackshear
Communicable Disease Unit Lead	CD Control/PHN	Dawn Bankson
Communications & Health Promotion Unit Lead	Communications Specialist	Stephanie Rushing
Logistics Section Chief	Medical & PPE Supplies Coordinator	Holly Duffy
Finance/Administration Section Chief	IC Administrative Assistant	Lisa Griggs

Public Health Operations

- **Clinical Education and Support: COVID-19 ECHOs**
  - NWTEC/NPAIHB has hosted 78 COVID-19 ECHO clinics
  - 9,512 participants, and
  - Answered 1,152 questions
- **Mental Health Education and Support**
  - Receive data when persons of concern use the words "Native" or "Indigenous" and text to communicate with a Crisis Text Line (CTL) counselor at 741741
  - Behavioral Health Needs Assessment - Plans to conduct 10 key informant interviews with behavioral health, chemical dependency and MAT providers.
- **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 80 Facility Reviews/Inspections, Risk Assessments
  - Collaborated with CDC to conduct virtual Clinical Infection Control consults
  - 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

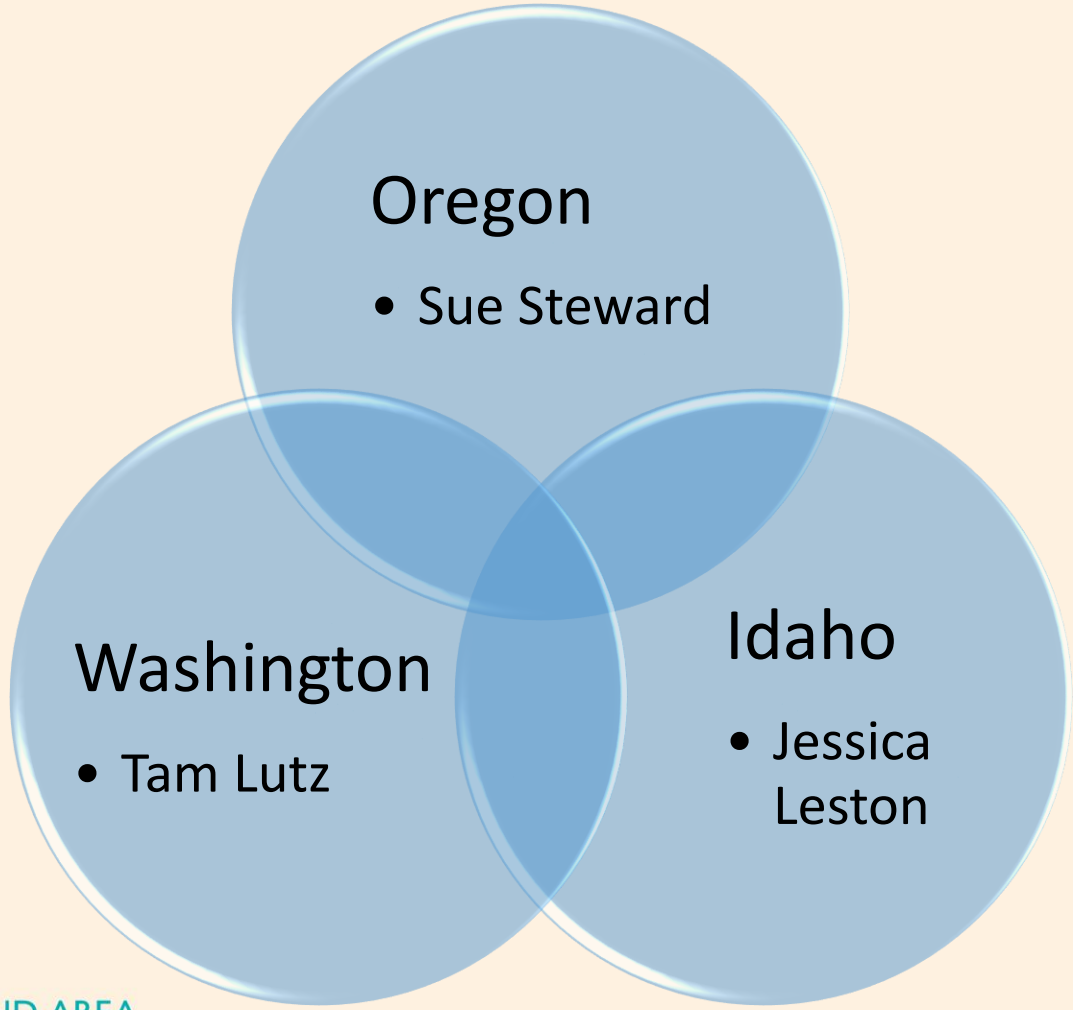
Planning & Information Support

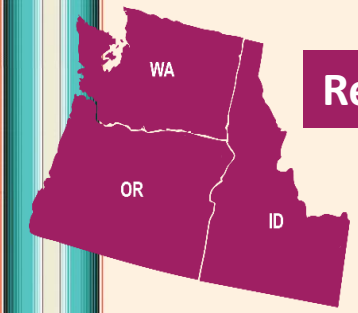
- **Surge Staffing & Resources**
  - Management of Emergency CDC Funds Distribution to Tribes
  - CDC Foundation Surge Staffing – ended 3/31, 2 short extensions
- **Logistics & PPE**
  - Respiratory Fit Test Kits for Clinics
  - Diabetes Patients' Health Promotion Kits
  - PPE & Medical Supplies: 9200 nitrile gloves, 102 containers of hospital-grade disinfecting wipes, 3550 disposable surgical masks, 2180 N95 respirators, 2 air purifiers, 1 Temperature Scan Kiosk and Extension Kit and more

Planning & Information Support

- **Data Collection & Analysis**
  - Bi-weekly regional data reports
  - Technical Assistance in Data Analysis for Tribes
- **Medical Counter Measure Planning – VACCINES!**
  - Coordinating with IHS and States
  - NW only - created and support 42 VAMS clinic portals to facilitate vaccine reporting to CDC
  - National - provided training: COVID 19 Vaccine Data Management – part of a team that delivered 34 classes (6,066 participants) in November and December, with twice weekly office hours ongoing
  - National - part of a team that developed telemedicine documentation guidance documents and training for IHS

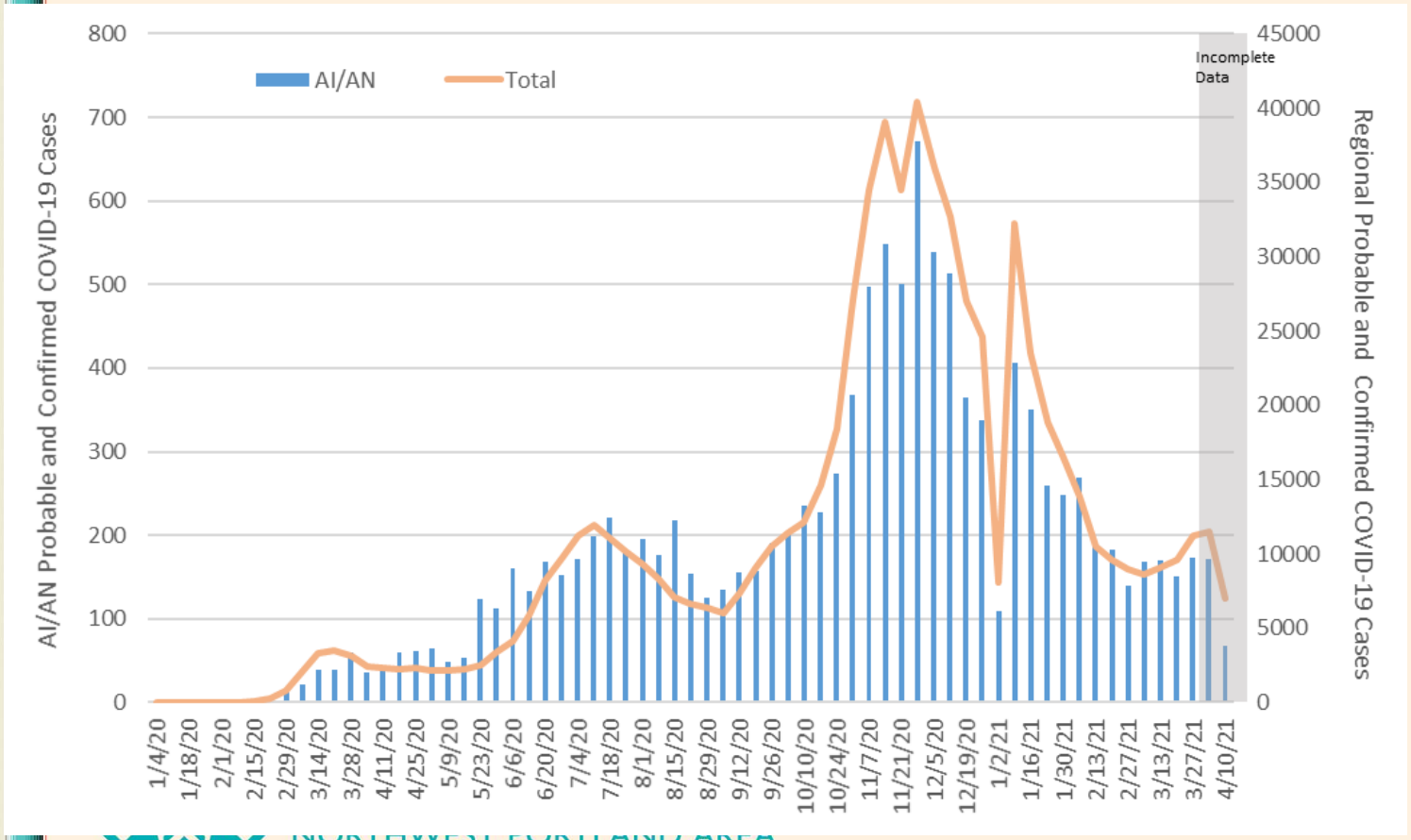
Situational Awareness & ICS Liaisons





Regional COVID-19 Data

EpiCurve of COVID-19 Cases by Week



NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Data Source: CDC COVID-19 Case Surveillance Data

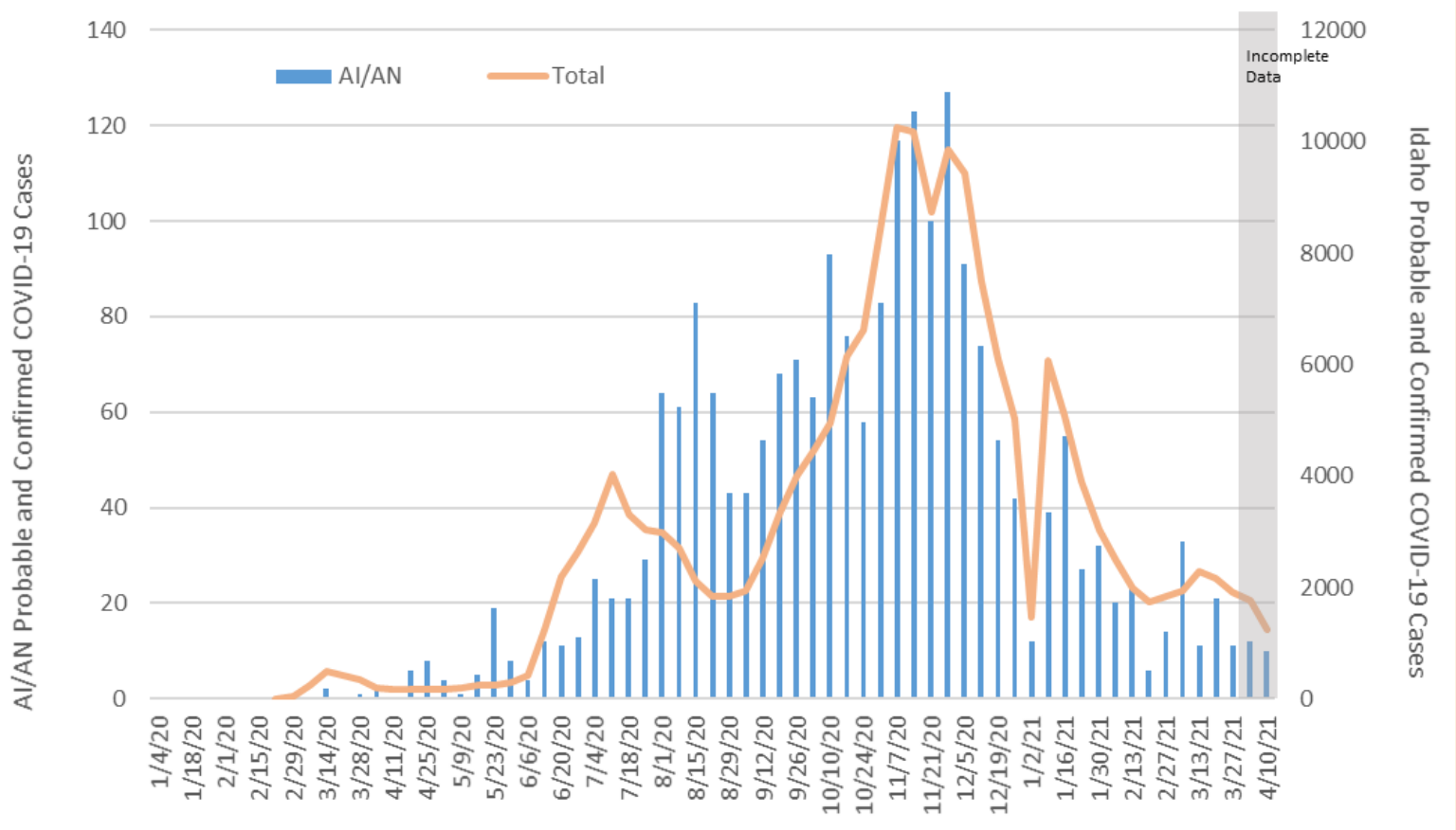
Characteristics of COVID-19 Cases through 4/12

Race		N	%
	AI/AN	12,005	1.6%
	Non-AI/AN	437,758	60.0%
	Unknown	279,295	38.3%
	Total	729,058	100.0%
Case Status		AI/AN	State Total
	Laboratory Confirmed	92.4%	90.7%
	Probable	7.6%	9.3%
Sex		AI/AN	State Total
	Male	46.0%	47.9%
	Female	53.0%	49.9%
	Other	0.0%	0.0%
	Missing/Unknown	1.0%	2.2%
Age Group		AI/AN	State Total
	0-9	7.0%	4.8%
	10-19	13.0%	11.4%
	20-29	21.4%	20.9%
	30-39	18.8%	17.6%
	40-49	14.8%	15.2%
	50-59	12.0%	12.9%
	60-69	7.9%	8.8%
	70-79	3.6%	4.9%
	80+	1.4%	3.4%
	Missing	0.0%	0.1%
Hospitalization Status		AI/AN	State Total
	Hospitalized	6.9%	5.1%
	Not Hospitalized	81.2%	81.2%
	Unknown	12.0%	13.7%

Idaho COVID-19 Data

IDAHO

EpiCurve of COVID-19 Cases by Week



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Data Source: CDC COVID-19 Case Surveillance Data

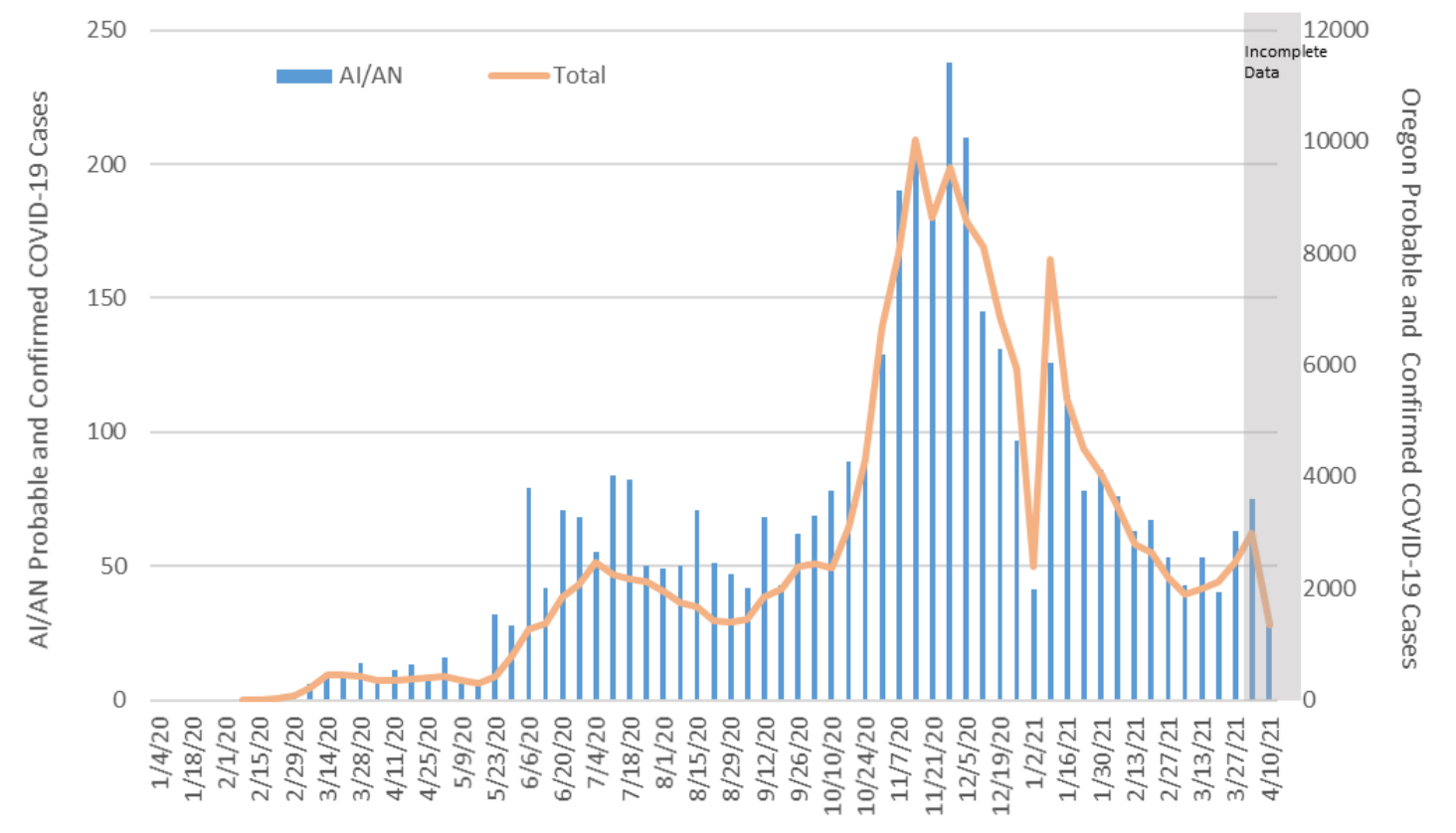
Characteristics of COVID-19 Cases through 4/12

Race		N	%
	AI/AN	2,171	1.2%
	Non-AI/AN	119,194	65.1%
	Unknown	61,841	33.8%
	Total	183,206	100.0%
Case Status		AI/AN	State Total
	Laboratory Confirmed	83.5%	80.3%
	Probable	16.5%	19.7%
Sex		AI/AN	State Total
	Male	40.5%	47.5%
	Female	56.3%	51.5%
	Other	0.0%	0.0%
	Missing/Unknown	3.2%	1.0%
Age Group		AI/AN	State Total
	0-9	6.6%	3.5%
	10-19	15.1%	11.9%
	20-29	19.2%	20.5%
	30-39	18.3%	16.7%
	40-49	14.4%	15.4%
	50-59	10.4%	13.1%
	60-69	9.2%	9.6%
	70-79	4.6%	5.7%
	80+	2.1%	3.6%
	Missing	0.0%	0.0%
Hospitalization Status		AI/AN	State Total
	Hospitalized	7.2%	4.0%
	Not Hospitalized	60.7%	66.9%
	Unknown	32.1%	29.2%

OREGON

Oregon COVID-19 Data

EpiCurve of COVID-19 Cases by Week



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

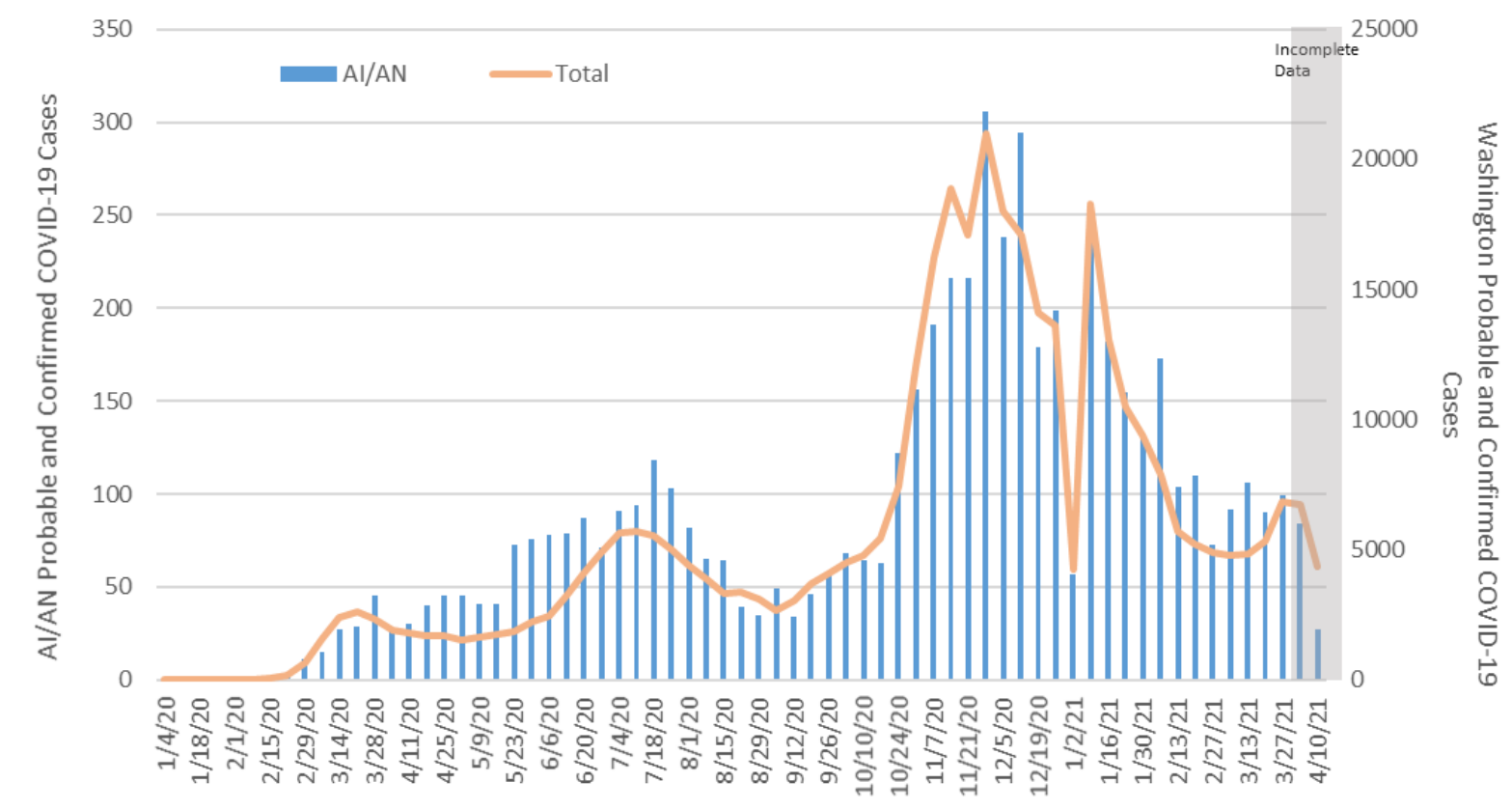
Data Source: CDC COVID-19 Case Surveillance Data

Characteristics of COVID-19 Cases through 4/12

Race		N	%
	AI/AN	4,057	2.4%
	Non-AI/AN	135,054	79.7%
	Unknown	30,402	17.9%
	Total	169,513	100.0%
Case Status		AI/AN	State Total
	Laboratory Confirmed	96.5%	96.3%
	Probable	3.5%	3.7%
Sex		AI/AN	State Total
	Male	45.5%	48.2%
	Female	53.5%	50.8%
	Other	0.1%	0.0%
	Missing/Unknown	0.9%	1.0%
Age Group		AI/AN	State Total
	0-9	7.3%	4.8%
	10-19	13.3%	11.2%
	20-29	21.2%	21.0%
	30-39	18.1%	17.4%
	40-49	15.3%	15.4%
	50-59	12.2%	12.8%
	60-69	7.6%	8.6%
	70-79	3.5%	5.0%
	80+	1.4%	3.7%
	Missing	0.0%	0.0%
Hospitalization Status		AI/AN	State Total
	Hospitalized	7.2%	5.3%
	Not Hospitalized	74.6%	67.4%
	Unknown	18.2%	27.2%

Washington COVID-19 Data

EpiCurve of COVID-19 Cases by Week

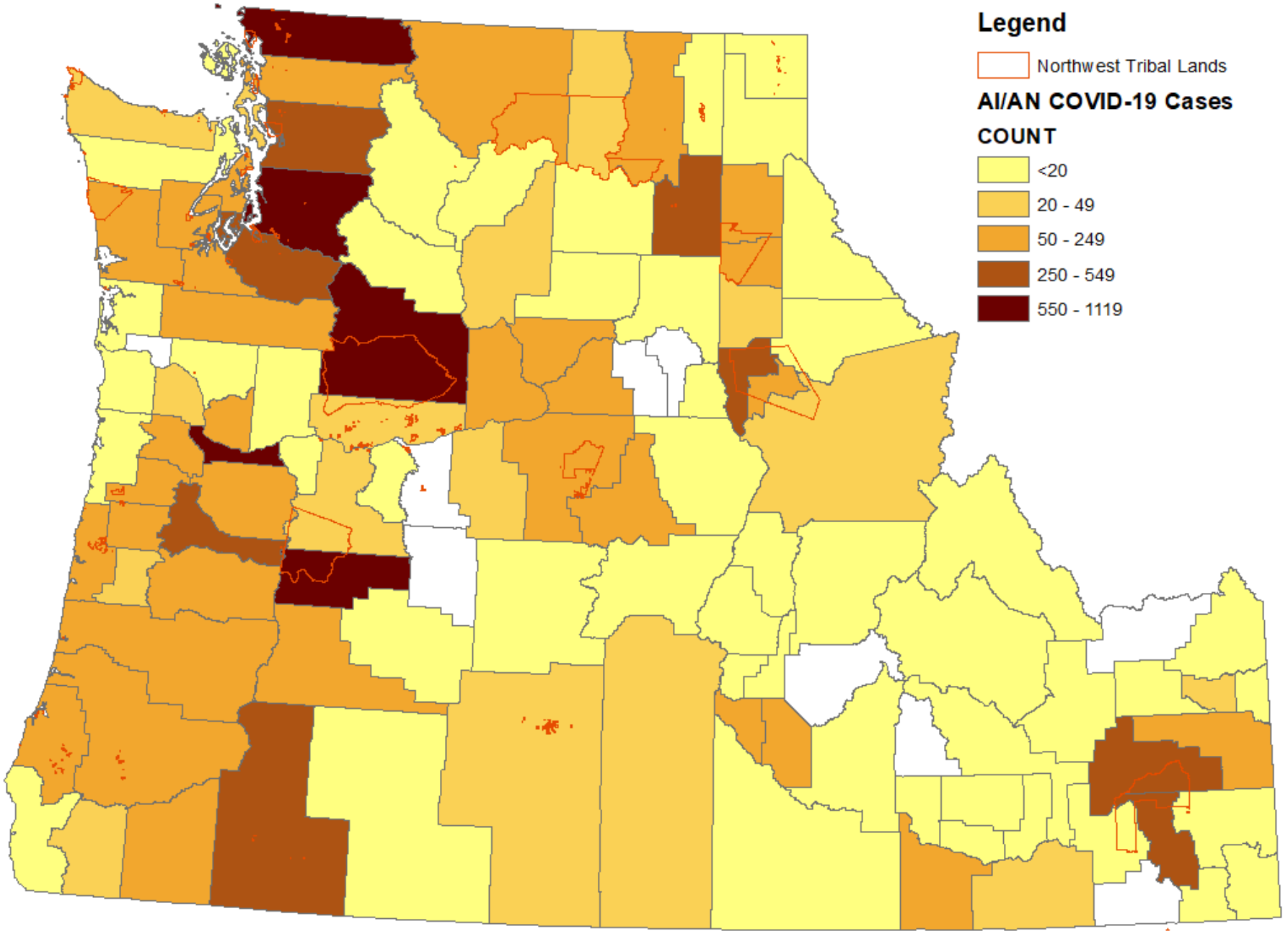


NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Data Source: CDC COVID-19 Case Surveillance Data

Characteristics of COVID-19 Cases through 4/12

Race		N	%
	AI/AN	5,777	1.5%
	Non-AI/AN	183,510	48.8%
	Unknown	187,052	49.7%
	Total	376,339	100.0%
Case Status		AI/AN	State Total
	Laboratory Confirmed	92.9%	93.3%
	Probable	7.1%	6.7%
Sex		AI/AN	State Total
	Male	48.5%	48.1%
	Female	51.4%	48.6%
	Other	0.0%	0.0%
	Missing/Unknown	0.1%	3.3%
Age Group		AI/AN	State Total
	0-9	6.9%	5.3%
	10-19	12.0%	11.3%
	20-29	22.4%	21.0%
	30-39	19.4%	18.2%
	40-49	14.6%	15.1%
	50-59	12.4%	12.9%
	60-69	7.6%	8.5%
	70-79	3.4%	4.4%
	80+	1.2%	3.2%
	Missing	0.1%	0.1%
Hospitalization Status		AI/AN	State Total
	Hospitalized	6.5%	5.6%
	Not Hospitalized	93.5%	94.4%
	Unknown	0.0%	0.0%


Legend
Northwest Tribal Lands
AI/AN COVID-19 Cases
COUNT
<20
20 - 49
50 - 249
250 - 549
550 - 1119

Leadership & Guidance

- **Engaging with Tribal Health Leadership**
  - Zoom Meeting Every Tuesday at 10, Forum for Information Exchange & Sharing

- **Technical Guidance & Support for Tribal Leader's Decision-Making**
  - "Vaccine Comparison Chart
  - "Scientific & Technical Guidance on Achieving Community Immunity"

- **Policy Advocacy**
  - Legislation & Funding
  - Vaccine Distribution

One Year Later…

Successes

- Adaptability & Innovation – developing case investigation and contact tracing from scratch
- Wrap around services and supports – quarantine & isolation
- Partnerships with IHS and the States

Challenges

- Still have mixed messages, Politicization of Public Health
- Structural and systemic inequities of course lead to health disparities
- Indian Health remains woefully underfunded

The Road Ahead

- Anticipate Operating under Public Health Emergency Declaration through 2021
- Vaccinations will be what wins the Battle
- How to integrating efforts into new Pandemic/COVID-19 Plans
- Given the Re$ources, Tribes Can Excel – will it continue?
- Focus on Improving Health Disparities
  - Demand for Resources to Strengthen PH Infrastructure
  - Addressing Social Determinants of Health
  - Research on COVID-19, Health Services & Policy Research

END

- THANK YOU!

- CELESTE DAVIS
- cdavis@npaihb.org
- 505.670.8380 (cell phone)

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Indian Health Service

NPAIHB-QBM – ZOOM MEETING

DEAN M. SEYLER

DIRECTOR, PORTLAND AREA

APRIL 20, 2021

Indian Health Service
Portland Area

Community Health Aide Program (CHAP)

Circular No. 20-06

- Policy was approved in FY2020
- Requires establishment of Area and National Certification Board
  - Responsible for certification of providers (Federal & Tribal)
  - Review and recommendation of certification training programs

Dear Tribal Leader Letter – Portland Area Certification Board

- Sent April 14, 2021
- Seeking Consultation and comments until **May 14, 2021**
  - Board make-up (seating plan)
  - Board candidacy requirements
  - Term limits
  - Representation (T1, TV, DST)

Indian Health Service
Portland Area

CRRSAA - Pub. L. No. 116-260

- Overall purpose still needs to fall under COVID-19
  - Vaccine Funding – Sent unilaterally (DTLL 2/2/21)
  - Testing Funding – Bilateral amendments, (DTLL 1/15/21)

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 correct for 2016-Present
  - New Employee – Michael Mummey, ISDA Financial Specialist (CSC)
  - If we have not contacted you please provide us final Passthroughs or salary information.

Indian Health Service
Portland Area

- 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 the FY20 Recurring Base, which runs through 1/27/2021

Indian Health Service
Portland Area

FY20 Catastrophic Health Emergency Fund (CHEF)

Status as of April 7, 2021

- 67 Total Cases
- 41 Total Amendments
- $2,471,289.00 Reimbursed
- $40,202.78 Pending Reimbursements
- 92% Total Reimbursed
- **FY20 CHEF Balance: $19,042,902**

Indian Health Service
Portland Area

FY21 Catastrophic Health Emergency Fund (CHEF)

Status as of April 7, 2021

- 9 Total Cases
- 4 Total Amendments
- $712,748 Reimbursed
- $58,145.43 Pending Reimbursements
- 92% Total Reimbursed
- **FY21 CHEF Balance: $53,000,000**

Indian Health Service
Portland Area

Division of Health Facility Engineering

Regional Specialty Referral Center Network

- IHS Continues to Explore Avenues to Support a Demonstration Project

Indian Health Service
Portland Area

Division of Health Facility Engineering

Combined Supportable Space Data Request

- Responses Were Due February 15th
- One Week Extension Provided
- 12 Tribes Responded (30 Tribes Last Year)
- Responding Tribes Are Eligible for FY21 BEMAR Funding Consideration
  - (Funds Will Be Available, Amount Still Being Determined)

Indian Health Service
Portland Area

Division of Sanitation Facilities Construction

- Positions Filled
  - Tribal Utilities Consultant, Olympic District Office: LCDR Sandra Redsteer P.E. sandy.redsteer@ihs.gov
  - Tribal Utilities Consultant, Portland Area Office: LCDR Jason Davis P.E. Jason.davis@ihs.gov

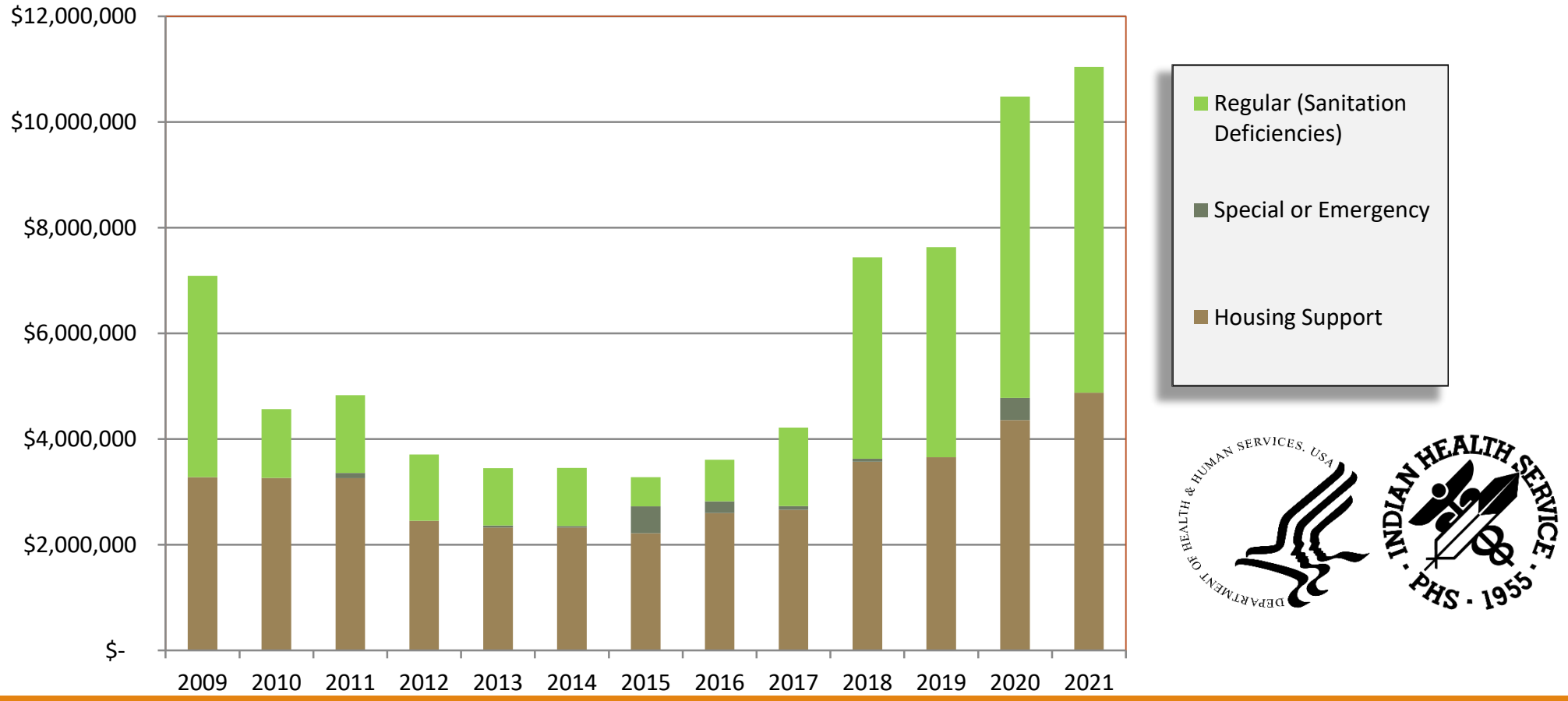
- Positions Pending
  - Environmental Engineers (2): 1 each at the Spokane District Office and Port Angeles Field Office

- Positions Vacant
  - (Coming soon): Senior Environmental Engineers (2)
    - – Port Angeles FO, Fort Hall FO
  - Engineering Technicians (2

- Contact: Alex Dailey, Portland Area DSFC Director, 503-414-7780 alexander.dailey@ihs.gov

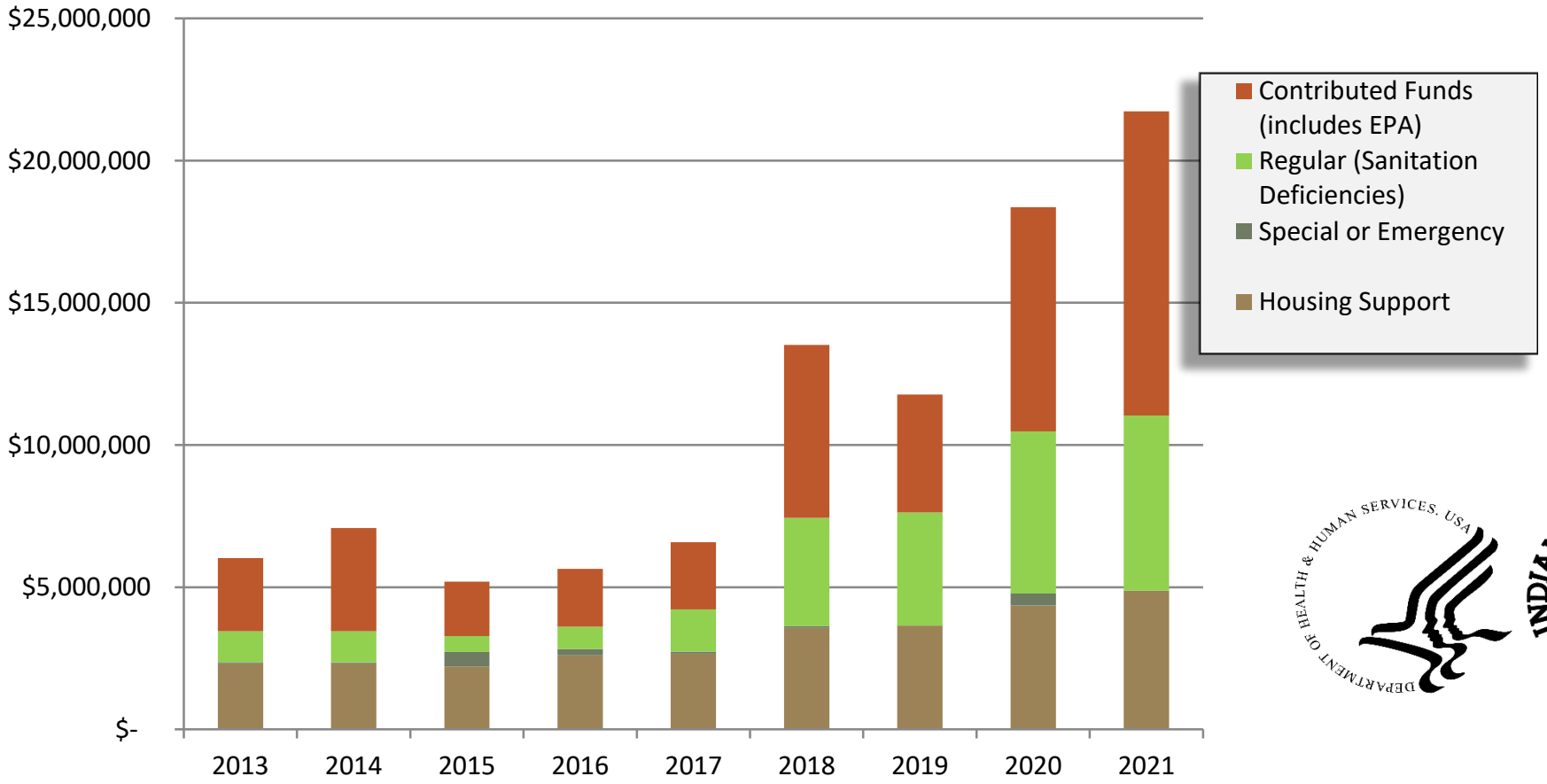
Indian Health Service Portland Area

Construction Funding (Portland Area) SFC



Indian Health Service Portland Area

Total Project Funding for Portland Area Sanitation Facilities Construction



Indian Health Service Portland Area

- 2021 appropriation resulted in 5.4% increase in IHS construction funding over last year.
- With contributions, there was an 18.4% increase in funding for IHS projects.
- 34 Projects currently on the draft FY21 Funding Plan
- Currently gathering needs for FY22 funding (Regular and Housing Projects)
- CARES Act funding: $10M nationally in 2020 for SFC
  - Resulted in $421,017 in funding for Portland Area
  - IHS developed 8 projects benefitting 11 Tribes
  - 4 of 8 projects complete, with funds disbursed to Tribes
    - Example: $23,517 for Colville Tribes to upgrade their well service truck to allow maintenance of community and individual wells, and to repair their existing sewer vacuum truck.


INDIAN HEALTH SERVICE
PHS · 1955 ·

Legislative Update

Cindy Darcy, D.C. Policy Consultant

April 20, 2021

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Spring Congressional Agenda Includes

- Gender discrimination in the workplace
- Expedited review of COVID–19 hate crimes
- Statehood for the District of Columbia
- Security supplemental appropriations bill
- Additional nominations – HHS, CMS, DOI
- Unaccompanied children at the U.S.-Mexico border, immigration
- Continuing response to the COVID-19 pandemic
- Voting rights
- Gun control, background checks
- Climate change
- Racial injustice and environmental justice
- Infrastructure
- Additional hearings on Administration's FY 2022 budget request

FY 2022 budget request

- The Administration's FY 2022 budget request puts the emphasis on discretionary spending for domestic programs like education, health care and environmental protection, while essentially maintaining funding for defense spending.

- The discretionary request proposes $769 billion for non-defense discretionary (NDD) funding in FY 2022, which is a 16% increase over the FY 2021 enacted level.

- The discretionary request proposes $753 billion for national defense programs, which is a 1.7% increase over the FY 2021 enacted level.

FY 2022 budget request (con't)

- Mandatory funding, tax proposals and details of discretionary spending to be released later.
- Not parity between NDD and defense spending = > Rs not happy
- House Appropriations Subcommittees have actively been holding both oversight hearings on federal agencies and hearings on the FY 2022 budget request.
- Tribal requests and the President's campaign promise to fully funding IHS have resulted in a $2.2 billion proposed increase to IHS, plus advance appropriations for IHS in FY 2023.

New for FY 2022 appropriations bills

- Spending caps are gone.
- Expect earmarks, after a ten-year absence, in the FY 2022 appropriations bills.
- Can make up a maximum of 1% of the $1.4 trillion in annual discretionary spending.
- A House member is limited to submit 10 “congressionally-directed spending” requests per fiscal cycle to the Appropriations Committee, without guarantee of their inclusion; is required to show community support for the request; and must publicly disclose the request.

Infrastructure proposal – Administration's American Jobs Plan

- Multiple House and Senate committees
- Roads and bridges now, health care, child care, support for caregivers later
- Opportunity: White House interested in ideas for caregiver support
- Republican alternative infrastructure plan
- Senate Appropriations Committee hearing 4/20
- Subcommittee for Indigenous Peoples of the United States (SCIP) hearing 4/21 on "Infrastructure in Indigenous Communities"
- Opportunity to submit written testimony by 5/5 on recommendations for regional referral specialty care centers and tribal public health infrastructure

Movement on tribal health-related bills

Litigation and Regulatory/Admin Update

April 20, 2021

NPAIHB Quarterly Board Meeting

virtual

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Indian Leadership for Indian Health

Agenda

- Litigation Updates
- American Rescue Plan Act (ARPA) Funding Allocation Decision Review
- Federal Policy Updates
- NPAIHB Policy Resources
- Upcoming Regional and National Meetings
- CHAP Certification Board Update

Litigation-Contract Support Cost

- **Swinomish update**
  - April 13, 2021: DC Circuit affirmed the district court holding and concluded that ISDEAA or Swinomish's contract do not require IHS to pay the Community contract support costs for health care services funded by third-party revenues.
  - Potential next steps in this case: request for a rehearing by the panel or a rehearing by the full court en banc; or petition SCOUTS for a writ of certiorari
  - Only one court has ruled in favor of tribal contractors on CSC claims in the 2016 Sage Memorial case (New Mexico)
  - Tribes continue to litigate CSC claims across the U.S.—including in AK, SD, and WY.

Hobbs, Straus, Dean & Walker Client Memo dated Apr. 14, 2021

Litigation-ICWA Update

- **Brackeen v. Haaland (formerly Brackeen v. Bernhardt)**
  - 5th Circuit Case that challenges the constitutionality of the Indian Child Welfare Act (ICWA)
  - April 6, 2021, 5th Circuit published its en banc decision upholds that ICWA is constitutional. Congress has the plenary authority to enact ICWA! (good news)
  - However, the decision is 325 pages long with a number of concerning parts of the opinion that misunderstands the unique relationship between the U.S. and Tribal Nations.
  - Chart on whether Brackeen applies to your case: https://turtletalk.files.wordpress.com/2021/04/brackeen-v-haaland-decision-tree_april2021_pdf.pdf

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Source: NARF and TurtleTalk

Allocation Decision of American Recovery Plan Act (ARPA) IHS Funds

- $6 billion for Indian Health Service
  - $2 billion for lost reimbursements
    - **$1.92 billion to I/T facilities (CSC does not apply)**
    - **$80 million to UIOs**
  - $500 million for additional health services/PRC
    - **$480 million to I/T facilities H&C and PRC**
    - **$20 million to UIOs**
  - $140 million for IT, telehealth infrastructure, and EHR modernization
    - **$67 million to I/T facilities (CSC eligible)**
    - **$70 million for IHS for EHR modernization**
  - $600 million for COVID-19 vaccination related activities
    - **$526 million for I/T facilities (CSC eligible)**
    - **$50 million maintained by IHS for system improvements**
  - $1 billion to detect, diagnose, trace, monitor and mitigate COVID-19
    - **$960 million for I/T facilities (CSC eligible)**

Federal Policy Updates

- HCA submitted 1115 Waiver Amendment to CMS
  - Public comments due 5/2/2021
- Biden Administration Resumes the White House Council on Native American Affairs
  - Secretary Haaland will serve as Chair.
  - First meeting scheduled for 4/23/2021
- NPAIHB joins 29 Regional and Tribal Organizations in proposing infrastructure investments in Indian Country

NPAIHB Policy Resources

- Weekly COVID-19 Call Lists (Mondays)
- Weekly Legislative and Policy Updates (Tuesdays)
  - Legislation Tracker
  - DTLL/Regulations Tracker
- NEW Monthly Tribal Advisory Committee updates

Upcoming Regional & National Meetings

Apr 22	OMH Listening Session on Center for Indigenous Innovation and Health Equity 1pm-2pm Pacific
Apr 22	NPAIHB Tribal Caucus re VA Elimination of Co-Pays for AI/AN Veterans 3pm-4pm Pacific
Apr 27-29	NIHB National Tribal Public Health Summit
Apr 27	NPAIHB Tribal Caucus re CHAP Certification Board DTLL 3pm Pacific – Zoom invite coming soon!
Apr 28	VA Tribal Consultation on Elimination of Co-Pays for AI/AN Veterans 10am-12pm Pacific
Apr 28	THD Discussion on HIPAA Privacy Policy Notice of Proposed Rulemaking 2:30-3:30pm Pacific
Apr 30	White House COVID-19 Health Equity Task Force 11am-2pm Pacific

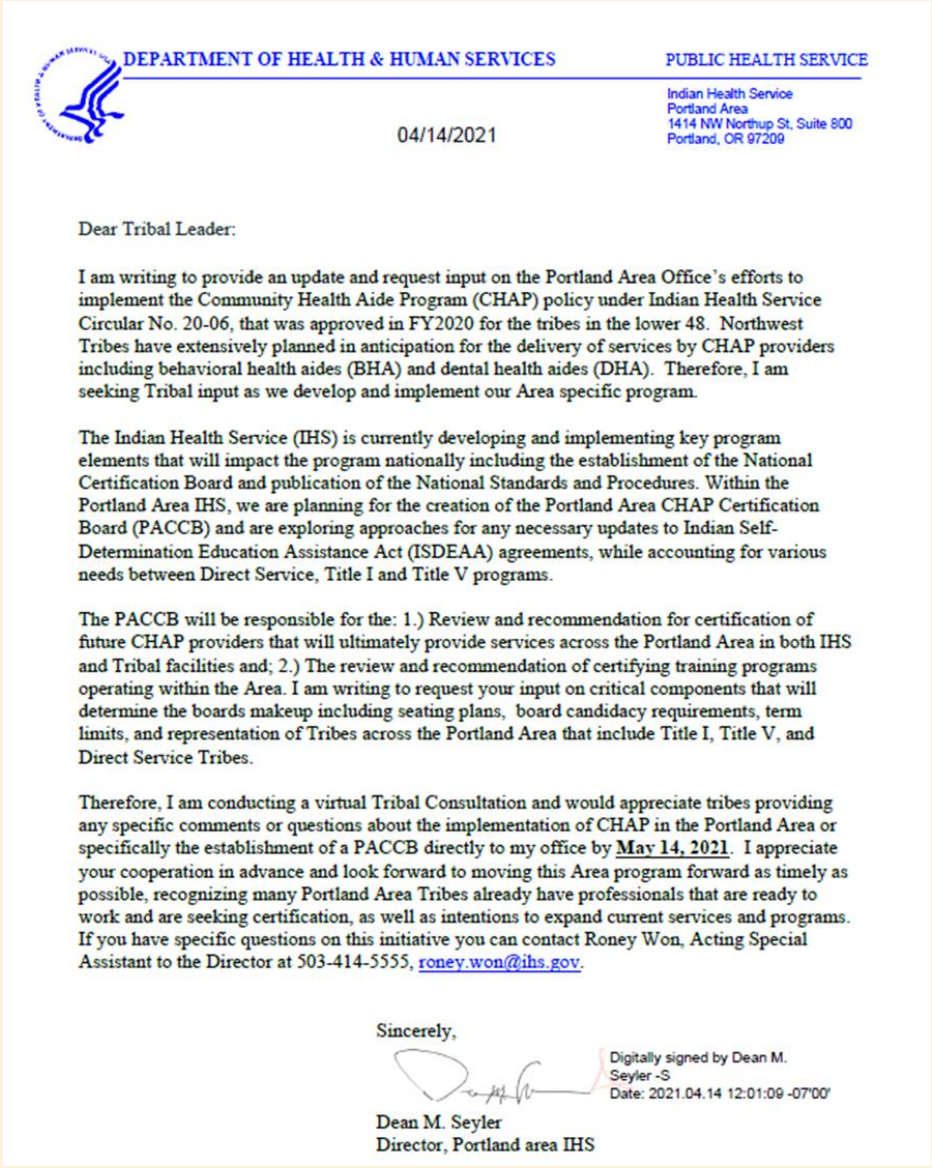
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Please contact Liz Coronado at ecoronado@npaihb.org or Veronica Smith at vsmith-contractor@npaihb.org for more information on any of these meetings

Portland Area Chap Certification Board (PACCB) Next Steps

- DTLL from Dean Seyler, April 14, 2021
- Packet prepared by NPAIHB
  - Copy of resolutions
  - Template letter for Tribes to respond
    - 4 Critical Component areas addressed:
      - Seating Plan
      - Board Candidacy Requirements
      - Term Limits
      - Representation of Tribes across the Portland Area
- Save the Date: Tribal Caucus

  April 27, 2021 at 3pm



DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE

Indian Health Service
Portland Area
1414 NW Northup St, Suite 800
Portland, OR 97209

04/14/2021

Dear Tribal Leader:

I am writing to provide an update and request input on the Portland Area Office's efforts to implement the Community Health Aide Program (CHAP) policy under Indian Health Service Circular No. 20-06, that was approved in FY2020 for the tribes in the lower 48. Northwest Tribes have extensively planned in anticipation for the delivery of services by CHAP providers including behavioral health aides (BHA) and dental health aides (DHA). Therefore, I am seeking Tribal input as we develop and implement our Area specific program.

The Indian Health Service (IHS) is currently developing and implementing key program elements that will impact the program nationally including the establishment of the National Certification Board and publication of the National Standards and Procedures. Within the Portland Area IHS, we are planning for the creation of the Portland Area CHAP Certification Board (PACCB) and are exploring approaches for any necessary updates to Indian Self-Determination Education Assistance Act (ISDEAA) agreements, while accounting for various needs between Direct Service, Title I and Title V programs.

The PACCB will be responsible for the: 1.) Review and recommendation for certification of future CHAP providers that will ultimately provide services across the Portland Area in both IHS and Tribal facilities and; 2.) The review and recommendation of certifying training programs operating within the Area. I am writing to request your input on critical components that will determine the boards makeup including seating plans, board candidacy requirements, term limits, and representation of Tribes across the Portland Area that include Title I, Title V, and Direct Service Tribes.

Therefore, I am conducting a virtual Tribal Consultation and would appreciate tribes providing any specific comments or questions about the implementation of CHAP in the Portland Area or specifically the establishment of a PACCB directly to my office by **May 14, 2021**. I appreciate your cooperation in advance and look forward to moving this Area program forward as timely as possible, recognizing many Portland Area Tribes already have professionals that are ready to work and are seeking certification, as well as intentions to expand current services and programs. If you have specific questions on this initiative you can contact Roney Won, Acting Special Assistant to the Director at 503-414-5555, roney.won@ihs.gov.

Sincerely,

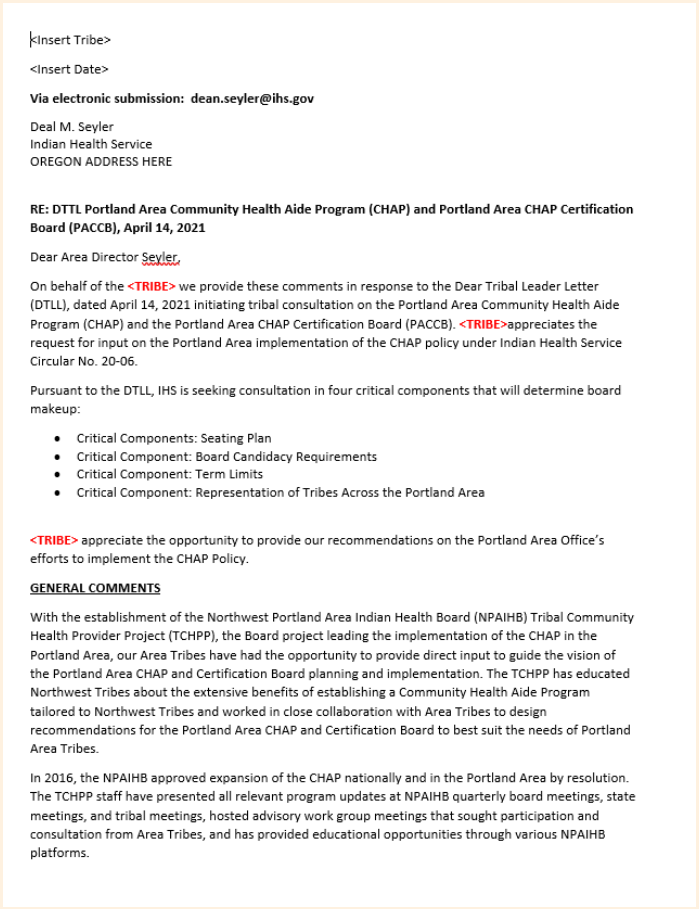
Digitally signed by Dean M. Seyler -S
Date: 2021.04.14 12:01:09 -07'00'

Dean M. Seyler
Director, Portland area IHS

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Packet Materials

1) Response letter template:



<Insert Tribe>

<Insert Date>

Via electronic submission: dean.seyler@ihs.gov

Deal M. Seyler
Indian Health Service
OREGON ADDRESS HERE

RE: DTTL Portland Area Community Health Aide Program (CHAP) and Portland Area CHAP Certification Board (PACCB), April 14, 2021

Dear Area Director Seyler,

On behalf of the <TRIBE> we provide these comments in response to the Dear Tribal Leader Letter (DTLL), dated April 14, 2021 initiating tribal consultation on the Portland Area Community Health Aide Program (CHAP) and the Portland Area CHAP Certification Board (PACCB). <TRIBE>appreciates the request for input on the Portland Area implementation of the CHAP policy under Indian Health Service Circular No. 20-06.

Pursuant to the DTLL, IHS is seeking consultation in four critical components that will determine board makeup:

- Critical Components: Seating Plan
- Critical Component: Board Candidacy Requirements
- Critical Component: Term Limits
- Critical Component: Representation of Tribes Across the Portland Area

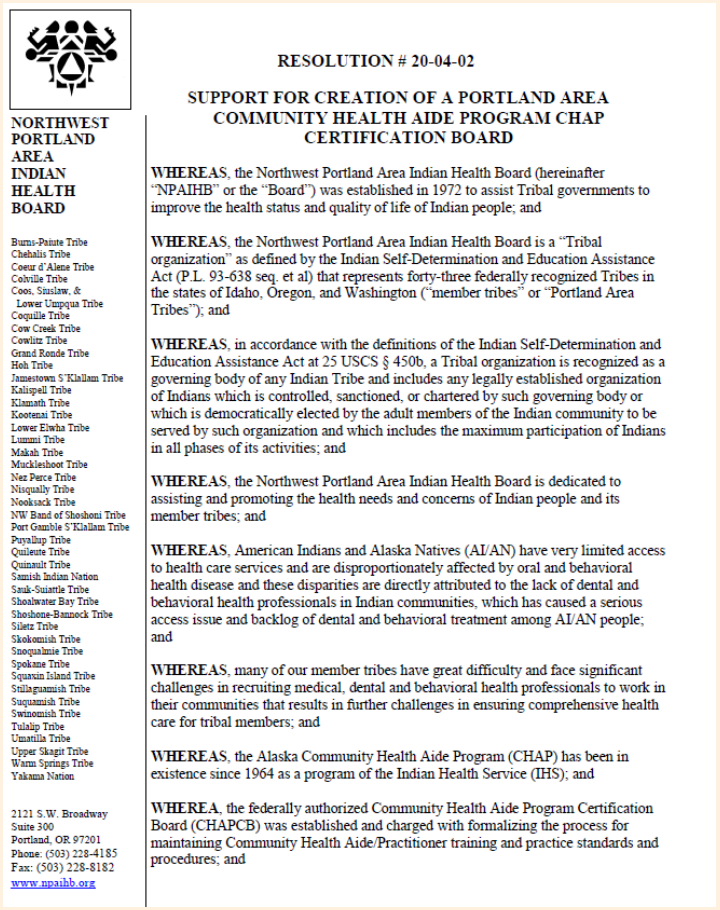
<TRIBE> appreciate the opportunity to provide our recommendations on the Portland Area Office's efforts to implement the CHAP Policy.

GENERAL COMMENTS

With the establishment of the Northwest Portland Area Indian Health Board (NPAIHB) Tribal Community Health Provider Project (TCHPP), the Board project leading the implementation of the CHAP in the Portland Area, our Area Tribes have had the opportunity to provide direct input to guide the vision of the Portland Area CHAP and Certification Board planning and implementation. The TCHPP has educated Northwest Tribes about the extensive benefits of establishing a Community Health Aide Program tailored to Northwest Tribes and worked in close collaboration with Area Tribes to design recommendations for the Portland Area CHAP and Certification Board to best suit the needs of Portland Area Tribes.

In 2016, the NPAIHB approved expansion of the CHAP nationally and in the Portland Area by resolution. The TCHPP staff have presented all relevant program updates at NPAIHB quarterly board meetings, state meetings, and tribal meetings, hosted advisory work group meetings that sought participation and consultation from Area Tribes, and has provided educational opportunities through various NPAIHB platforms.

2) Copy of Resolution # 20-04-02



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

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

RESOLUTION # 20-04-02

SUPPORT FOR CREATION OF A PORTLAND AREA COMMUNITY HEALTH AIDE PROGRAM CHAP CERTIFICATION BOARD

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 Northwest Portland Area Indian Health Board 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" or "Portland Area 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 Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of Indian people and its member tribes; and

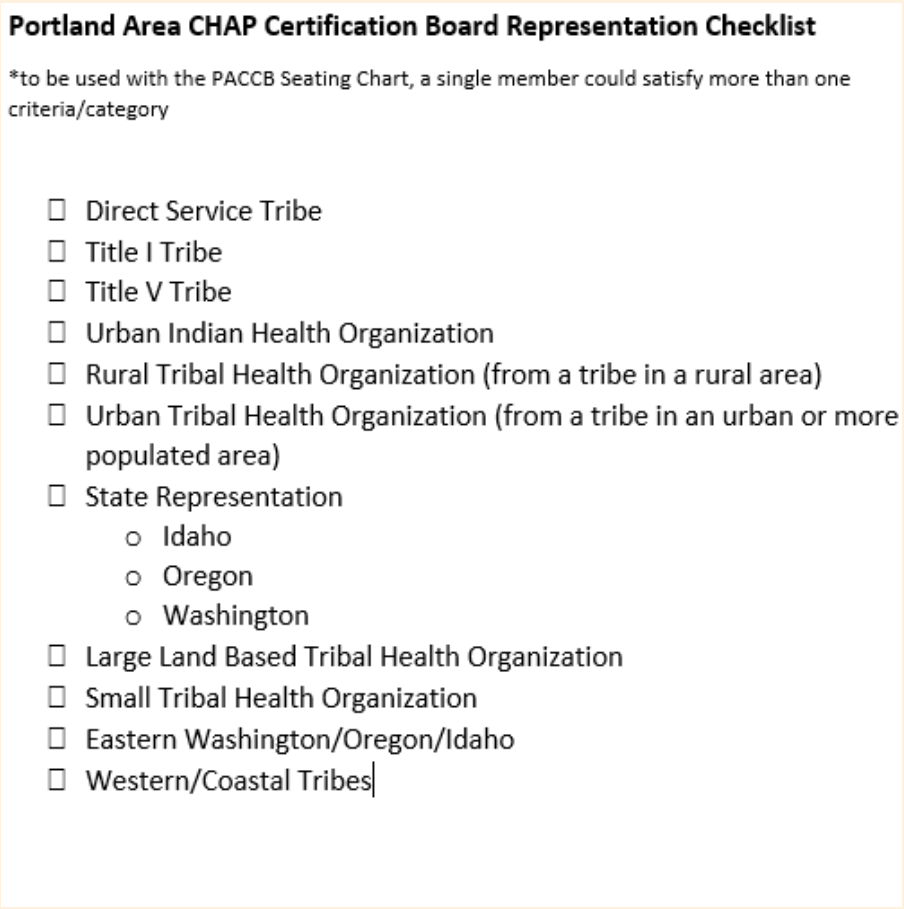
WHEREAS, American Indians and Alaska Natives (AI/AN) have very limited access to health care services and are disproportionately affected by oral and behavioral health disease and these disparities are directly attributed to the lack of dental and behavioral health professionals in Indian communities, which has caused a serious access issue and backlog of dental and behavioral treatment among AI/AN people; and

WHEREAS, many of our member tribes have great difficulty and face significant challenges in recruiting medical, dental and behavioral health professionals to work in their communities that results in further challenges in ensuring comprehensive health care for tribal members; and

WHEREAS, the Alaska Community Health Aide Program (CHAP) has been in existence since 1964 as a program of the Indian Health Service (IHS); and

WHEREA, the federally authorized Community Health Aide Program Certification Board (CHAPCB) was established and charged with formalizing the process for maintaining Community Health Aide/Practitioner training and practice standards and procedures; and

3) PACCB Representation Checklist:



Portland Area CHAP Certification Board Representation Checklist

*to be used with the PACCB Seating Chart, a single member could satisfy more than one criteria/category

- ☐ Direct Service Tribe
- ☐ Title I Tribe
- ☐ Title V Tribe
- ☐ Urban Indian Health Organization
- ☐ Rural Tribal Health Organization (from a tribe in a rural area)
- ☐ Urban Tribal Health Organization (from a tribe in an urban or more populated area)
- ☐ State Representation
  - ○ Idaho
  - ○ Oregon
  - ○ Washington
- ☐ Large Land Based Tribal Health Organization
- ☐ Small Tribal Health Organization
- ☐ Eastern Washington/Oregon/Idaho
- ☐ Western/Coastal Tribes

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

4) PACCB 13 Member Seating Chart

5) Dear Tribal Leader Letter from Area Director Dean Seyler- April 14, 2021

Portland Area CHAP and Certification Board Response

- **4 Critical Components that will determine PACCB makeup**
  - Seating Plan
  - Board Candidacy Requirements
  - Term Limits
  - Representation of Tribes Across the Portland Area
- **Plus one more critical component:**
  - Adopting the Standards and Procedures

Seating Plan Recommendations:

- Adopt the attached Portland Area CHAP Certification Board Seating Chart as recommended by the PACCB Workgroup.
- Adopt the nomination recommendations of the PACCB Workgroup incorporated in the Board Seating Chart.
- House PACCB at NPAIHB and staffed by the NPAIHB Tribal Community Health Provider Project.

Board Candidacy Requirements Recommendations:

- Adopt the attached Portland Area CHAP Certification Board Seating Chart as recommended by the NPAIHB PACCB Workgroup
- Adopt the following process for seating the first board as recommended by the NPAIHB PACCB Workgroup

Term Limits Recommendations:

- The PACCB itself create a process through its bylaws for nominating each position of the PACCB to the Portland Area IHS Area Director.
- The PACCB, through its bylaws determine any term limits and other issues such as nominations, removals, meeting frequency, quorum requirements, technical advisors, executive sessions, rules of order to follow, notice of general and special meetings, codes of conduct, fiscal years, how to deal with vacancies, planned or unexpected, officers, executive committees, what the PACCB will and will not pay for (per diem, travel, etc. . .) and more.

Representation of Tribes Recommendations:

- Do not tie specific tribal or geographic representation to specific seats.
- Use the attached Portland Area CHAP Certification Board Representation Checklist for the PACCB be used in tandem with the attached PACCB seating chart to ensure diverse tribal representation on the PACCB.

Standards and Procedures Recommendations:

- Adopt a process that directs the PACCB to accept (or reject) the draft Portland Area S&P as a basis for the CHAP in the Portland Area at their first meeting.
- The PACCB itself create a process through its bylaws for amending the Portland Area S&P as necessary.

Questions or Comments

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Alzheimer's Disease & Related Dementias: *New Funding & New Opportunities*

A Virtual Listening Session

Tribal Consultation & Urban Confer on Implementation Priorities

April 2021

NOTE

- External, non-IHS links included in this presentation do not constitute official government endorsement on behalf of the Indian Health Service (IHS). The IHS makes no representations regarding the quality, content, completeness, suitability, adequacy, sequence, accuracy or timeliness of such information and disclaims any responsibility for errors.
- All webinars are recorded for on-demand viewing. Recordings will be posted to Tribal Consultation and Urban Confer | Division of Clinical and Community Services (ihs.gov)

Overview

- An Overview of the Problem: *Alzheimer's Disease & Related Dementias in Indian Country*
- Partnerships
- Current Needs
- Q&A Session

An Overview of the Problem

Alzheimer's Disease & Related Dementias in Indian Country

Dementia is….

Memory loss and **difficulty with** some of the following:

- **Naming** (things, people)
- **Doing** (simple mechanical tasks, like buttoning a button)
- **Recognizing** (people, places)
- **Behaving** (a change in the way the elder to normally behaves)
- **Thinking** (problem solving)
- **Calculating** (numbers)
- **Planning and Organizing** (first this, then that…)

and it **interferes with function** (the elder's ability to do the usual things of life).

Alzheimer's Disease is….

The most common kind of dementia

Other common dementia syndromes include:

- Vascular Dementia
- Lewy Body Disease (LDB)
- Frontotemporal Dementia (FTD)
- Traumatic Brain Injury (TBI)
- Alcohol-related Dementia

We need to make a diagnosis because…

Other illnesses cause confusion and difficulties with memory

- We want to recognize and treat those illnesses!

Understanding what kind of dementia helps us provide better care

- Different kinds of dementia have a different time course and set of symptoms
- Different expectations for families
- Some differences in treatment

The way we make a diagnosis is…

Always

- History (the story) – from the elder and from family members or others
- Physical examination – including a good neurologic examination
- Cognitive testing – testing memory, calculation, problem solving, language, and the ability to do multi-step tasks
- Lab tests (blood tests) – to be sure it is not something else

Often but not always

- Brain scan (CT or MRI)

Sometimes but not always

- Specialized neurocognitive testing (more detailed, lengthy testing of thinking, memory, calculation, problem solving, and language)

The diagnosis of dementia is usually made by…

- Primary Care Physicians
- Geriatricians
- Nurse Practitioners
- Physician Assistants (PA)

- Sometimes with the help of
  - Neurologists
  - Psychiatrists
  - Psychologists

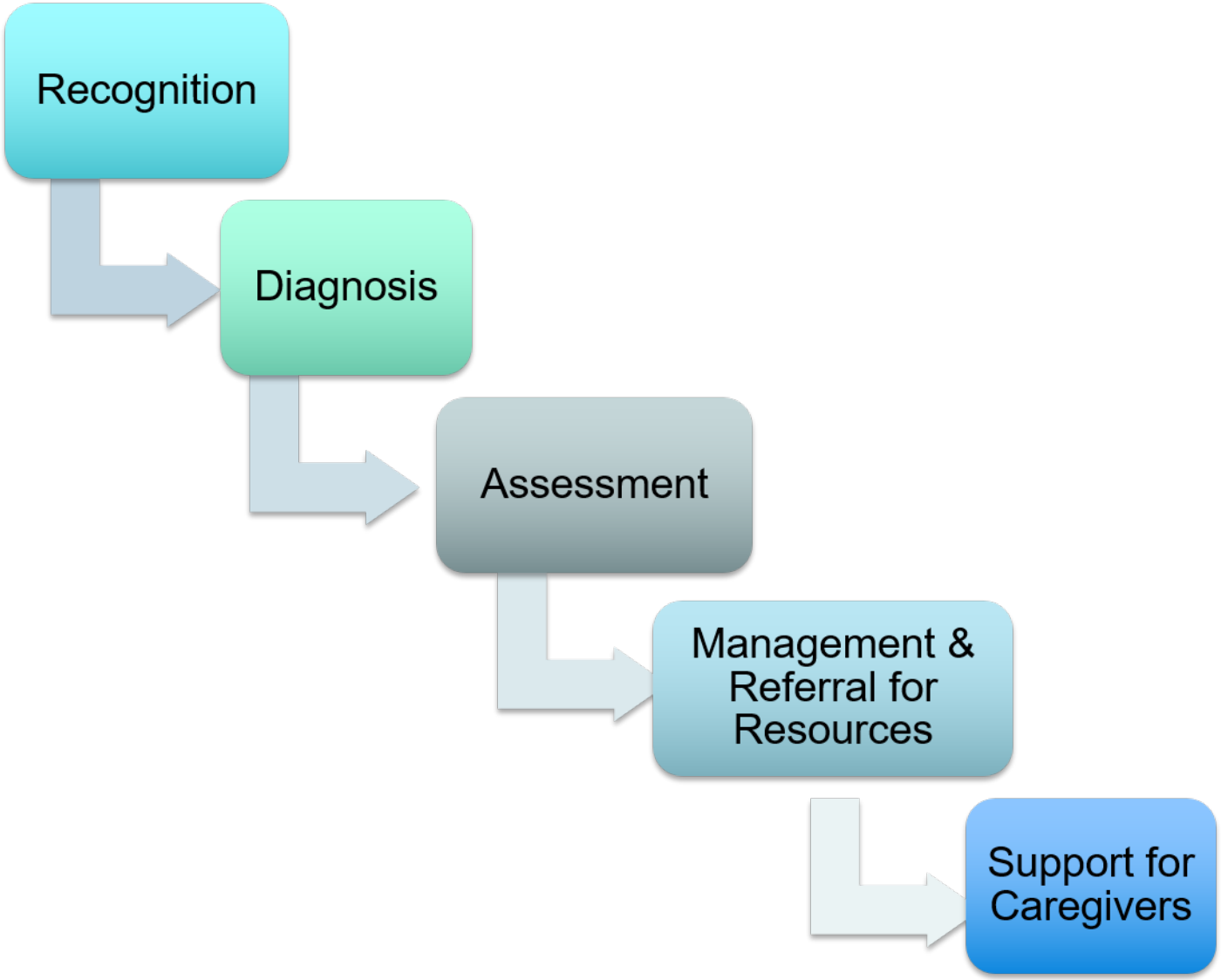
And we know that….

- The best care is team care
- Care of the individual living with dementia includes care for their caregiver(s)
- **Now** we can often **prevent** or **delay the onset** of Alzheimer's disease and related dementia's through avoidance of risk factors

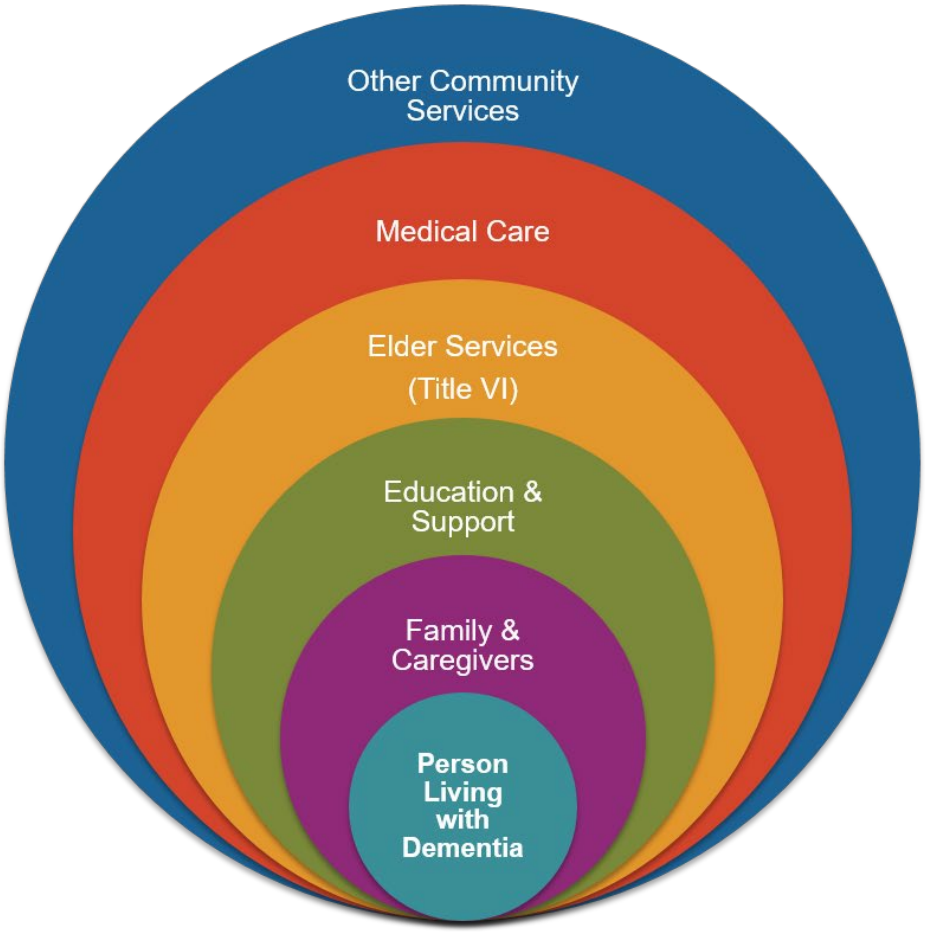
  Brain Health = Heart Health

- **Soon** (in the predictable future) there will be specific therapies that can change the course of the Alzheimer's disease

What are the Key Steps in Medical Care?



What Does it Take to Care for the Individual Living with Dementia in the Community?



IHS Partnership with Tribal & Urban Programs to Improve the Care of Elders

- Director's Initiative Long Term Services & Supports Tribal Grants 2002-2012
- Tribal Conferences (with CMS, ACL/AoA) to share LTSS best practices & address policy: 2000, 2002, 2007, 2010, 2011, 2016
- Trainings at annual National Title VI (Senior Center) Directors Meetings
- NICOA Biennial Conference Education & Listening Sessions
- Palliative Care training & support
- Fall & Injury Prevention Guidelines & support for Tribal Fall Injury Prevention programs through Tribal Injury Prevention Cooperative Agreement Program (with the CDC)
- IHS Chief Clinical Consultant in Geriatrics & Palliative Care (Dr. Winchester): Consultation, Presentations, Education & Training

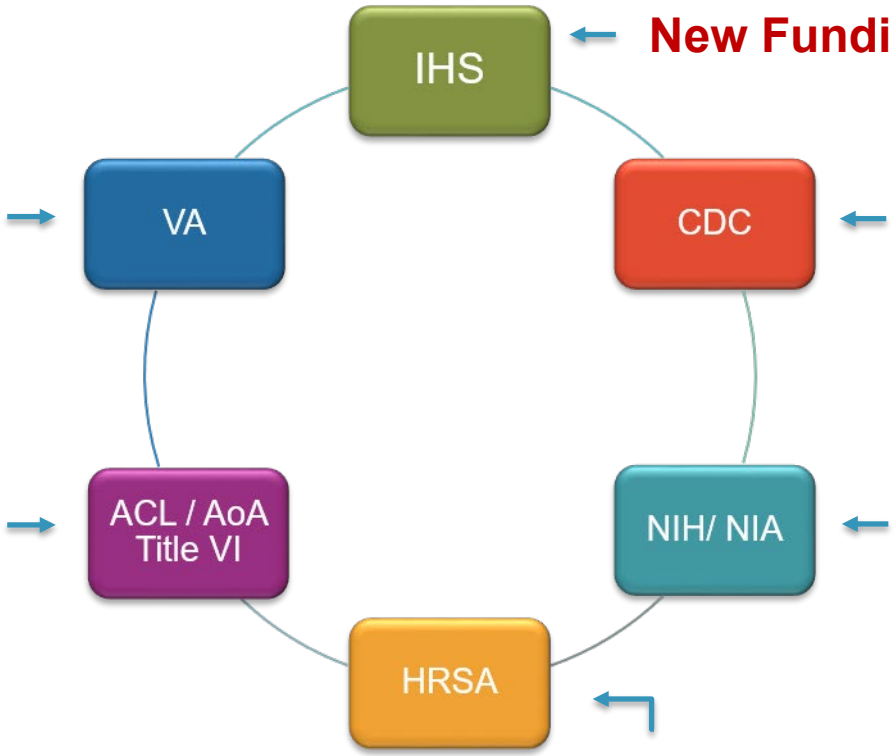
Priorities

- Increase Recognition of Dementia in the Community
  - Earlier diagnosis
  - Education & supportive services
  - Earlier access to treatment that can change the course of the disease, when it is available
- Improve Diagnosis, Assessment & Management by IHS, Tribal, & Urban Indian Health Programs
  - Including care for the caregiver
- Tribal Models of Comprehensive Care for Persons with Dementia
  - Tribes will build innovative & responsive models of care that address: Recognition, Diagnosis, Assessment, Management & Referral, & Support for the Caregiver
- Data: Understand the Impact of Dementia & the Effectiveness of Care

Federal Resources & Partnerships to Support Tribal & Urban Health to Address Alzheimer's Disease

Rural Interdisciplinary Team Training (RITT)

ABCD Caregiver Coach Training



Healthy Brain Initiative Roadmap for Indian Country

Bold Grant to IAIA

Senior Centers

Caregiver Support

Alzheimer's Disease Programs Initiative (ADPI) Tribal Grants

Alzheimer's Disease Research Centers

Geriatric Workforce Enhancement Programs (GWEP)

Dementia Curriculum

Ending the HIV & HCV Epidemic: *New Funding & New Opportunities*

A Virtual Learning Session

Tribal Consultation & Urban Confer Implementation Priorities

Overview

- Program Overview
  - *HIV in Indian Country*
  - *What is Ending the HIV Epidemic: A Plan for America?*
- Tribal Listening Sessions & Engagement
- Implementation Priorities
- Q&A Session

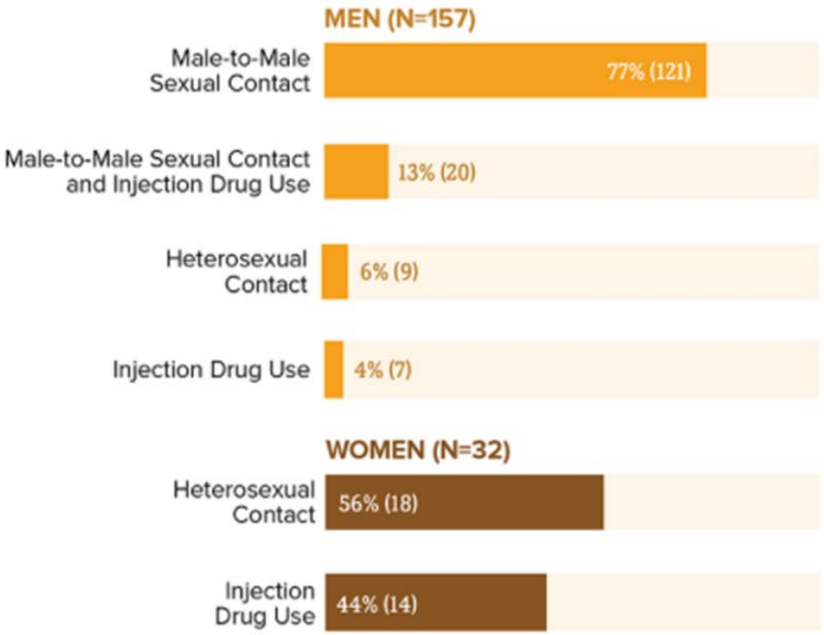
Program Overview

HIV and HCV in Indian Country

HIV in Indian Country

New HIV Diagnoses Among AI/AN in the US and Dependent Areas by Transmission Category and Sex, 2018 [d]

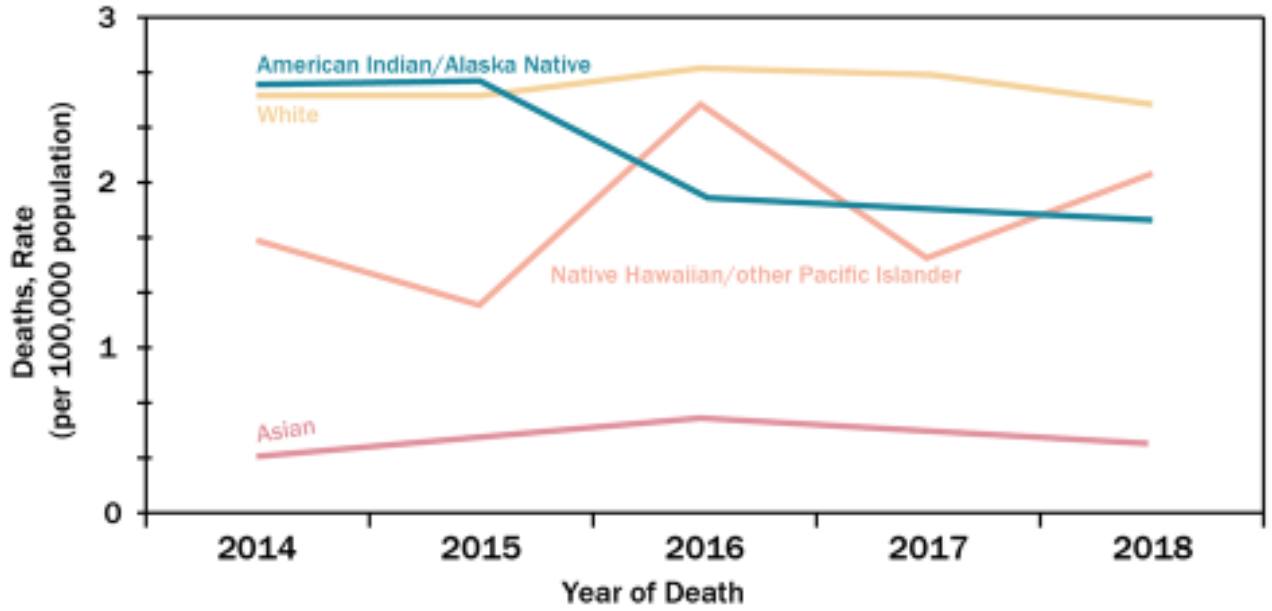
Most new HIV diagnoses were among AI/AN gay and bisexual men.



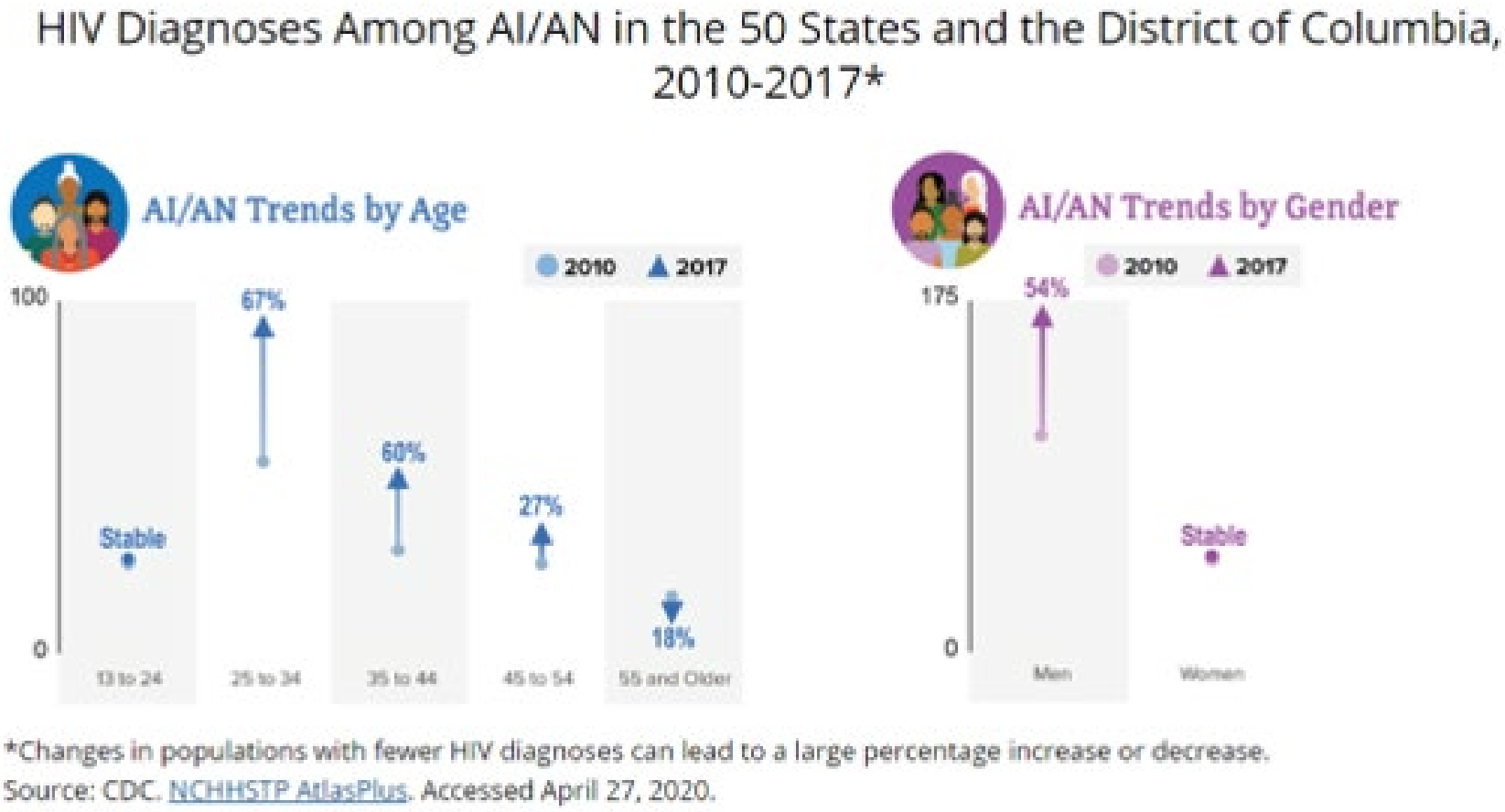
Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2018 (Preliminary) [PDF – 10 MB]. *HIV Surveillance Report* 2019;30.

U.S. RATES OF DEATH (AI/AN)

For Persons with Diagnosed HIV Infection, by Race/Ethnicity, 2014-2018



HIV in Indian Country

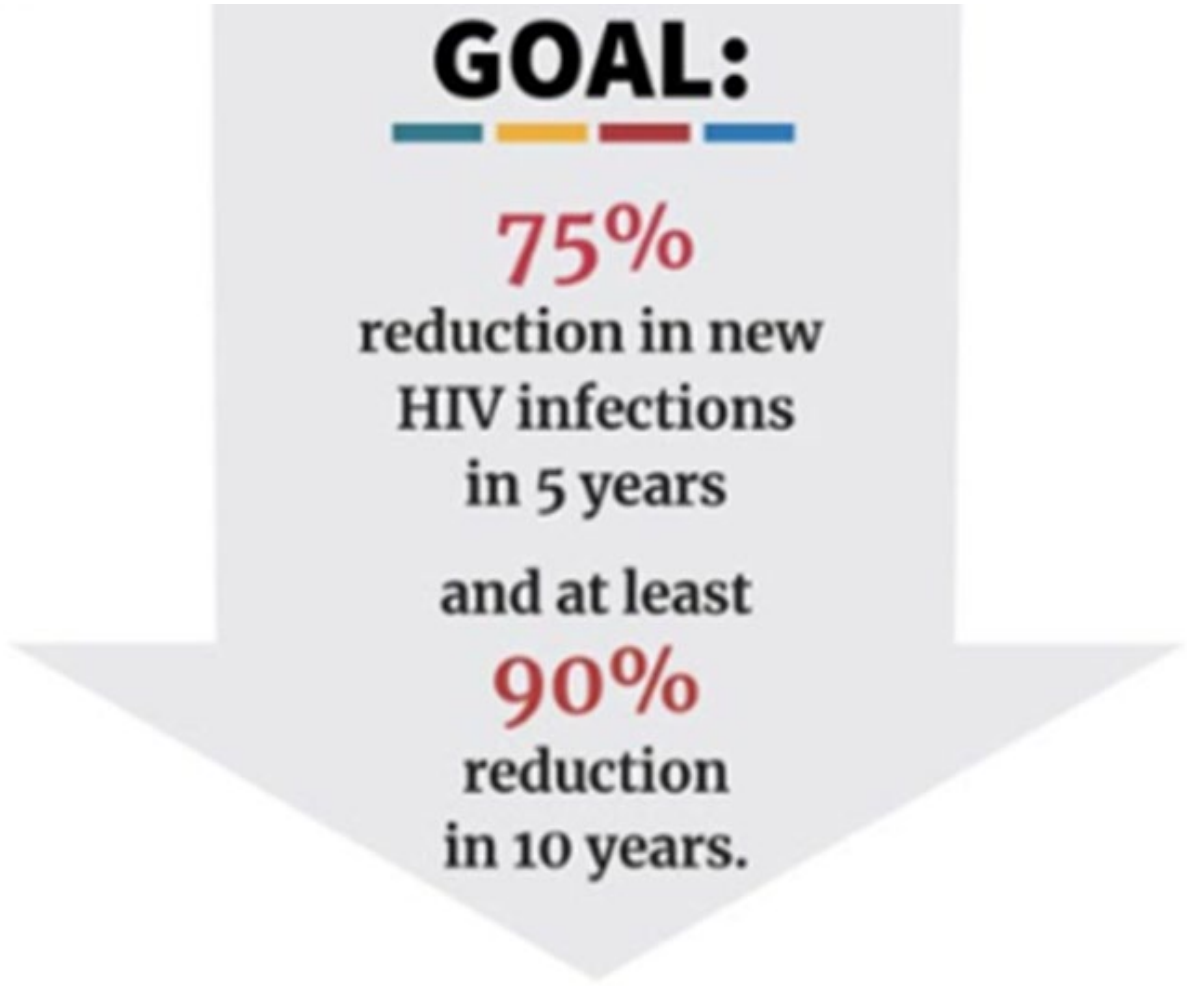


*Changes in populations with fewer HIV diagnoses can lead to a large percentage increase or decrease.
Source: CDC. NCHHSTP AtlasPlus. Accessed April 27, 2020.

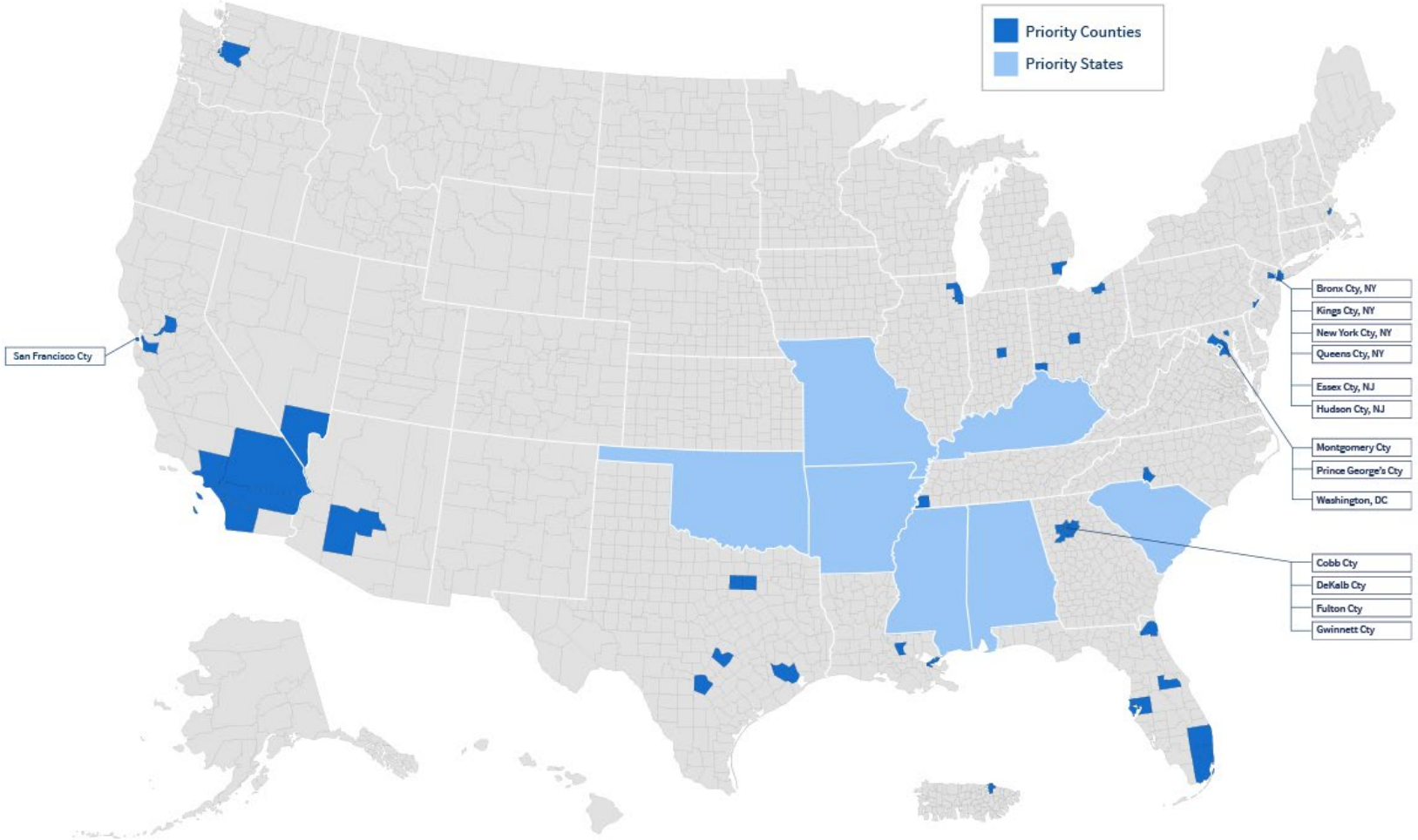
Ending the HIV Epidemic (EHE)

> We have a once-in-a-generation opportunity to end the HIV epidemic in the United States. Now is the time.

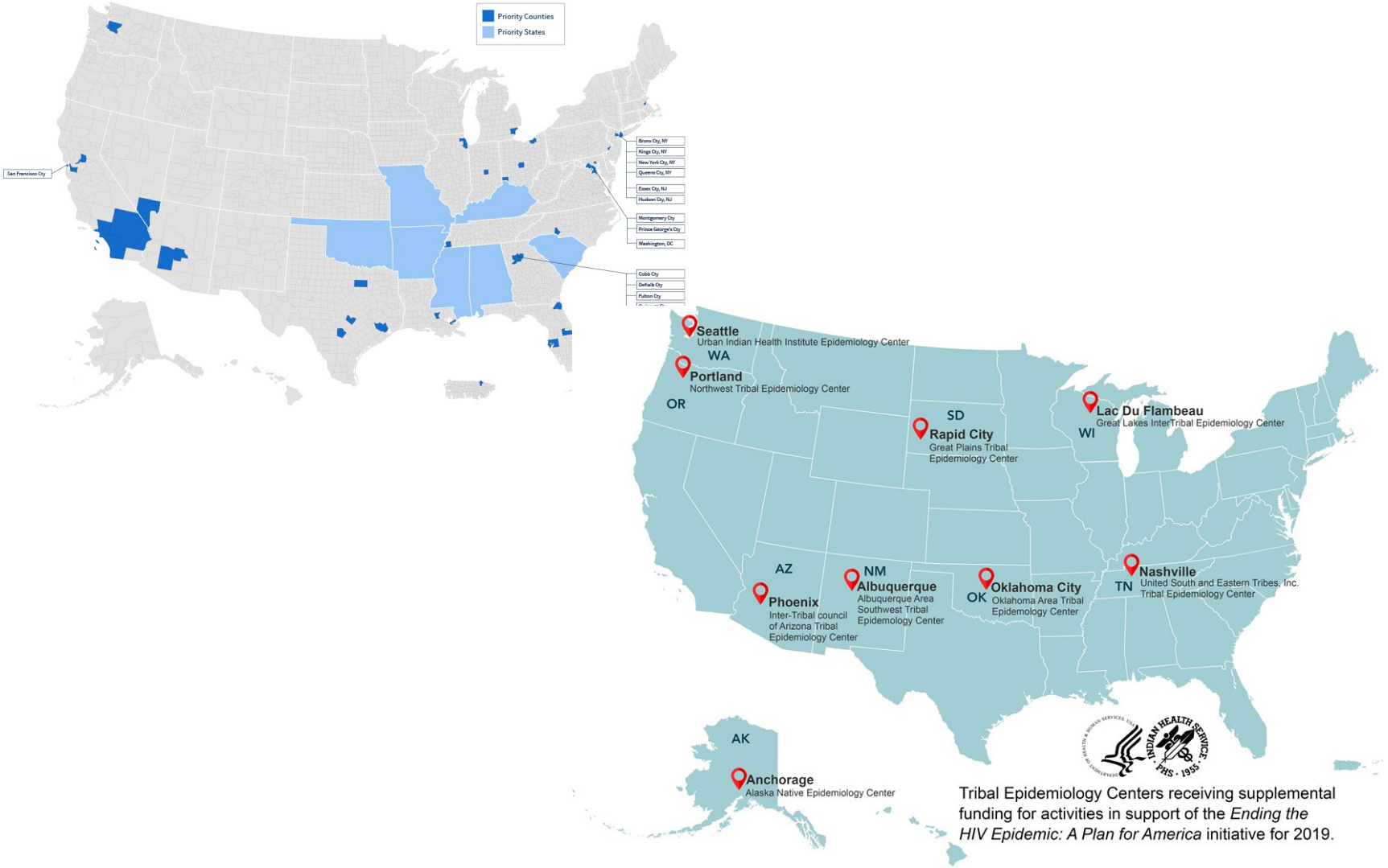
Ending the HIV Epidemic



Priority Geographical Areas: Phase I



Priority Geographical Areas & Tribal Epi Centers



Tribal Epidemiology Centers receiving supplemental funding for activities in support of the *Ending the HIV Epidemic: A Plan for America* initiative for 2019.

Challenges & Opportunities

Inequality

Impact of undiagnosed and untreated HIV

Stigma

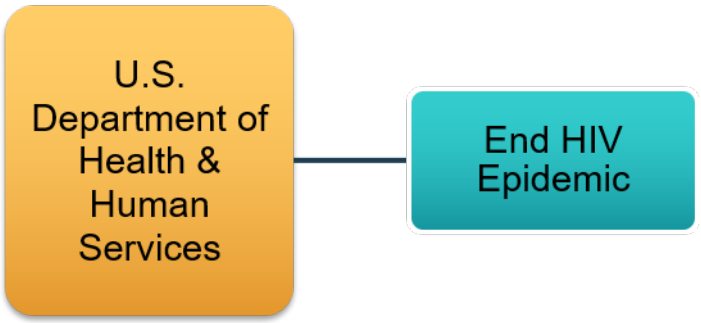
Progress has plateaued

Powerful HIV prevention and treatment tools are now available

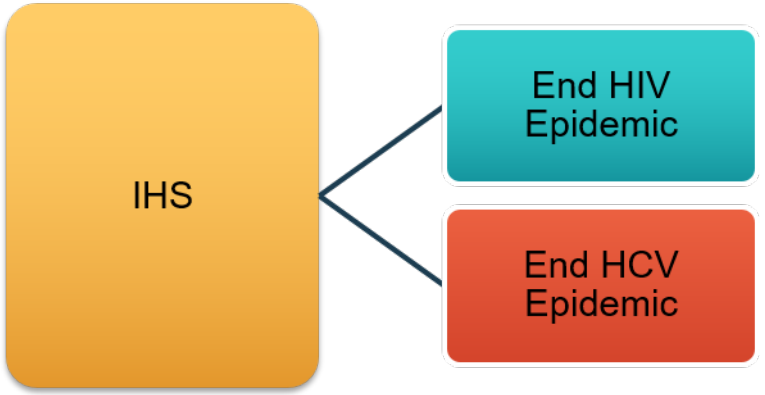
We can end HIV

National EHE & Indian Country EHE

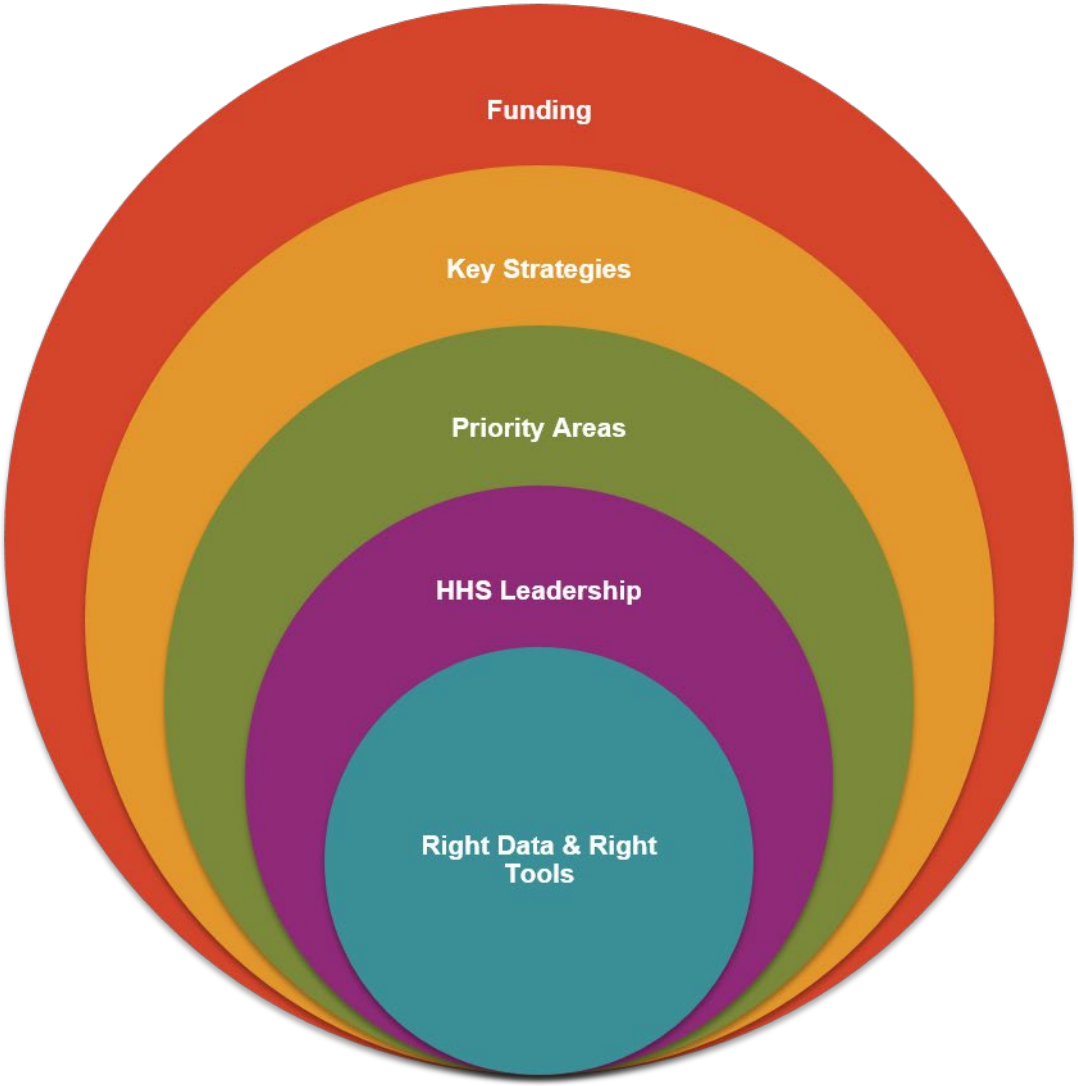
National EHE



Indian Country EHE



EHE Structure



EHE & Social Determinants of Health

Key Strategies of the Plan

Tribal Listening Sessions & Engagement

Engaging Tribes HIV in Indian Country

EHE & Tribal Consultation: Winter/Spring 2020

General Themes & Recommendations

Question & Answer

Questions may be entered into the chat or via phone.
Please state your name, IHS Area, and Tribe for the record.

Questions for Consideration

A few questions for consideration to begin our open discussion include:

- How the IHS might use available **funding** to support **sustainable, comprehensive models of care** for persons living with dementia and their families through IHS, Tribal, and Urban Indian health programs?
- How the IHS might **invest** in an effort to improve **awareness, early recognition, and diagnosis** of Alzheimer's disease and related dementias, in partnership with Tribal communities?
- How the IHS might **invest** in **competency-based training for all clinical staff** to improve diagnosis, assessment, and management of Alzheimer's disease and related dementias in IHS, Tribal, and Urban Indian health programs?
- How the IHS might **invest** in **evaluation and data** to assess the impact of Alzheimer's disease and related dementias, the needs of those living with dementia and their families, and the effectiveness of efforts to address and improve management of Alzheimer's disease?

Questions for Consideration

A few questions for consideration to begin our open discussion include:

- How the IHS might use available funding to support IHS, Tribal, and Urban Indian health programs to achieve the Ending the HIV Epidemic goal of a 75% reduction in new HIV infections by 2025 and at least a 90% reduction by 2030?

- How should IHS focus on the key strategies for implementing the Ending the HIV and HCV Epidemic? Specifically,
  1. Diagnosing all people with HIV and HCV as early as possible?
  2. Treating people with HIV or HCV rapidly and effectively to reach sustained viral suppression?
  3. Preventing new HIV and HCV transmissions by using proven interventions, including pre-exposure prophylaxis and syringe service programs?
  4. Responding quickly to HIV and HCV outbreaks to get prevention and treatment services to people who need them?

Tribal Consultation & Urban Confer

IHS is accepting comment via email until June 1, 2021.
To submit comment:

– Email consultation@ihs.gov or urbanconfer@ihs.gov
Subject Line: Alzheimer's Disease Initiative Funding

OR

– Email consultation@ihs.gov or urbanconfer@ihs.gov
Subject Line: Ending HIV Epidemic Initiative Funding

General Program Questions

National Elder Care Program

E-mail: IHSDCCS@ihs.gov

Web: www.ihs.gov/eldercare/

National HIV/HCV Program

E-mail: richard.haverkate@ihs.gov

Web: www.ihs.gov/hivaids/ and www.ihs.gov/dccs/hcv/

National and Regional Tribal Advisory Committee (TAC) Updates

NPAIHB Quarterly Board Meeting

April 21, 2021

Virtual Meeting

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Indian Leadership for Indian Health

Health and Human Services, Secretary's Tribal Advisory Committee (STAC)

- Primary purpose of HHS Secretary's Tribal Advisory Committee (STAC) is to seek consensus, exchange view, share information, provide advice and/or recommendations, or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation, or Executive Order.
- Portland Area Representative:
  - Ron Allen, Jamestown S'Klallam Tribe (Primary)
  - Andy Joseph, Confederated Tribes of the Colville Reservation (Alternate)
- Technical Advisor:
  - Laura Platero, lplatero@npaihb.org

- **Last Meeting** Feb 26 – 27, 2021 **Next Meeting** May 5 – 6, 2021 *virtual*

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Centers for Disease Control and Prevention Tribal Advisory Committee (CDC TAC)

- CDC Tribal Advisory Committee (TAC) advises CDC/ATSDR on policy issues and broad strategies that may significantly affect AI/AN communities. Assists CDC/ATSDR in fulfilling its mission to promote health and quality of life by preventing and controlling disease, injury, and disability through established and ongoing relationships and consultation sessions.
- Portland Area Representative:
  - Steve Kutz, Cowlitz Indian Tribe (Primary)
  - Sharon Stanphill, Cow Creek Band of Umpqua Tribe of Indians (Alternate)
- Technical Advisor:
  - Candice Jimenez, cjimenez@npaihb.org

- Last Meeting Feb 06, 2021 **Next Meeting** Aug or Oct, 2021

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Center for Medicare and Medicaid Services Tribal Technical Advisory Group (CMS-TTAG)

- The CMS-TTAG serves as an advisory body to CMS. Provides expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/AN people served by Titles XVIII, XIX, and XXI of the Social Security Act or any other health care program funded (in whole or in part) by CMS.
- Portland Area Representative:
  - John Stephens, Swinomish Indian Tribe (Primary)
- Technical Advisors:
  - Veronica Smith, vsmith-contractor@npaihb.org; and Liz Coronado, ecoronado@npaihb.org.

- **Last Meeting** Mar 10 – 11, 2021 **Next Meeting** Jul 21 - 22, 2021 *virtual*

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Medicare, Medicaid, and Health Reform Policy Committee (MMPC)

- MMPC is a standing committee of the National Indian Health Board (NIHB), chaired by a member of the NIHB Board of Directors. The primary purpose of the MMPC is to provide technical support to the CMS TTAG
- Membership in MMPC is open to individuals authorized to represent a tribe, tribal organization, urban Indian program, or the IHS.
- MMPC has three sub-committees, Regulations, Managed Care, and IHS/Tribal

- **Last Meeting** Mar 09, 2021 **Next Meeting** July 20, 2021

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

IHS Direct Service Tribal Advisory Committee (DSTAC)

- IHS Director established the Direct Service Tribes Advisory Committee (DSTAC) to address health service delivery issues and concerns important to direct service tribes. The work of the Committee is specifically aimed at the areas of trust, data and budget.
- Portland Area Representative:
  - Greg Abrahamson, Spokane Tribe of Indians (Representative)
- Technical Advisor: Liz Coronado, ecoronado@npaihb.org

- **Last Meeting** Apr 15, 2021 **Next Meeting** May 20, 2021 *virtual*

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

IHS Federal Appropriations Advisory Board (FAAB)

- The Federal Appropriations Advisory Board (FAAB) evaluates existing facilities policies, procedures, and guidelines and recommends changes if necessary. The FAAB participates in the development and evaluation of any proposed new policies, procedures, and guidelines of facilities construction priorities. In addition, should any of the recommendations necessitate changes in law, this group will recommend desired legislative changes.
- Portland Area Representative
  - Eric Metcalf, Coquille Indian Tribe (Primary)
  - Pending (Alternate)
- **Technical Advisor:** Celeste Davis, cdavis@npaihb.org

- **Last Meeting** Apr 12, 2021 **Next Meeting** TBD

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

IHS Information Systems Advisory Committee (ISAC)

- The Information Systems Advisory Committee was established to guide the development of a co-owned and co-managed Indian health information infrastructure and information systems. ISAC goals include the creation of flexible and dynamic information systems, and that information systems are available, accessible, useful, cost effective, and user friendly for local level providers, while continuing to create standardized aggregate data that supports advocacy for Indian health programs at the national level.
- Portland Area Representative
  - Nickolaus Lewis, Lummi Nation (Primary)
  - Nate Tyler, Makah Tribe (Alternate)
- **Technical Advisor:** Veronica Smith, vsmith-contractor@npaihb.org

- **Last Meeting** Mar 31 – Apr 01, 2021 **Next Meeting: TBD**

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

IHS National Budget Formulation Workgroup

- IHS organized the Budget Formulation Workgroup to assist the agency in formulating upcoming fiscal year budgets. Develops program priorities, policies, budget recommendations by ensuring active participation of tribal governments and tribal organizations in the formulation of the IHS budget request and annual performance plan.
- National Tribal Co-Chairs: **Amber Torres, Victor Joseph and Andy Joseph**
- Portland Area Representatives
  - Steve Kutz, Cowlitz Tribe (Primary)
  - Andy Joseph, Confederated Tribes of the Colville Reservation (Alternate)
- Tribal Technical Advisors:
  - Liz Coronado, ecoronado@npaihb.org and Laura Platero, lplatero@npaihb.org
- **Last Meeting** February 11-12 *virtual* **Next Meeting** *virtual*

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

IHS Purchased and Referred Care (PRC) Workgroup

- The IHS Purchased and Referred Care (PRC) Workgroup provides recommendations to the Director, IHS, on strategies to improve the Agency's contract health services (PRC) program. The Workgroup reviews input received to improve the CPRC program; evaluate the existing formula for distributing CHS funds; and recommend improvements in the way PRC operations are conducted within the IHS and the Indian health system.
  - Eric Metcalf, Coquille Indian Tribe (Primary)
  - Elizabeth "Ann" Jim, Shoshone-Bannock Tribes (Alternate)
- Technical Advisor:
  - Veronica Smith, vsmith-contractor@npaihb.org

- **Last Meeting** Mar 16 – 18, 2021 **Next Meeting** Oct 20-21, 2021 *in Denver CO*

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

IHS Tribal Leader Diabetes Committee (TLDC)

- The IHS Director established the Tribal Leaders Diabetes Committee (TLDC) in 1998 to assist in developing a successful partnership between IHS and Tribal diabetes programs and in deciding the process for distribution of resources from the Balanced Budget Act of 1997 Special Diabetes Program for Indians (SDPI).
- Portland Area Representative:
  - Cassandra Sellards-Reck, Cowlitz Tribe (Primary)
  - Sharon Stanphill, Cow Creek Band of Umpqua Tribe of Indians (Alternate)
- Technical Advisor:
  - Veronica Smith, vsmith-contractor@npaihb.org
- **Last Meeting** Mar 09, 2021 **Next Meeting** Jun 15, 2021 *virtual*

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

IHS Tribal Self Governance Advisory Committee (TSGAC)

- At the recommendation of self-governance tribes, representatives from the self-governance tribes and Indian Health Service staff developing guidelines for establishment of the Tribal Self-Governance Advisory Committee (TSGAC). Provides information, education, advocacy, and policy guidance for implementation of self-governance for implementation of self-governance within the Indian Health Service.
- Portland Area Representative:
  - Ron Allen, Jamestown S'Klallam Tribe (Primary)
  - Tyson Johnston, Quinault Indian Nation (Alternate)
- Technical Support:
  - Liz Coronado, ecoronado@npaihb.org and Veronica Smith, vsmith-contractor@npaihb.org
- **Last Meeting** Feb 17, 2021 **Next Meeting** Summer, 2021

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

National Institute of Health Tribal Advisory Committee (NIH-TAC)

- The National Institutes of Health (NIH) Tribal Advisory Committee (TAC) is advisory to the NIH, and provides a forum for meetings between elected Tribal officials (or their designated representatives) and NIH officials to exchange views, share information, and seek advice concerning intergovernmental responsibilities related to the implementation and administration of NIH programs.
- Portland Area Representatives
  - Steve Kutz, Cowlitz Indian Tribe (Primary)
  - Jeromy Sullivan, Port Gamble S'Klallam Tribe (Alternate)
- **Technical Advisor:** Tam Lutz, tlutz@npaihb.org

- **Last Meeting** Mar 16, 2021

Next Meeting Apr 20, 2021

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Substance Abuse Mental Health Administration Tribal Technical Advisory Committee (SAMHSA TTAC)

- The SAMHSA TTAC provides a venue wherein Tribal leadership and SAMHSA staff can exchange information about public health issues, identify urgent mental health and substance abuse needs, and discuss collaborative approaches to addressing these behavioral health issues and needs.
- Portland Area Representatives:
  - Marilyn Scott, Upper Skagit (Primary)
  - Nate Tyler, Makah Tribe (Alternate) - *Pending*
- Technical Advisor: Candice Jimenez, cjimenez@npaihb.org

- Last Meeting Jun 15-16, 2020

Next Meeting May 12 – 13, 2021

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

No Meetings Since Last QBM

- HRSA Tribal Advisory Group (HRSA-TAG)
- IHS Catastrophic Health Emergency Fund (CHEF)
- IHS Community Health Aide Program Technical Advisory Group (CHAP-TAG)
- IHS National Tribal Advisory Committee on Behavioral Health (NTAC)
- Portland Area Fund Distribution Workgroup (FDWG)
- Portland Area Facilities Advisory Council (PAFAC)

Committee Vacancies

- **Portland Area Facilities Advisory Committee** *(PAFAC)*
  - *Direct Service – three vacancies*
  - *Title I – two vacancies*
  - *Federal – one vacancy*

Questions and Discussion

Northwest Tribal Epidemiology Center Update

Victoria Warren-Mears

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Indian Leadership for Indian Health

Overview for TEC 11/2020 - present

Outline

- **Public Health Improvement**
- **New Data Reports and Dash Boards**
  - Alzheimer's Data
    - **BOLD Project**
  - Communicable Disease Data
    - **HIV/AIDS and Hepatitis C**
- **Tribal Food Sovereignty Survey Update**
- **Northwest NARCH**
- **Trans and Gender Affirming Care Project Update**
- **Youth Sexual Health**

Questions

- Use the chat box for questions, or unmute yourself, *6 if you are calling in on your telephone

Public Health Improvement & Training (PHIT)

- OR Tribal Public Health Improvement
  - 8 tribal capacity/expertise assessments completed with 9th scheduled for April 2021, final reports by June 2021, Action Plans by end of 2021
  - Survey modernization workgroup: BRFSS & Oregon Healthy Teens
- WA Tribal Public Health Improvement
  - Data Partners Meeting held February 2021, release and review of data briefs
  - Identification of tribal assets for prevention and control of communicable disease (survey)
- Other PHIT Activities
  - Survey on communicable disease, public health training needs, and health priorities ID, OR, WA THDs/Clinic Directors/Delegates: www.surveymonkey.com/r/NPAIHB-PHIT2021
  - CDC Data Modernization project, 2020-2022: NPAIHB data systems, staff training

New Data Reports and Dashboards

- Four new data reports on communicable diseases in Washington now available:
  - HIV
  - Sexually Transmitted Infections
  - Hepatitis B & C
  - Tuberculosis
- Visit https://www.npaihb.org/idea-nw/ for these and other data reports

- Regional and state COVID-19 data dashboards updated regularly with AI/AN-specific data:

https://www.npaihb.org/covid-19-data-dashboard/

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Linkage with Idaho COVID-19 case data

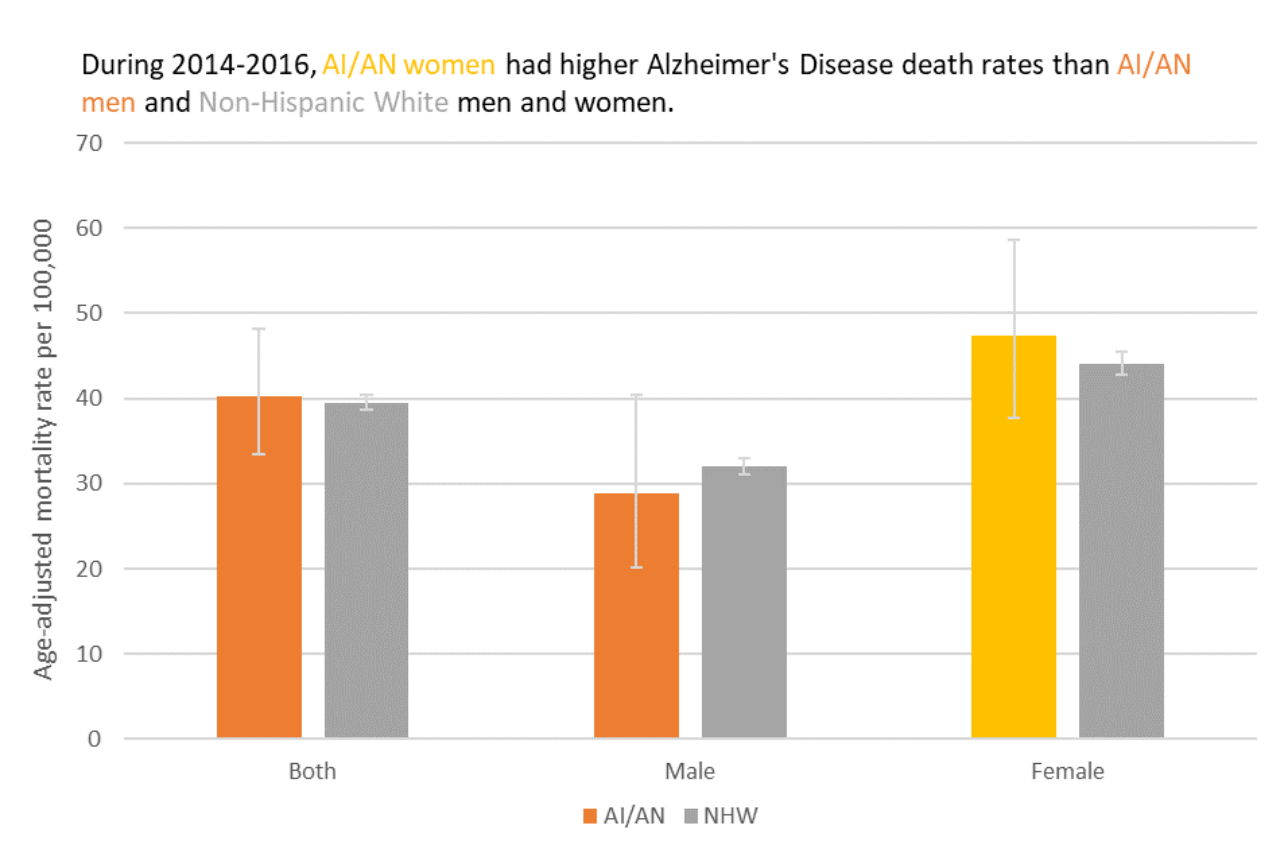
- NWTEC signed a data sharing agreement to improve identification of AI/AN COVID-19 cases in Idaho through linkages with the Northwest Tribal Registry
- Our first linkage earlier this month found:
  - 992 misclassified AI/AN COVID-19 cases since the beginning of the pandemic
  - 58% of these misclassified AI/AN cases had missing or unknown race information, while 29% were misclassified as White
  - Correcting race information for these 992 cases would increase the number of AI/AN COVID-19 cases in Idaho from 2,121 to 3,113, a 47% increase
- We plan to repeat these linkages on a quarterly basis and will use the corrected data to provide a more accurate picture of COVID-19 burden among AI/AN communities in Idaho

Cognitive Decline among American Indian/Alaska Native people

- **Nationally, about 1 in 6 AI/AN adults aged 45 years and older reported experiencing Subjective Cognitive Decline**
  - 63% of these people had to give up day-to-day activities
  - The majority (88%) of these people had at least one chronic condition
  - 50% of people with Subjective Cognitive Decline said it interfered with social activities, work, or volunteering

Source:
Centers for Disease Control and Prevention. Subjective Cognitive Decline among American Indian/Alaska Native Adults. April 2019. Available at: https://www.cdc.gov/aging/data/pdf/2015-2017-american-Indian-alaska-native-cognitive-decline-h.pdf.

Alzheimer's Disease Mortality for Northwest AI/AN people



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Northwest Tribal Elders Project

Building our Largest Dementia Infrastructure (BOLD)

- 3 Year Funding Cycle: Capacity Building – CDC funding
- Year 1 Focus
  - Establish Tribal Advisory Committee (Elder Committee)
  - Capacity Building in NPAIHB tribal programs
  - Needs Assessment with Tribal Communities/health programs
  - Develop a strategic plan addressing ADRD
  - Using first-ever public health guide focused on dementia in AI/AN (CDC Road Map for Indian Country)
  - Year 2 – awareness campaign, provide resources and training (community, provider, and caregiver)

Project staff:

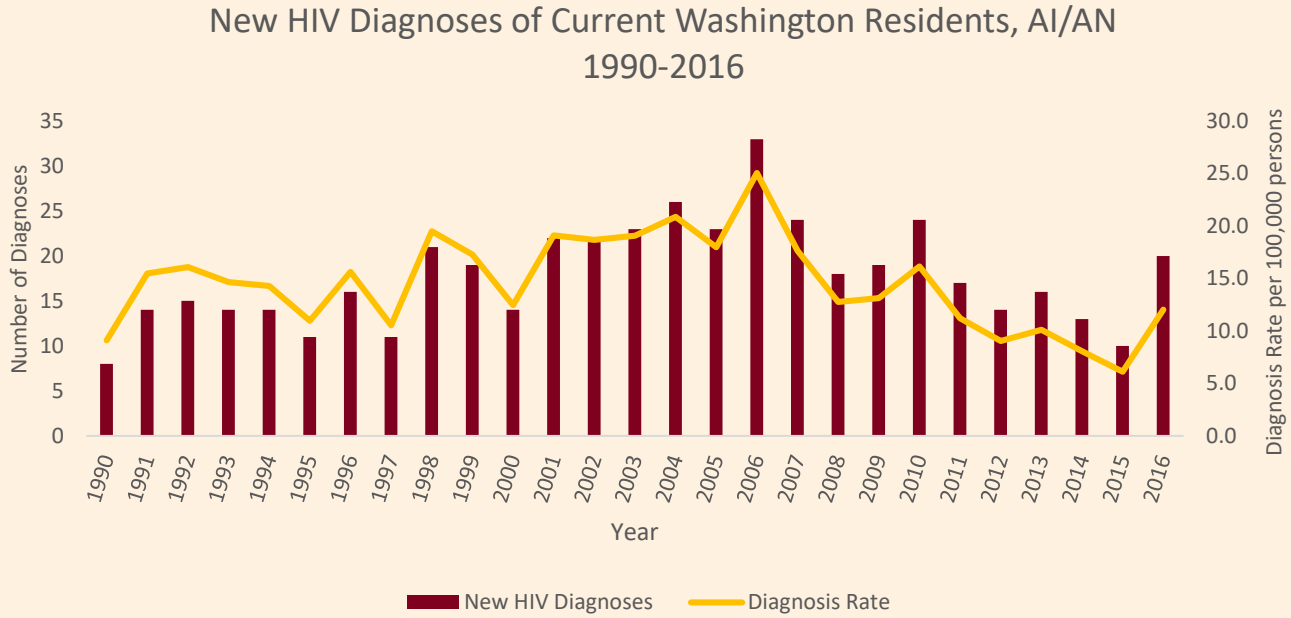
Kerri Lopez, Project Director Klopez@npaihb.org

Chandra Wilson, Project Coordinator cwilson@npaihb.org

Washington HIV

- As of 2016, there were 13,312 people living with HIV in Washington, 504 (nearly four percent) of whom were American Indian/Alaska Native.

- Diagnosis rates among AI/AN vary between 1990 and 2016, with an overall decline in diagnoses over the last ten years.
  - In 2016, there was an increase in both the number and rate of new HIV diagnoses.



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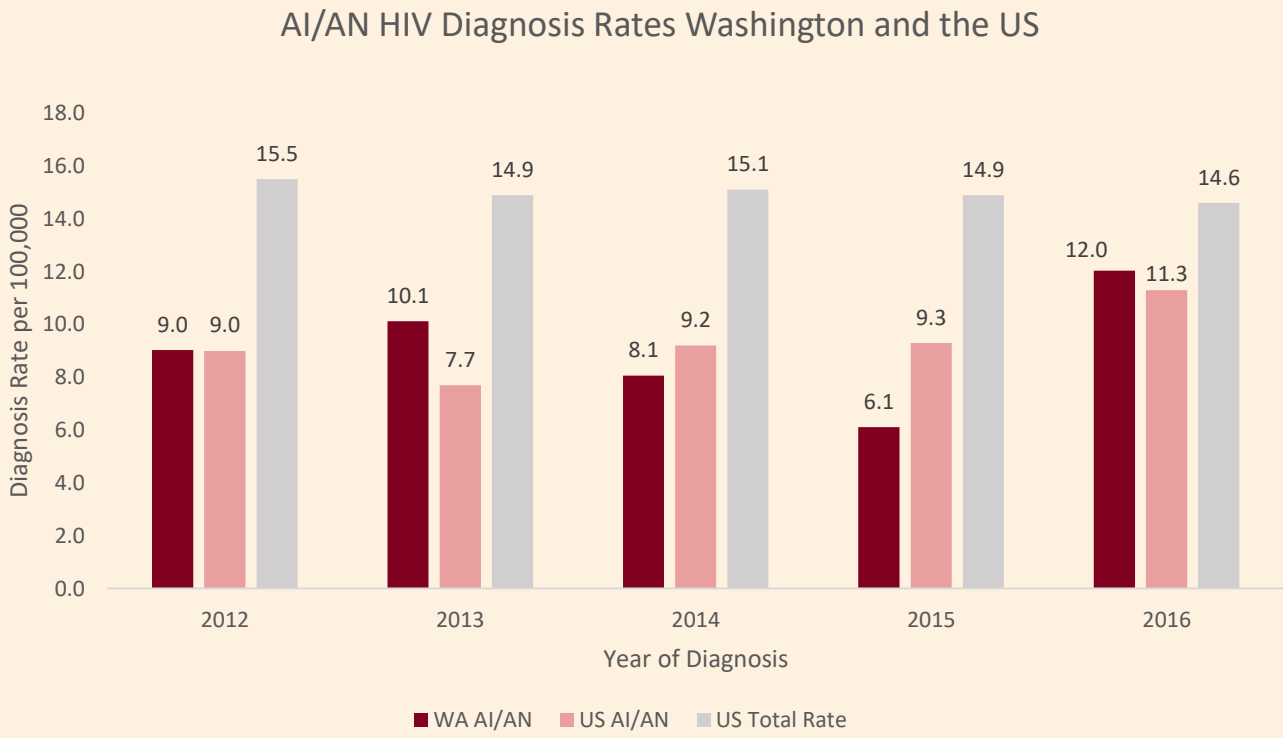
Washington HIV

- Overall, AI/AN HIV diagnosis rates in Washington have been lower than the US diagnosis rate.
- With the exception of 2013 and 2016, Washington AI/AN HIV diagnosis rates have been either the same or slightly lower than the US AI/AN diagnosis rate.



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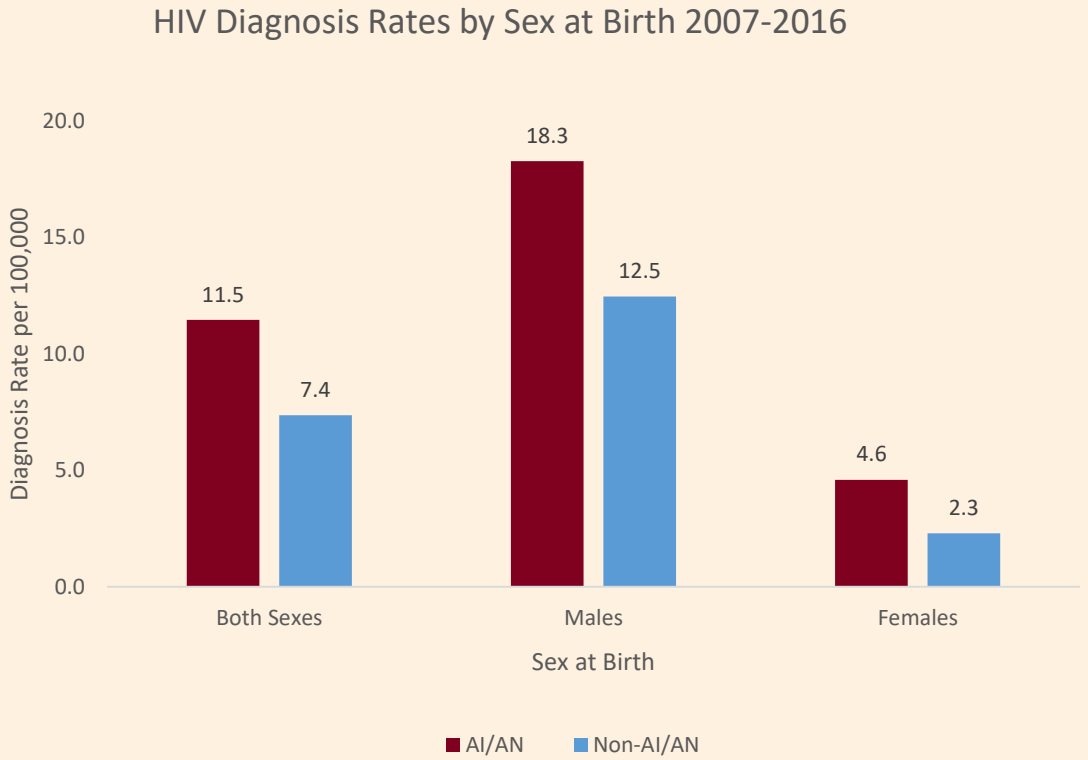
Washington
HIV

- The AI/AN HIV diagnosis rate for both males and females between 2007 and 2016 in Washington was 1.6 times higher than their Non-AI/AN counterparts.

- The male AI/AN diagnosis rate was 1.4 times higher than the male Non-AI/AN diagnosis rate and the female AI/AN diagnosis rate was two times higher than the female Non-AI/AN diagnosis rate.



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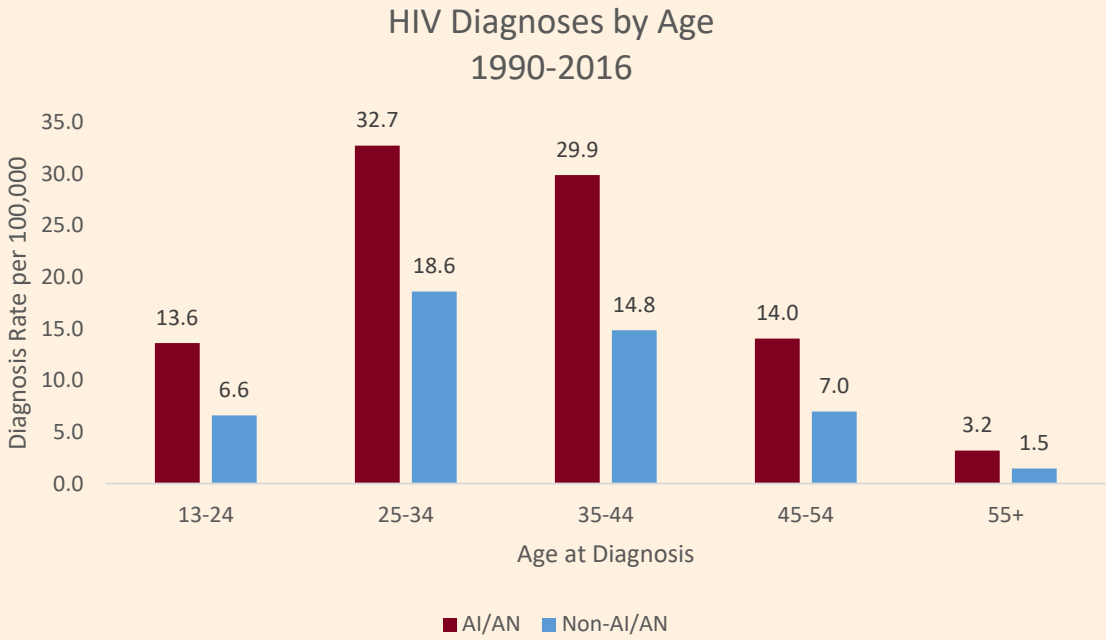
Washington
HIV

- Most HIV diagnoses among AI/AN in Washington occurred between the ages of 25 and 44 and is highest among those between the ages of 25 and 34.

- The overall age distribution of HIV diagnoses in Washington is similar between AI/AN and Non-AI/AN.
  - However, the rate of diagnosis is double in almost every age category.



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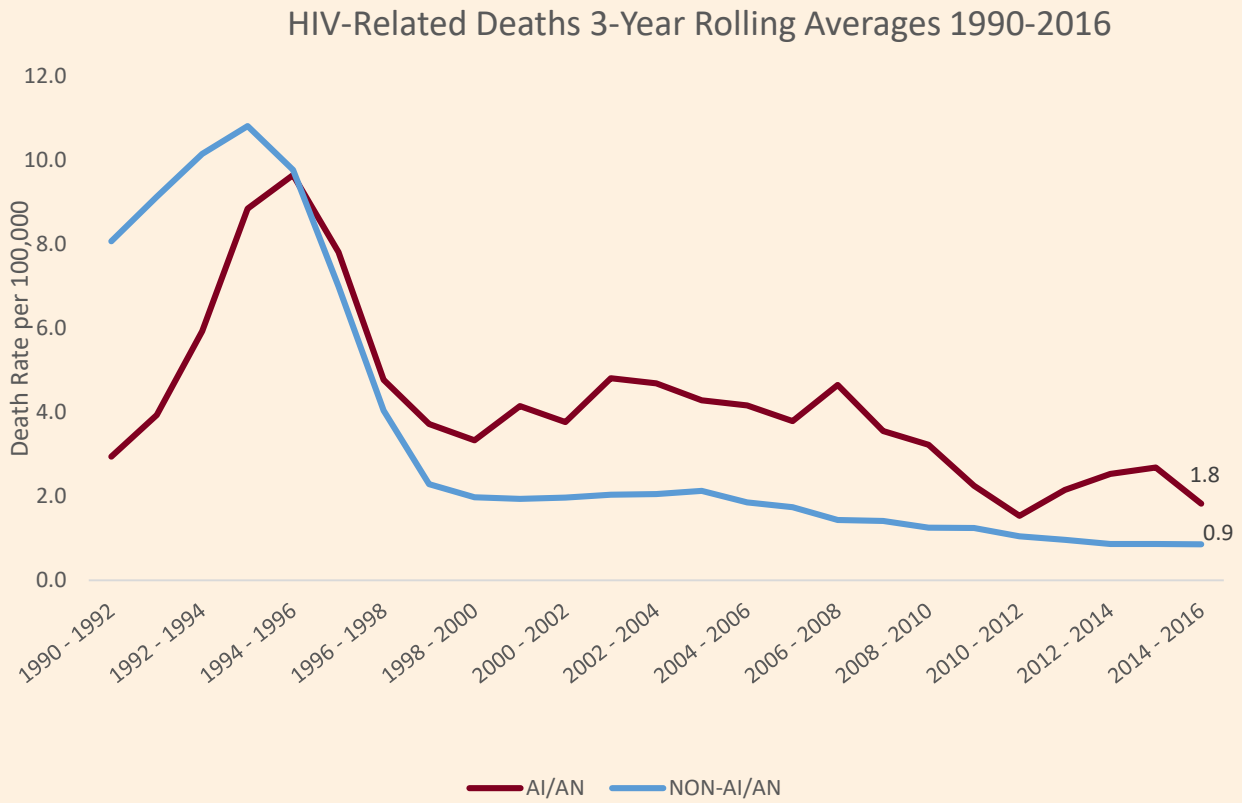
Washington
HIV

- While HIV-related deaths have fallen since the early to mid-nineties for all persons living with HIV, AI/AN HIV death rates are still disproportionately higher than their Non-AI/AN counterparts, with an average rate double the death rate of Non-AI/AN in 2014-2016.



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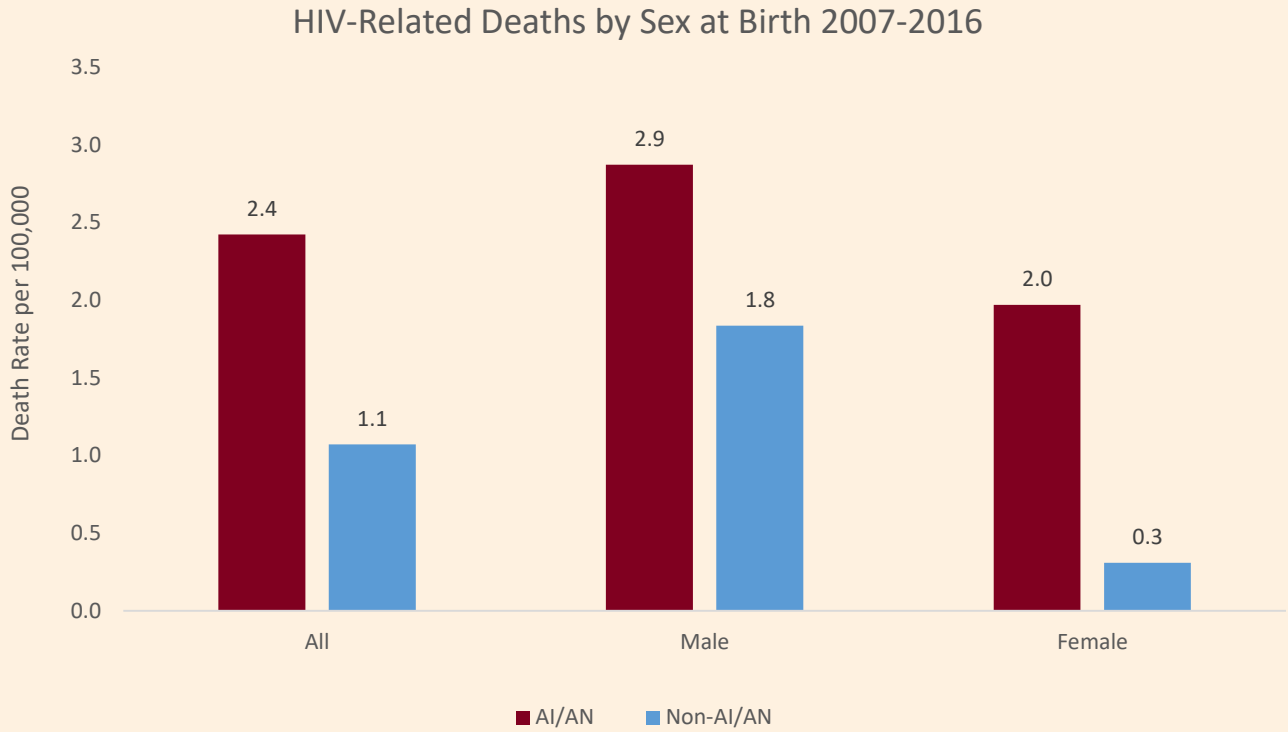
Washington
HIV-Related Deaths

- Between 2007 and 2016, overall death rates for AI/AN in Washington were double those of their counterparts.
- When examining rates specific to sex at birth, the death rate for AI/AN males is 1.6 times higher than Non-AI/AN and females have a death rate **nearly seven times** that of Non-AI/AN females.



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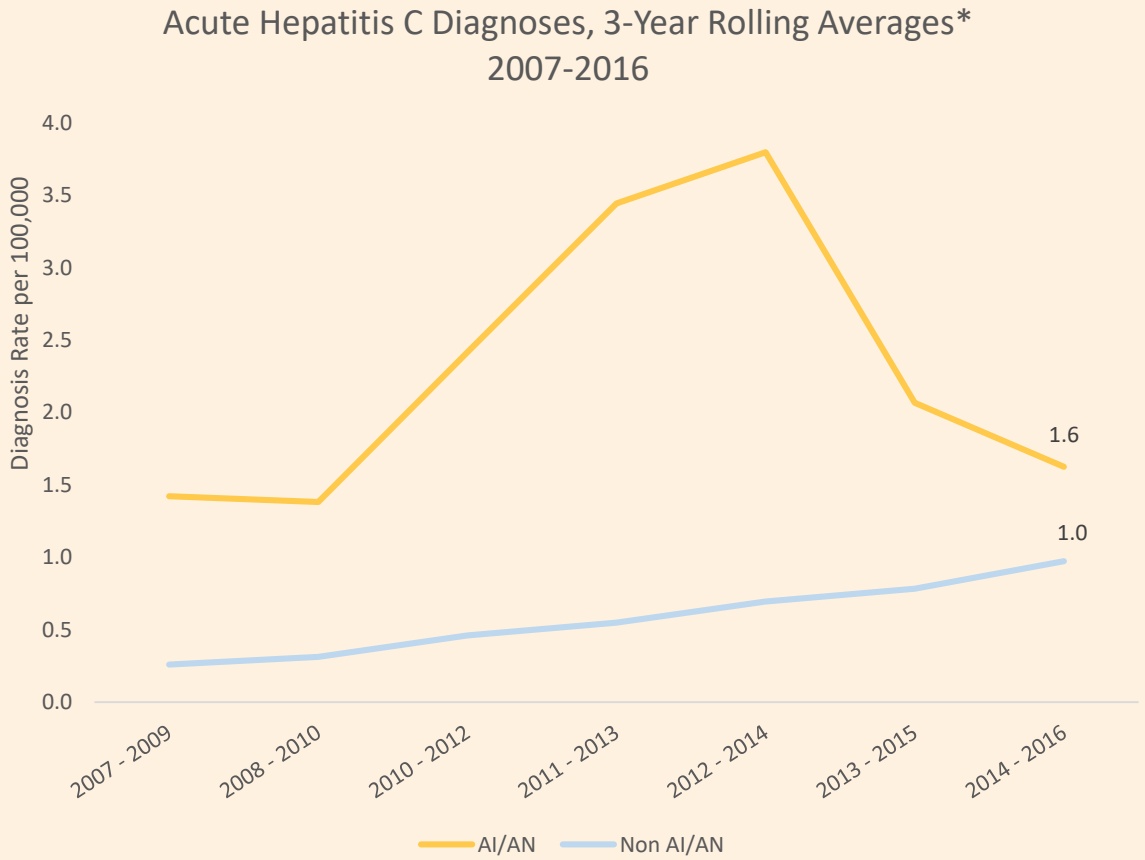
Washington
Acute Hepatitis C

- A total of 30 cases of acute HCV were reported among AI/ANs in Washington between 2007-2016, which was nearly six percent of all acute HCV diagnoses during the ten-year period.

- New HCV infection diagnoses fluctuated during this time, with a low between 2009-2011 and a peak in 2012-2014, mirroring the peak in new acute HBV diagnoses among AI/AN in Washington during the same period.



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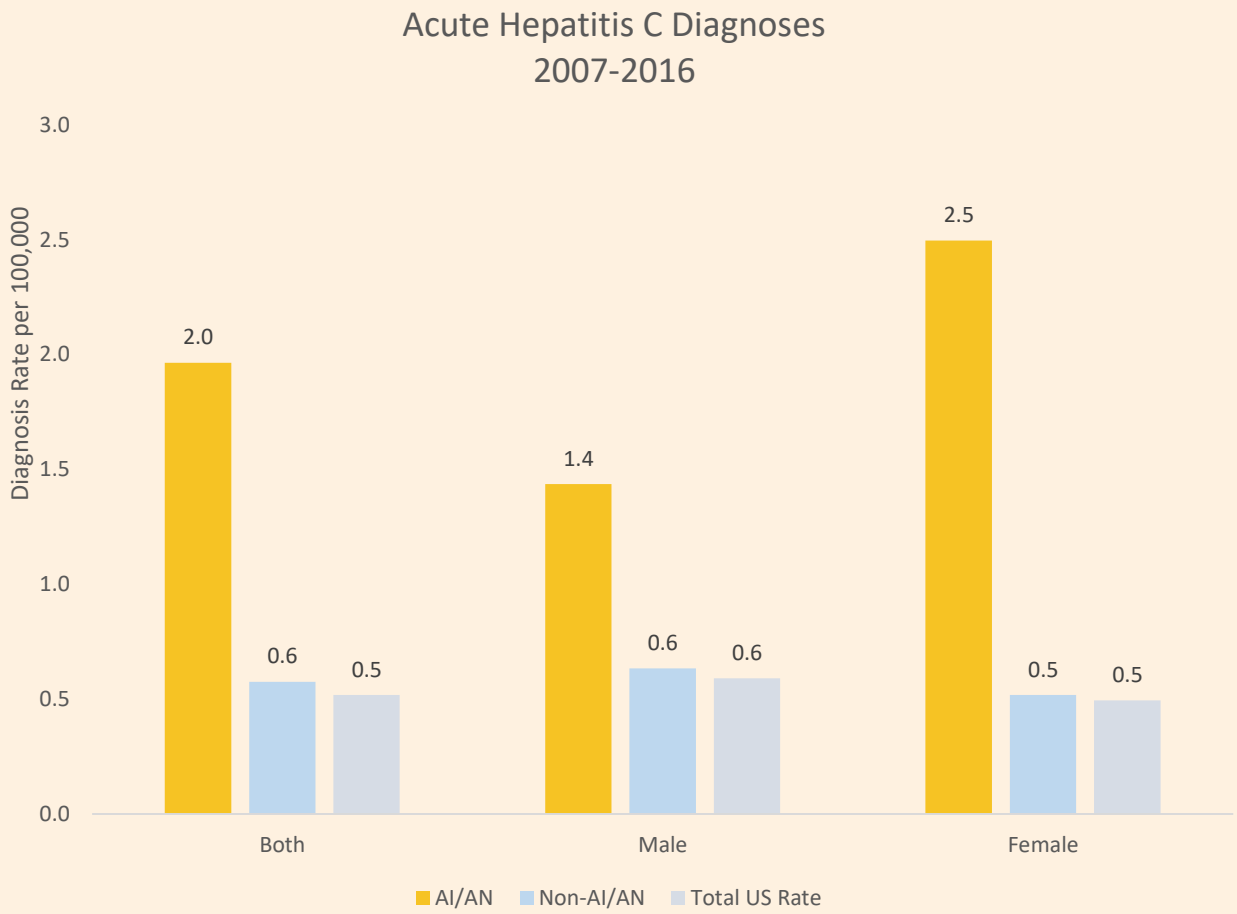
Washington
Acute Hepatitis C

- Between 2007 and 2016, the diagnosis rate of acute HCV for AI/ANs in Washington was four times higher than the national rate of acute HCV diagnoses and over three times that of Non-AI/ANs in Washington.

- AI/AN males had a diagnosis rate 2.3 times higher than their Non-AI/AN peers and AI/AN females had a diagnosis rate five times that of Non-AI/AN females.



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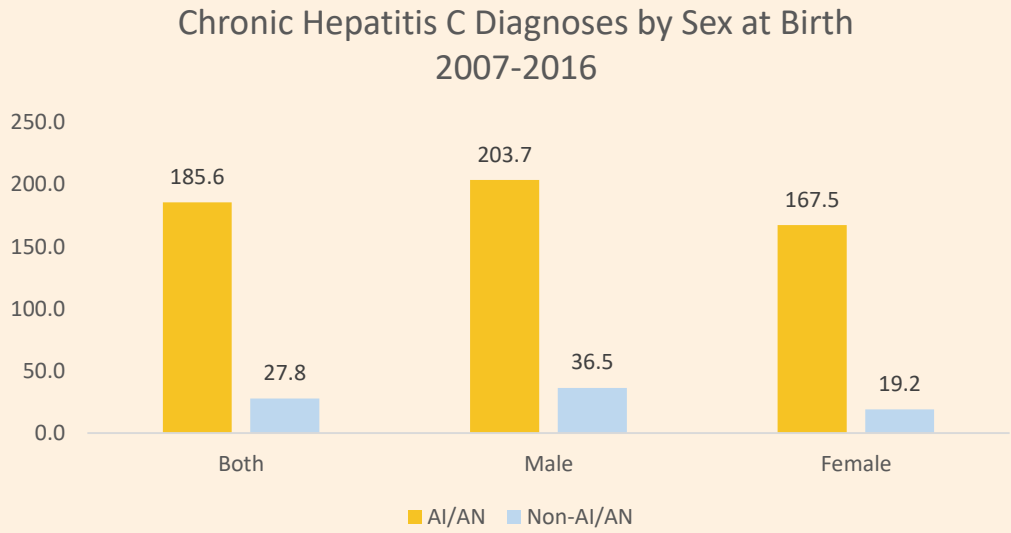
Washington
Chronic Hepatitis C

- There were a total of 2,835 chronic HCV diagnoses among AI/ANs in Washington during the 2007-2016 period, which accounted for nearly five percent of all chronic HCV diagnoses.

- Chronic HCV diagnoses were 6.7 times higher for AI/ANs in Washington than Non-AI/ANs between 2007-2016.
  - While the rate for AI/AN males was 5.6 times higher than Non-AI/AN males, the greatest disparity was between AI/AN females and their Non-AI/AN peers: **AI/AN females had a diagnosis rate nearly nine times that of Non-AI/AN females.**



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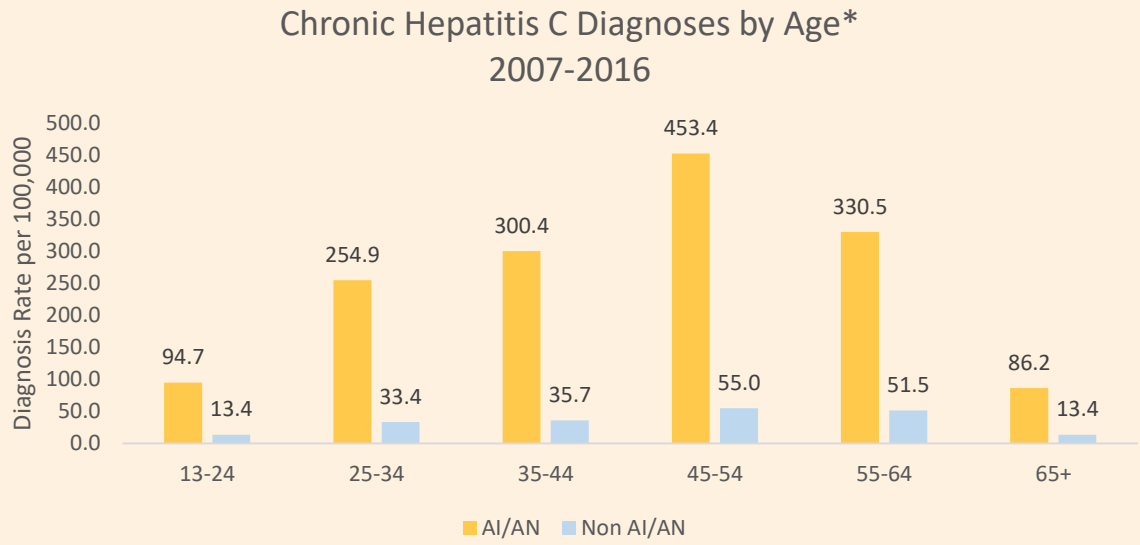
Washington
Chronic Hepatitis C

- All age groups for AI/AN chronic HCV diagnoses were at least seven times higher than Non-AI/AN persons in Washington.
- The greatest disparities were between the ages of 35-44 and 45-54, with diagnosis rates for AI/AN persons 8.4 and 8.2 times higher than Non-AI/AN persons, respectively.



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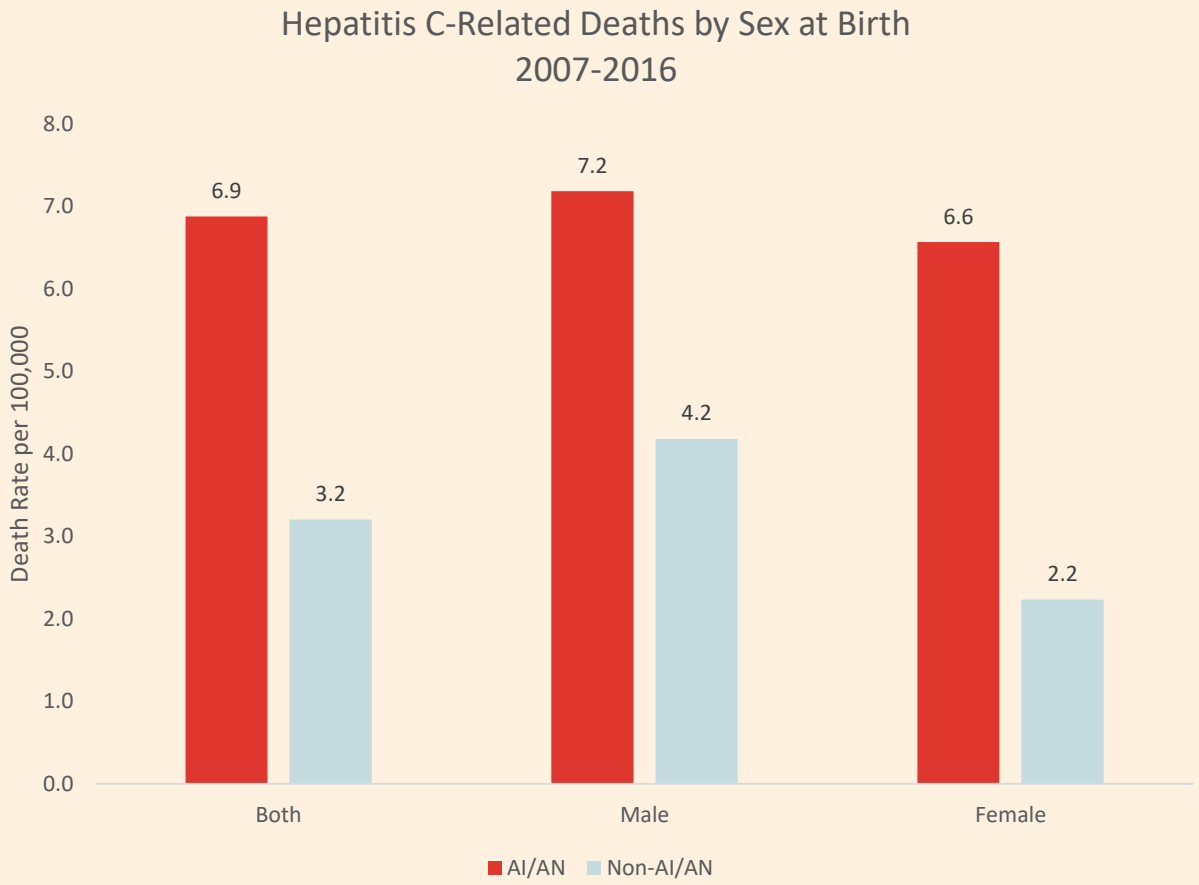
**Diagnosis rates for persons under the age of 13 have been suppressed due to the small amount of diagnoses for these age groups (cases <5).*

Washington
Hepatitis C-Related Deaths

- The overall death rate for AI/ANs in Washington between 2007 and 2016 was about two times higher than the death rate of their Non-AI/AN counterparts.

- When examining death rates by sex at birth, AI/AN males had a death rate 1.7 times higher than that of Non-AI/AN males and women had the greatest disparity, with a death rate three times higher than Non-AI/AN females.



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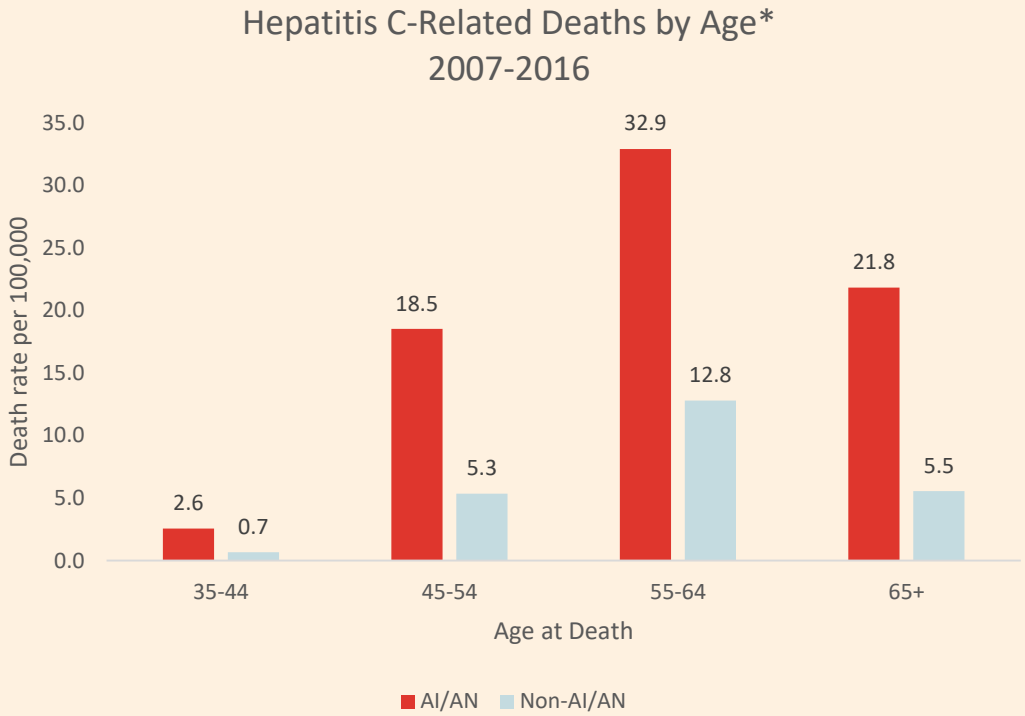
Washington
Hepatitis C-Related Deaths

- While every age group for AI/AN persons in Washington had a death rate at least twice as high as Non-AI/AN persons, adults aged 35-44 and 65 and older had a death rate four times that of Non-AI/AN persons.



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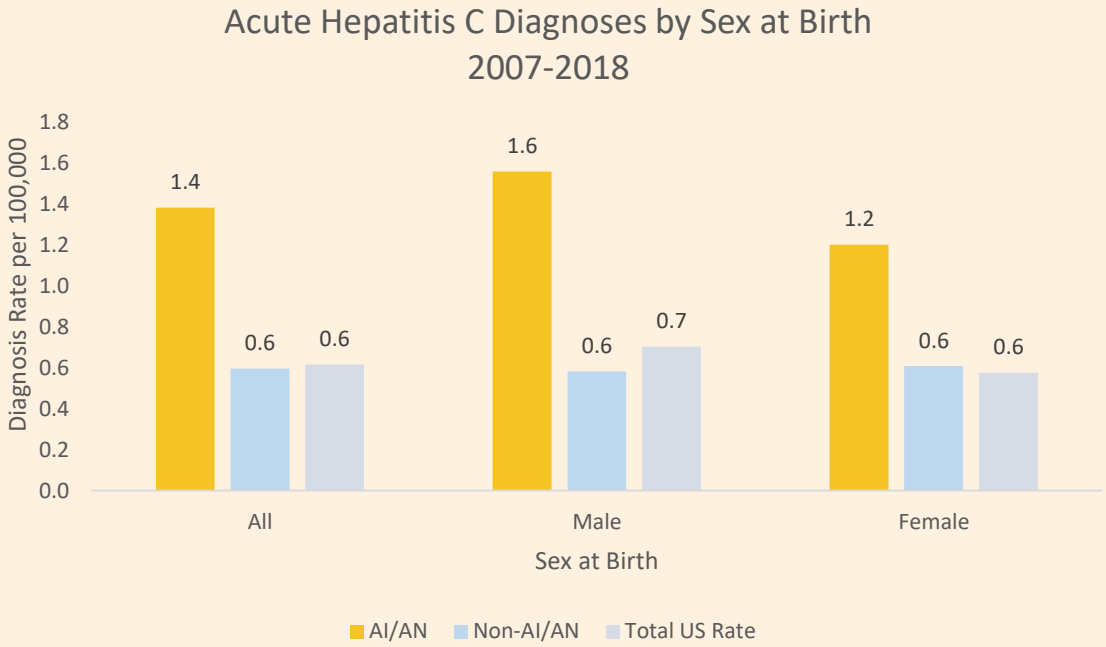
**Diagnosis rates for persons under the age of 35 have been suppressed due to the small amount of diagnoses for these age groups (cases <5).*

Oregon
Acute Hepatitis C

- A total of 14 cases of acute HCV were reported among AI/AN persons in Oregon between 2007-2018, which was nearly five percent of all acute HCV diagnoses during the twelve-year period.

- The diagnosis rate for new HCV infections for AI/AN persons in Oregon was over two times that of Non-AI/AN persons in Oregon and of the total national rate.
  - Male AI/AN persons had a rate 2.7 times higher than Non-AI/AN persons.



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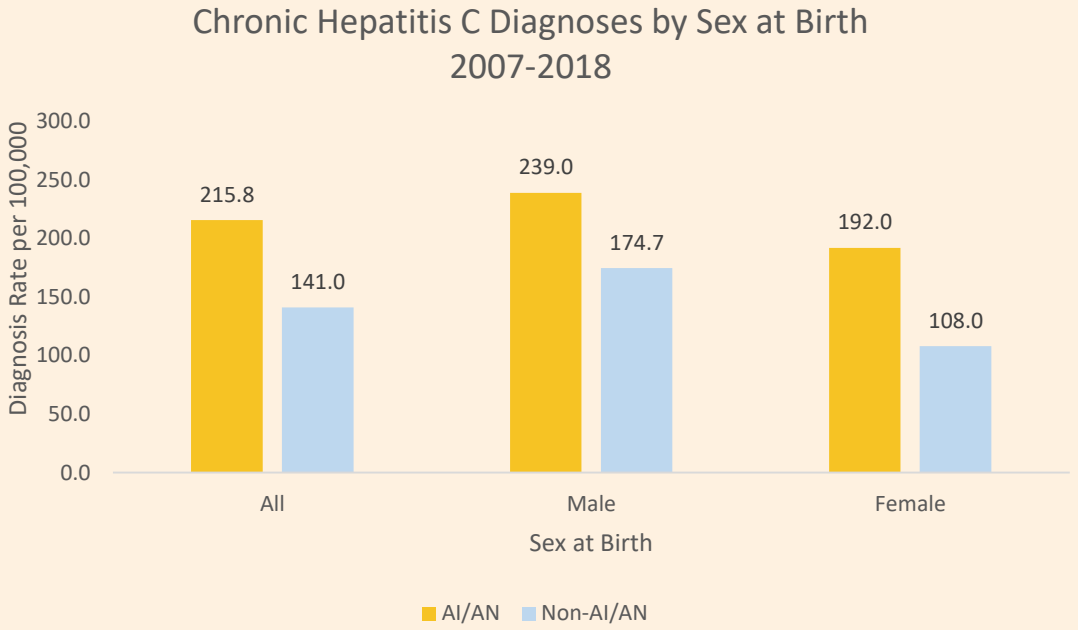
Oregon
Chronic Hepatitis C

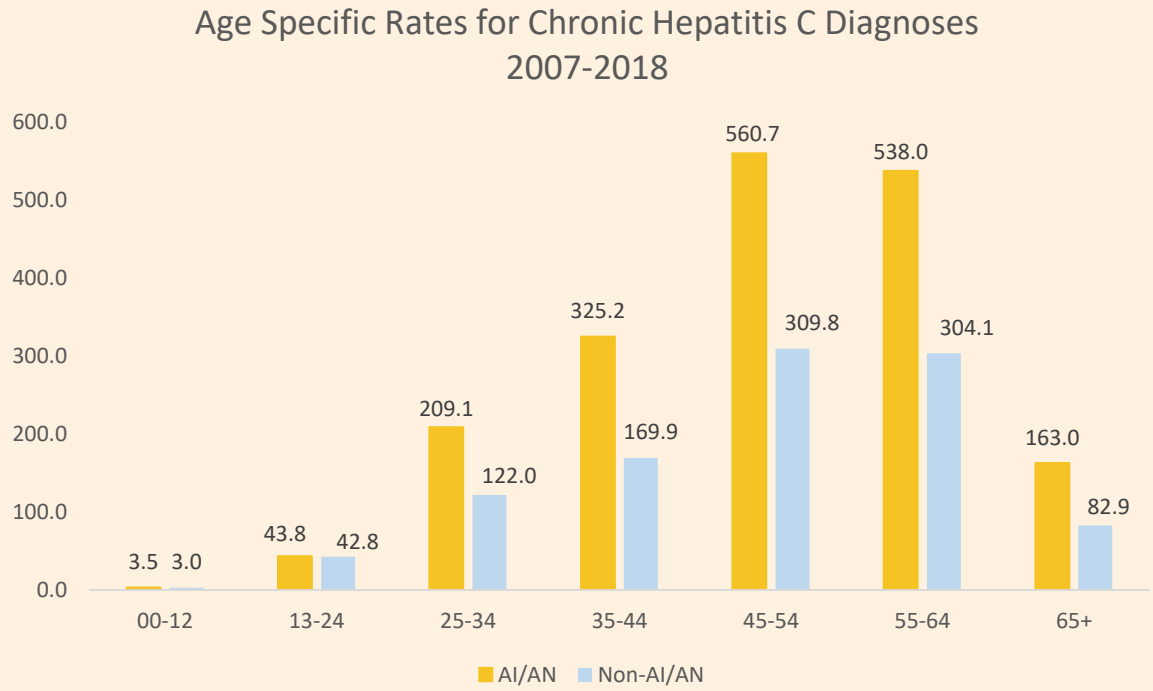
- There were a total of 2,187 hepatitis C diagnoses for AI/AN persons between 2007 and 2018 in Oregon, which accounted for three percent of all HCV diagnoses within that time period.

- Between 2007 and 2018, the diagnosis rate of chronic HCV for AI/ANs in Oregon was 1.5 times higher than that of their Non-AI/AN peers.
  - AI/AN males had a diagnosis rate 1.4 times higher than their Non-AI/AN peers and AI/AN females had a diagnosis rate nearly two times that of Non-AI/AN females.



Oregon
Chronic Hepatitis C

- While diagnosis rates were greater for AI/AN persons across all age groups, the rate for those aged 25 and older was nearly two times that of Non-AI/AN persons.



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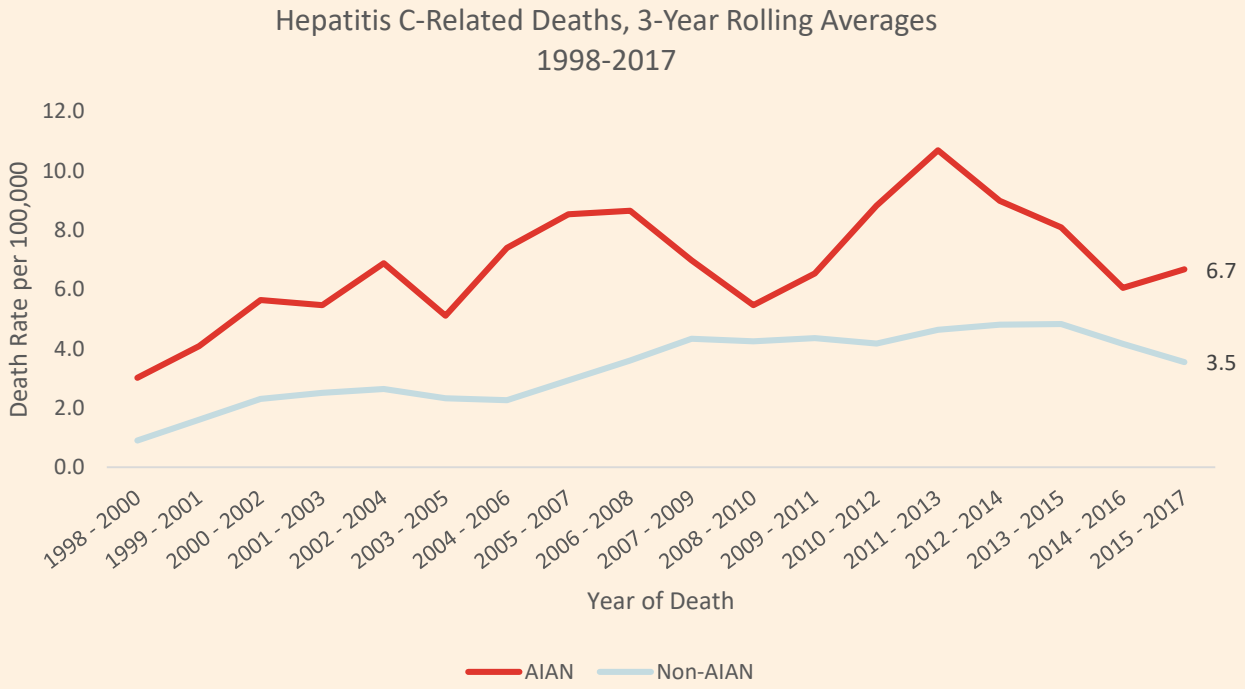
Oregon
Hepatitis C-Related Deaths

- The rate of HCV-related deaths in Oregon among AI/AN persons fluctuated over the last twenty years, with a low of 3.0 deaths per 100,000 between 1998 and 2000 and a high of 10.7 deaths per 100,000 between 2011-2013.

- While the death rate for AI/ANs in Oregon between 2015 and 2017 was below the national AI/AN death rate for HCV-related deaths in 2017 (10.24 deaths per 100,000), the trend shows a slight increase from the previous three years.



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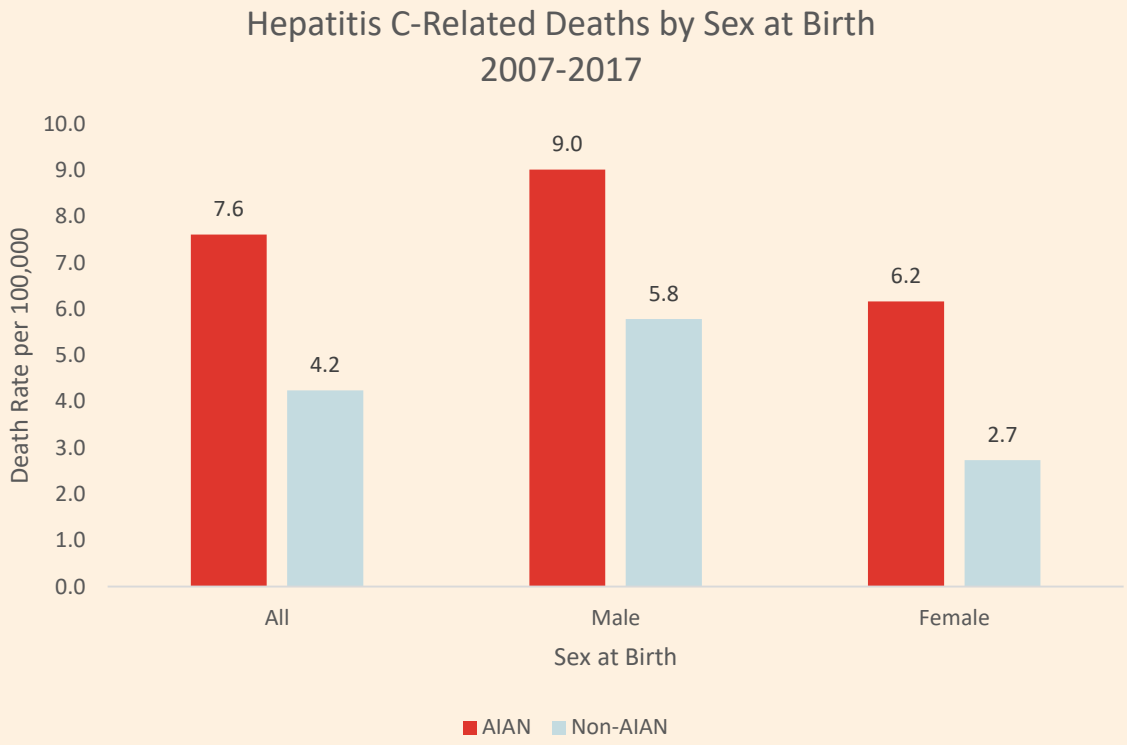
Oregon
Hepatitis C-Related Deaths

- The overall death rate for AI/ANs in Oregon between 2007 and 2017 was nearly two times higher than the death rate of their Non-AI/AN peers.

- When examining death rates by sex at birth, AI/AN males had a death rate 1.6 times higher than that of Non-AI/AN males and women had the greatest disparity, with a death rate two times higher than Non-AI/AN females.



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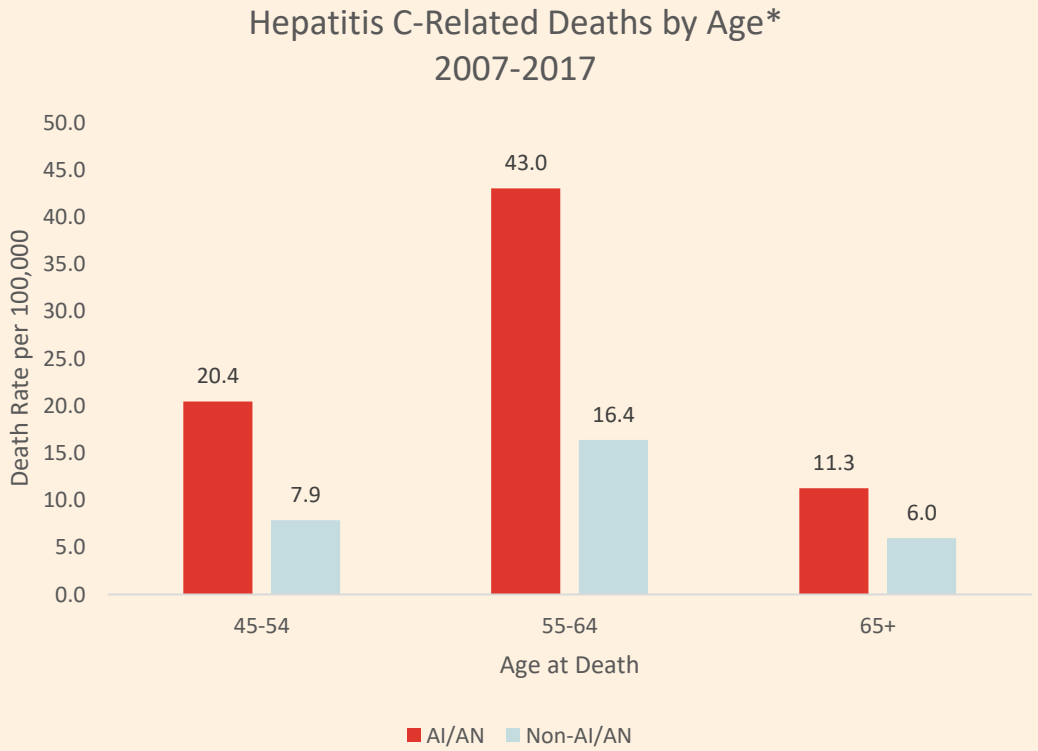
Oregon
Hepatitis C-Related Deaths

- While the HCV-related death rate for AI/AN persons was higher than Non-AI/AN persons across the age groups examined, the disparity was greatest among those between the ages of 45 and 64, with a death rate 2.6 times higher than Non-AI/AN persons.



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**Diagnosis rates for persons under the age of 45 have been suppressed due to the small amount of diagnoses for these age groups (cases <5).*

About the Data

- Counts less than five have been suppressed.
- Crude rates are used for both diagnoses rates and death rates for all data briefs.
- HIV Deaths includes records with the following ICD codes for HIV as the underlying cause of death: ICD-9 (042, 043, 044), ICD-10 (B20, B21, B22, B23, B24).
- HCV Deaths includes records with the following ICD codes for HCV as the underlying cause of death: ICD-10 (B17.1, B18.2).

Data Sources:

- **Washington Data Sources**:
  - Department of Health Office of Infectious Disease HIV Surveillance
  - Washington Department of Health STD Program
  - Washington Department of Health Viral Hepatitis Program
  - Washington state death certificates
  - Washington Department of Health Tuberculosis Program
- **Oregon Data Sources:**
  - Oregon Health Authority
- **National Data Sources**:
  - Centers for Disease Control and Prevention (CDC) WONDER
  - National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) AtlasPlus

Tribal Food Sovereignty

- **Surveys and Assessments have launched!**
  - UW Food Security during COVID-19 in WA State
- **Regional Food Sovereignty Assessment (ID, OR, WA)**
- **Scholarship opportunities will be available soon:**
  - Funds up to $500/scholarship to support Native Agriculture-related business (including farmers, ranchers, fishers, and community gardens) for training and education purposes. Up to 16 awards will be available.
- **NW Tribal Food Sovereignty Coalition Annual Gathering 2021 goes virtual!**
  - A series of virtual gathering events will begin in June and will include community spotlight presentations, cooking demonstrations, and other trainings/activities focused on food sovereignty/food systems work in our region

NW Native American Research Center for Health (NARCH)

- Key participants: Warren-Mears, Weiser, Thomas, Cunningham, Davis, Livingston, Blackshear, Becker
- Current projects:

  Improving asthma management

  Cancer prevention and control fellowships

  Graduate school fellowships

Pending: Three additional training grants in sciences (? Summer start)

Preparing now: Undergraduate and high school science enrichment (with the blessing of the delegates; our Advisory group has approved)

Trans & Gender-Affirming Care Strategic Plan

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The Northwest Portland Area Indian Health Board, together with the Native Advocacy Workgroup for Trans Health, has recently published the *Trans & Gender-Affirming Care in I/T/U Facilities Strategic Vision and Action Plan*. This plan includes information designed to ensure clinical environments serving Indigenous people are affirming for all clients, especially those who identify as trans or gender-diverse. The plan includes sample policies and strategies to make clinical environments more affirming.

Access the strategic plan: bit.ly/2slgbtqstrategicplan

NPAIHB
Indian Leadership for Indian Health

NPAIHB telehealth/Indian Country ECHO opportunities

- PrEP
- Pharmacy Led SUD Care
- Hep C/SUD
- Diabetes
- Trans & Gender-Affirming Care
- Peer Recovery
- COVID-19
- HIV/AIDS
- Tuberculosis
- Community Health
- Maternal and Child Health
- Harm Reduction
- Community Health Aide Program
- Behavioral Health

Affirming Environments Self-Assessment

We've already worked with five PNW tribes to enhance affirming environments.

Individual clinical consultations are available to determine current level of affirmation and strategies for improvement.

- Contact Morgan at mthomas@npaihb.org

Two Spirit & LGBTQ Affirming Environments Clinical Self-Assessment:

- Visit bit.ly/2slgbtqaffirming.
- Text ASSESS to 97779

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Funding Still Available for Youth Sexual Health Project

- 4-6 WA Tribal Sub recipients, Youth Access to and Experience with Sexual Health Care
- Applications Due:
  - April 26, 2021
  - May 24, 2021
- Applications are reviewed on a rolling basis, the last week of each month. Applicants will be notified by the NPAIHB within two weeks
- Open office hours: Tuesday's and Thursday's via Zoom
- Contact, Celena McCray cmccray@npaihb.org

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Questions or Comments

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Northwest Portland Indian Area Health Board
VA OTGR Update

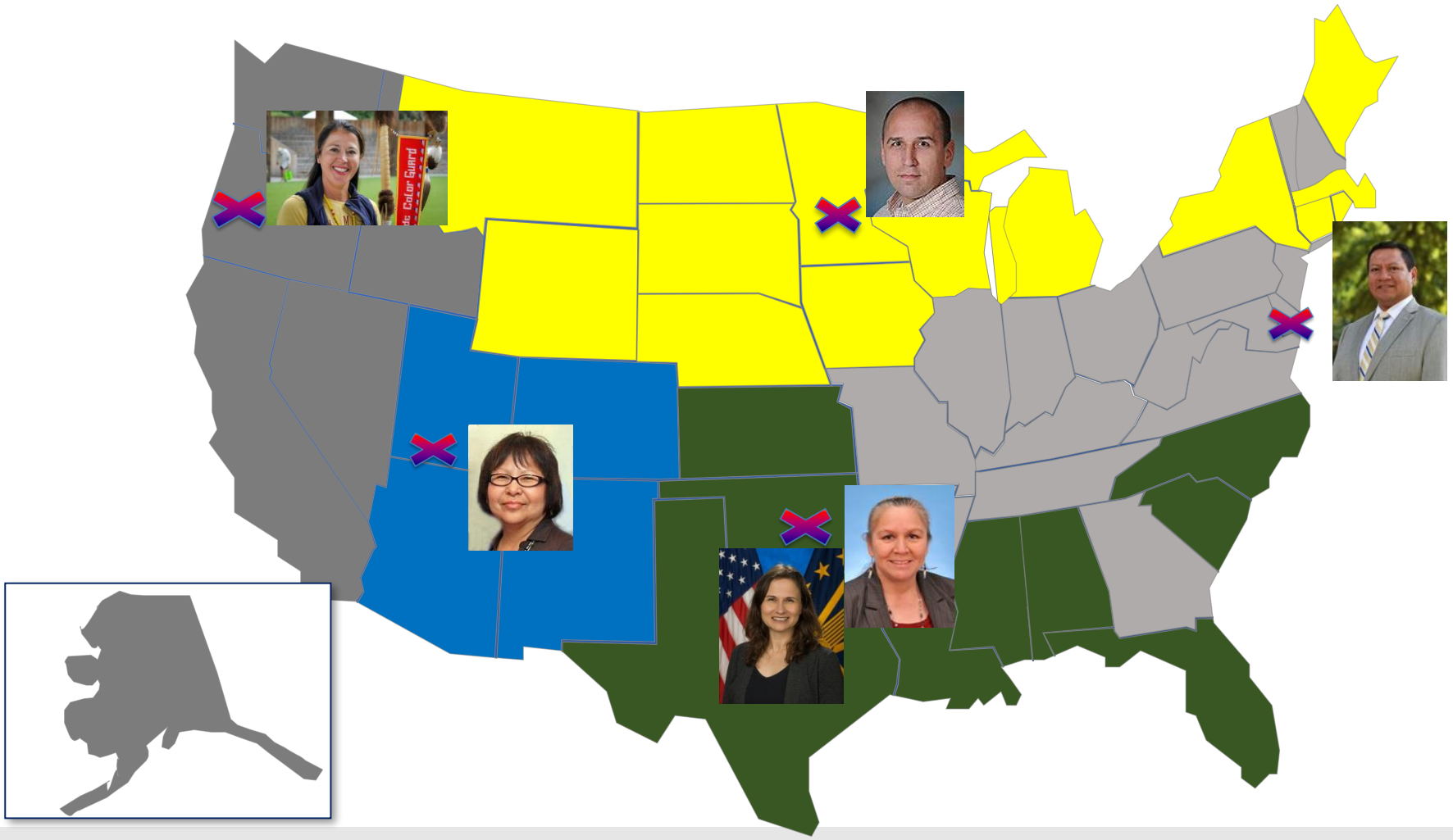
April 22, 2021

Stephanie Birdwell, Director, VA OTGR

Terry Bentley, Regional Specialist, VA OTGR



VA Office of Tribal Government Relations (OTGR)



Office of Tribal Government Relations

VA | U.S. Department of Veterans Affairs

Recent Enactments of the 116th Congress: Native Veterans legislation Updates

- Reimbursements to Indian Health Service and PRC (HR 6237)- Status: A series of informational calls were held between VHA, IHS and members from IHS's PRC workgroup to gain an understanding of the PRC program. VA and IHS office of general councils are working together on details of the legislation.
- Co-pay prohibitions for Native American Veterans (HR 7105 section 3002) – Status: March 29 DTLL for consultation, virtual session April 29 and written comments due by May 29, 2021
- State Veterans Homes Grants (HR 7105 section 3004) – Status: Listening sessions held March 3, 2021 – DTLL forthcoming for consultation
- HUD-VASH (section 4206) – Status: Secured and increased funding
- VA Tribal Advisory Committee (HR 7105 section 7002) – Status: Nominations and first committee meeting to occur by Sept 2021
- Urban Indian Health Programs and Reimbursement Agreements with VHA (HR 6237) – Status: VHA is working National Council of Urban Indian Health and IHS Office of Urban Indian Programs to understand scope of services, clinic locations, and anticipated Veteran volume. Listening session was held March 23 with NCUIH.

Current VA Consultation

- Joint Agency Tribal Consultation with Department of Veterans Affairs, U.S. Department of Treasury, Social Security Administration; U.S. Small Business Administration on the Presidential Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships (seeking input on how we can improve Departments and Agency's Tribal Consultation Policy. DTLL sent March 8, virtual consultation sessions April 6, April 7, and April 8 with written consultation due April 9, 2021

- Co-pay prohibitions for Native American Veterans (HR 7105 section 3002) – Status: March 29 DTLL for consultation, virtual session April 29 and written comments due by May 29, 2021

- VA / IHS MOU update – Consultation Report being drafted

Virtual Outreach - OTGR Webex Wednesdays

4/7/21	**Native American Veterans: Federal Employment**	Kelly Woodall, Steven Juneau, Courtney Bernal, Allison Phillips
4/21/21	**VA Education 101**	Terry Warren, Stakeholder, Engagement, Education Office
4/28/21	**VA vaccinations in Tribal Communities**	Dr. Jane Kim

Regional Updates

- Regional Webex trainings offered
  - March 25, 2021 – Complex PTSD & Whole Health (55 attended)
  - June 8, 2021 – Behavioral Health Series, Part 2 – Dr. Sarah Sunigah
- Virtual Claims events with tribes
  - Confederated Tribes of Grand Ronde
  - Viejas Tribe
  - Rincon Tribe
- Tribal Veteran Representative (TVR) Virtual Training will be held on April 28-29, 2021 in collaboration with ODVA hosted by Confederated Tribes of the Umatilla Indian Reservation

Regional Updates

VA-IHS/THP Reimbursement Agreements Through February 2021

Executive Summary

	Jan 2021	Feb 2021	Difference	FY21	Program Inception to
Disbursed	$1,620,603.35	$2,211,951.56	$591,348	$8,283,709	$131,558,647
Unique Veterans	1,581	2,313	732	4,361	12,198
Inpatient Claims	493	406	-87	1,898	7,349
Outpatient Claims	3,610	5,526	1,916	18,819	368,691
Total Claims	4,103	5,932	N/A	20,717	376,040

IHS/THP Feb 2021

	IHS	THP
Claims	2423	3509
Unique Veterans	911	1435
Disbursed	$664,515.71	$1,547,435.85

OTGR Team and Contact Information

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David.Ward@va.gov

www.va.gov/tribalgovernment - Main website

Tribal.agreements@va.gov – VA-IHS-THP Reimbursement Agreements

Tribal.Consultation@va.gov – email for tribal leaders to submit inquiries directly to VA

COVID-19 BEHIND THE IRON DOORS

The Impact on Native American Religious Services & Cultural Programming within Oregon State Prisons During a Pandemic

Northwest Indian Health Board
April 22, 2021
Trish Jordan, RN,BSN
RED LODGE TRANSITION SERVICES

The Road to Incarceration

Historical Trauma	Physical, Sexual, Emotional Abuses	Substance Abuse
Poverty	Hopelessness	Associates
Community norms	Profiling	Gang affiliation
	Drug economics	

- Under-educated
- Mental health issues
- School to Prison Pipeline
- Dysfunctional family dynamics
- One or both parents have been incarcerated
- Wrong place at the wrong time…
- Intimate partner initiated
- No boundaries/PTSD
- Human trafficking victim

WHAT IS NATIVE AMERICAN RELIGIOUS SERVICES?

- Cultural and spiritual programming
- Talking Circle
- Drum Practice
- Smudge
- Sweatlodge
- Pipe Ceremony
- Wellbriety
- Parenting Classes
- Behavioral health classes
- Pipe Ceremony
- Hair Cutting Ceremony
- Medicine bags and medicines
- Giveaway
- Sacred Foods Ceremony
- Pow Wow
- Spirit Run
- Winter Solstice Sweat
- Art projects
- Flutes
- Special guests
- Native American Heritage Month

Programming is dependent on volunteers and space being provided
Each Prison is its own little Island

WHY IS NATIVE AMERICAN RELIGIOUS SERVICES NEEDED?

- Connection to Spirit
- Behavioral Health
- Holistic values
- Sense of belonging
- Personal identity
- Foundation upon which to rebuild
- Healing the Wounded Spirit
- Adult mentoring
- Respect for all life
- Maintain cultural and tribal sovereignty
- Lifeline to community

- Native Americans are incarcerated at a rate of 38% higher than the national average
- Native Americans are 3X more likely to be killed by police than any other racial group
- and religious freedom for an almost invisible population
- 70% of youth taken into federal custody are Native American (1)
- Native Americans experience violence at 2 X the national average (2)
- Native people need to connect with one another
- Reentry begins upon incarceration

Spring Celebration 2006, Coffee Creek Correctional Facility

Photo Courtesy of OPB- Root Digging near Simnashio, OR

Root digging April 2019 near Simnashio, OR Photos courtesy of OPB

Photo courtesy of OPB- Root digging near Simnashio, OR
April, 2019

Photos Courtesy of OPB- Spring Celebration
Coffee Creek Correctional Facility
Minimum and Medium Unit 2019


Photo Courtesy of OPB- Red Lodge Ladies
preparing for Spring Celebration 2019

Photo Courtesy of OPB- Elder helping prepare food for Spring Celebration 2019


Photo Courtesy of OPB- Preparing for Spring Celebration 2019
KIA
765 KUQ

Photo Courtesy of OPB- Coffee Creek Correctional Facility. Spring Celebration 2019

Photo Courtesy of OPB- Coffee Creek Correctional Facility
Spring Celebration, 2019

Photo courtesy of OPB, Snake River Correctional Institution. Aug. 25th, 2019


Deer Ridge Correctional Institution 2018
GIANTS
BASEBALL


Two Rivers Correctional Institution 2018

Santiam Correctional Institution 2017

Photo courtesy of OPB. Snake River Correctional Institution Aug. 25, 2019

COVID-19: Infections Among U.S. Prisoners Have Been Triple Those of Other Americans

- Over 1,400 new Adult in Custody infections and seven deaths, on average, have been reported daily
- Social distancing is not an option
- Testing was not a priority early in the pandemic
- One in three AIC in state prisons have had the virus
- 2,700 inmates have died according to the New York Times research tracking

- More than 525,000 reported infections nationwide in our prisons
- Deaths could have been prevented according to public health officials and Criminal Justice experts
- Disorganized response to virus in most prisons
- Over 138,00 prison and jail correctional officers and other workers were sickened and 261 died
- Oregon Dept of Corrections taken to Court and ordered to vaccinate ALL inmates who request immunization
- New strains of the virus are a real concern!

- https://www.nytimes.com/live/2021/04/10/world/covid-vaccine-coronavirus-cases

Oregon State Penitentiary 2008 Big Yard Pow wow

Columbia River Correctional Institution and Forest Camp Pow wow 2011

TIER 1	TIER 2	TIER 3	TIER 4
Institution without symptoms of COVID-19	Institution with confirmed COVID-19	Institution with confirmed COVID-19 AND expanded testing	Entire institution quarantined for 14 days
Screening questions for staff upon entry to building. Temperature taken	Heightened employee screening protocol	Continue heightened employee screening protocol	Continue heightened employee screening protocol
All institutions test according to screening presentation	Quarantine housing block or work space which positive AIC came from	All symptomatic staff shall seek medical care and testing via community care, requesting priority handling for COVID-19	All symptomatic patients tested for COVID-19. Conduct symptom interviews daily.
Suspected COVID cases put into respiratory isolation/distancing	Close contacts identified symptomatic AIC placed in isolation	Quarantine of the housing block. Conduct symptom interviews of all patients daily	If any new cases identified while entire institution in quarantine, the 14 day observation period re-starts
All Intake AIC's screened and quarantined for 14 days	If any new cases- Expand contact tracing and proceed to tier 3	If any new positive cases, expand contact tracing and proceed to tier 4	If 6 feet distancing is not possible, face coverings required to be worn by all staff
If 6 feet distancing is not possible, face coverings	If 6 feet distancing is not possible, face coverings	If 6 feet distancing is not possible, face coverings	

Early Medical Release Eligibility

Who does not Qualify?	What are the Criteria?	What should AIC Submit to be considered?	How long will the process take?
An AIC who has not completed a minimum term of incarceration under Measure 11	The age of the AIC	Information on the factors listed under criteria. DOC medical staff approval	Several weeks to several months
An AIC who is serving a sentence that is not eligible for a sentence reduction	A medical authority's determination of whether the AIC is unable to move from place to place without assistance	DOC director or designee's recommendation	Safe placement secured within the community and medical continuation of care
An AIC who is sentenced to life in prison	Whether the AIC has a terminal illness, life expectancy less than 12 months	Board of Parole makes final decision	Reviewing medical documentation and getting feedback from DOC takes time
An AIC who is prohibited under any other applicable state law	Whether advancing the release date is compatible with the best interest of society		


Deer Ridge Correctional Institution 2017


Deer Ridge Correctional Institution 2017

Eastern Oregon Correctional Institution 2012

Two Rivers Correctional Institution Largest Workplace COVID-19 Outbreak in Oregon!

- 48.9% of AIC confirmed positive
- 13 deaths at TRCI in January 2021
- 434 positive cases in January 2021 (789 total cases 48.9%)
- Six housing units out of power Dec. 16th to Dec. 24th
- Sack lunches for days
- Tier 4 lockdown for weeks at a time
- Limited showers and phone calls due to lockdown
- No visitors
- Mail is slow

Spring Celebration 2016 Coffee Creek Correctional Facility

Institution	Employee 1st case	Total positive	AIC (Adult in Custody) 1st case	Total Positive	Spike	Total Population % positive
CCCF	06/10/2020	43	09/15/2020	240	Dec-Jan	858 (28%)
CCIC	09/15/2020	12	Unknown	85	Unknown	unknown
CRCI	09/21/2020	25	12/05/2020	258	Dec-Jan	514 (50.2%)
DRCI	11/03/2020	45	09/05/2020	283	Dec-Jan	734 (38.6%)
EOCI	06/08/2020	76	07/07/2020	459	July-Nov	1,592 (29%)
MCCF	12/01/2020	15	12/12/2020	40	Dec-Jan	164 (24.4%)
Non Inst.	08/01/2020	30	N/A	N/A	Oct-Jan	Unknown
OSCI	08/05/2020	42	09/27/2020	252	Oct-Jan	798 (31.6%)
OSP	03/27/2020	123	05/02/2020	386	May-June Dec-Jan	1,485 (26%)
PRCF	08/24/2020	20	12/12/2020	69	Dec-Jan	238 (29%)
SCCI	05/12/2020	7	04/10/2020	27	Dec-Jan	153 (17.7%)
Red lettering indicates evacuation during fires						

Institution	Employee 1st case	Total positive Employee	AIC (Adult in Custody) 1st case	Total Positive AIC	Spike	Total Population % positive
SCI	04/03/2020	34	04/03/2020	119	Dec-Feb	455 (26.2%)
SFFC		0	03/06/2020	4	Dec-Feb	155 (2.6%)
SRCI	06/23/2020	230	07/03/2020	494	July-Aug Oct-Jan	2,932 (16.8%)
TRCI	04/30/2020	127	05/20/2020	769	Aug-Oct Dec-Jan	1,693 (45.4%)
WCCF	Unknown	Unknown	Unknown	Unknown		Unknown
TOTAL AIC and Employee Population	(4,404 employees)	829 positive 18.8%	(12,404 AIC)	3,485 positive 28.1%		
Total Deaths				42		0.33%
Total Native American Deaths				4		9.5%

Photo courtesy of OPB. Snake River Correctional Institution August 25,2019

NPAIHB Strategic Plan

2020-2025

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Our Vision:

Health and Wellness for the 7th Generation

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.

Strategic Priorities

1

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

2

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

3

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

4

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

5

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

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

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.

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

5-Year Organizational Goals

- Board leadership guide and manage organizational growth: Larger Board staff, Acquire own building
- Board staff create new avenues to share tribal health best practices and feature model programs in the Pacific NW
- QBM meetings are fully represented by NW Tribes and Youth Delegates, and are well-attended by other community stakeholders
- Thriving Board programs address our most vulnerable community members: maternal and child health, youth, elders, and veterans
- Board staff 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 works together to tackle challenging regiona construction, State-wide CHSDA, climate change, and e

10-Year Organizational Goals

- Our Board successfully advocates for and receives full funding for health services at the State and Federal level
- Our Board inspires and prepares our Tribal Public Health workforce, including the next wave of Indian policy leaders
- Our EpiCenter has a robust research agenda that is Native-led and Native-staffed
- Our Board tackles challenging regional issues, including: building a Regional Specialty Referral Center(s) and/or IHS Hospital(s)
- Our Board is prepared to assume DHHS, IHS, State functions, when best for our Tribes or those services

NPAIHB Strategic Plan Report

January 2021 – March 2021

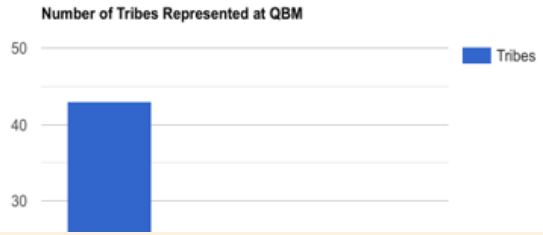
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

LEADERSHIP

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

During this period, the NPAIHB hosted 1 Quarterly Board Meeting to facilitate face-to-face communication and resource sharing with state and federal programs:

Date	Tribes
01/20/2021	Burns Paiute Tribe, Chehalis Tribe, Coeur d'Alene Tribe, Colville Tribes, Confederated Tribes Coos, Lower Umpqua, and Siuslaw Indians, Confederated Tribes of the Umatilla Indian Reservation, Coquille Tribe, Cow Creek Band of Umpqua, Cowlitz Tribes, Grand Ronde Tribe Hoh Tribe, Jamestown S'Klallam Tribe, Kalispel Tribe, Klamath Tribes, Kootenai Tribe, Lowe Elwha Klallam Tribe, Lummi Nation, Makah Tribe, Muckleshoot Tribe, Nez Perce Tribe, Nisqually Tribe, Nooksack Tribe, NW Band of Shoshone, Port Gamble S'Klallam Tribe, Puyal Tribe, Quileute Tribe, Quinault Indian Nation, Samish Indian Nation, Sauk-Suiattle Tribe, Shoalwater Bay Tribe, Shoshone-Bannock Tribes, Siletz Tribes, Skokomish Tribe, Snoqualmi Tribe, Spokane Tribe, Squaxin Island Tribe, Stillaguamish Tribe, Suquamish Tribe, Swinomis Tribe, Tulalip Tribe, Upper Skagit Tribe, Warm Springs Tribes, Yakama Indian Nation

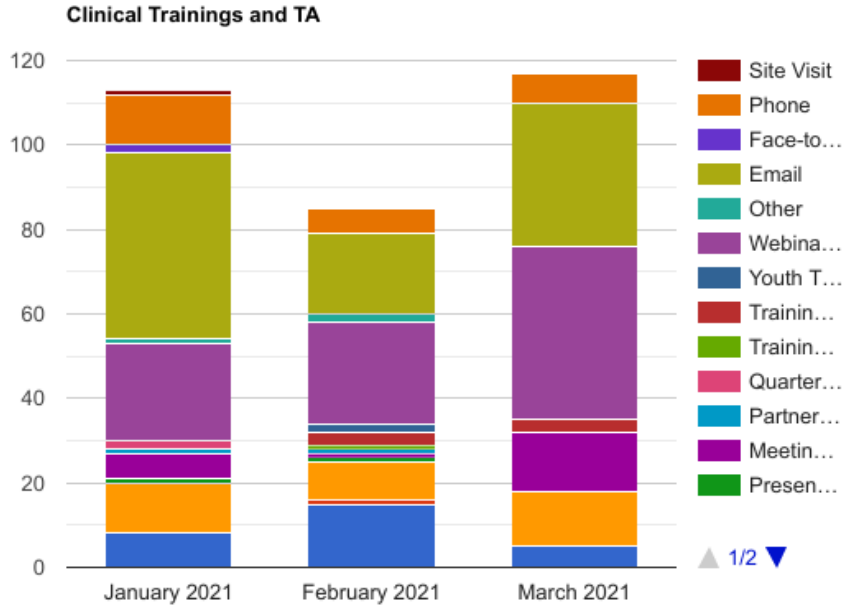


NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Capacity Building

During this period, the NPAIHB provided 159 NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on healthcare management principles and Information Technology.

- ECHO Training or Clinical Consultation (Goal 1) = 34
- TA on Clinical support (Goal 1) = 46
- TA on Healthcare management (Goal 1) = 10
- TA on IT assistance (Goal 1) = 12



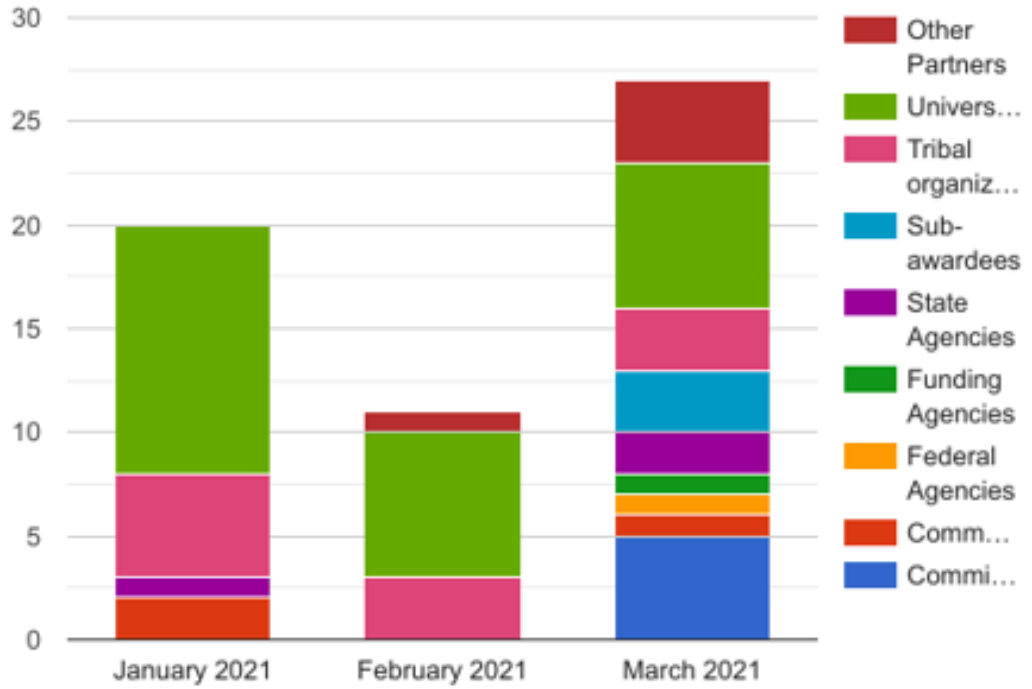
PARTNERSHIPS

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

During this period, the NPAIHB built and maintained effective, collaborative relationships with 58 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.

Partners

Date	Partner Name	Partner Type
01/06/2021	Oregon Health Science University	University
01/09/2021	Oregon Health Science University	University
01/14/2021	ITCA; ANTHC	Tribal Organization
01/14/2021	University of Texas School of Public Health	University
01/14/2021	University of Colorado mHealth Impact Lab	University
01/14/2021	ITCA; ANTHC	Tribal Organization
01/14/2021	University of Texas School of Public Health	University
01/16/2021	Oregon Health Science University	University



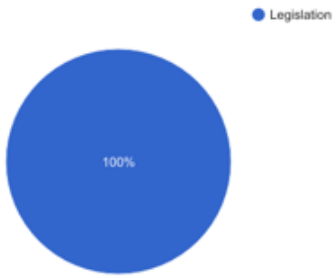
POLICY AND LEGISLATION

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

During this period, the NPAIHB facilitated 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.

During this period, the NPAIHB remained 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 assessed their impact on the Northwest Tribes.

Date	Title	Type
01/25/2021	Dental Therapy stakeholders meeting	Legislation
01/04/2021		Legislation



HEALTH PROMOTION

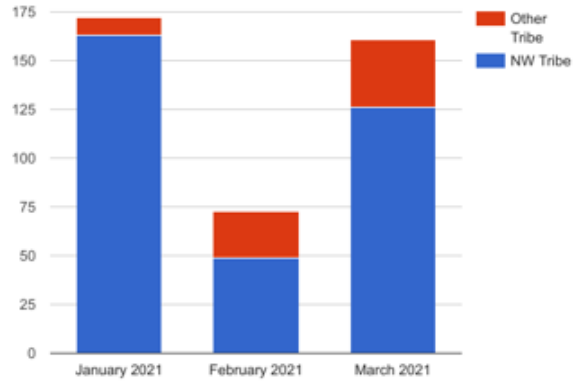
Support health promotion and disease prevention activities occurring among the Northwest Tribes.

During this period, the NPAIHB provided the following capacity building assistance (including training, technical assistance, and resource development) on priority health promotion and disease prevention topics.

Cumulative Health Promotion Activities:

- Calls: 80
- Meetings (external): 38
- Number of presentations provided: 8
    - Number of presentation attendees: 418
- Number of trainings provided: 36
    - Number of training attendees: 561
- Webinar or Zoom: 188

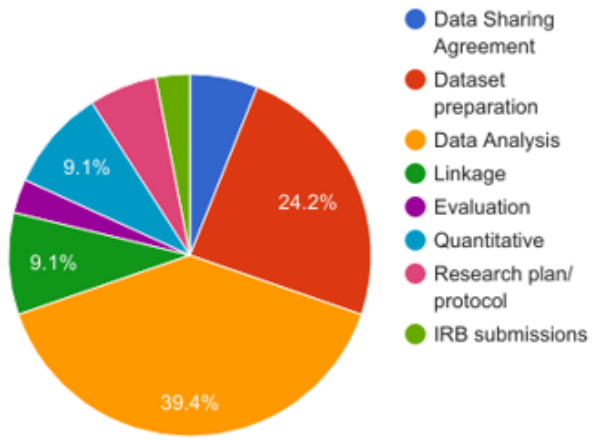
Training on Health Promotion and Disease Prevention Topics



RESEARCH AND SURVEILLANCE

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

During this period, the NW Tribal EpiCenter responded 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. During this period, the NW Tribal EpiCenter assessed 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.



Reports, Articles and Publications

During this period, the NW Tribal EpiCenter communicated the results of its research, surveillance, and capacity building activities to appropriate stakeholders. This information was 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.

Date	Title	Citation
01/31/2021	Suicide surveillance pilot project summary	
01/31/2021	Sovereign Bodies, Sovereign Histories	https://soundcloud.com/two spirittalks/sovereign-bodies-sovereign-histories
01/26/2021	Washington Youth Sexual Healthcare (WYSH) Project Recruitment	
01/22/2021	Youth Access and Experience with Sexual Healthcare	
01/31/2021	WA DOH Semi-Annual Progress Report - TPP	
01/01/2021	Posted NPAIHB Opioid Data Sources Inventory on TECCONNECT (Opioid Group)	
02/01/2021	"It Starts with You": Michael King, newly elected Two Spirit Tribal President	https://www.npaihb.org/it-starts-with-you/
02/28/2021	Completing the Circle	https://soundcloud.com/two spirittalks/completing-the-circle
02/14/2021	to love and mourn in the age of displacement: A Conversation with Alan	https://www.npaihb.org/alan-pelaez-lopez/

Questions or Comments

NPAIHB
Indian Leadership for Indian Health

Strategic Plan Report

01/01/2021 - 03/31/2021

All Projects and Cost Codes

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.

Strategic Priorities

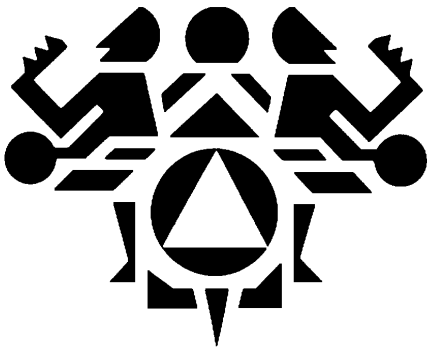
1. **Leadership**
   Be a national leader in tribal public health initiatives and support health infrastructure development for our member tribes.

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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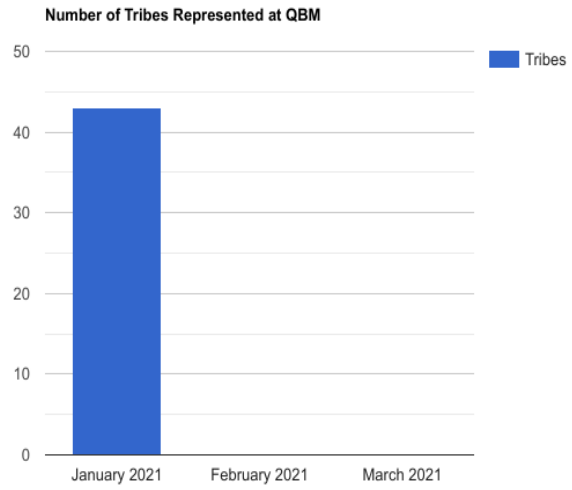
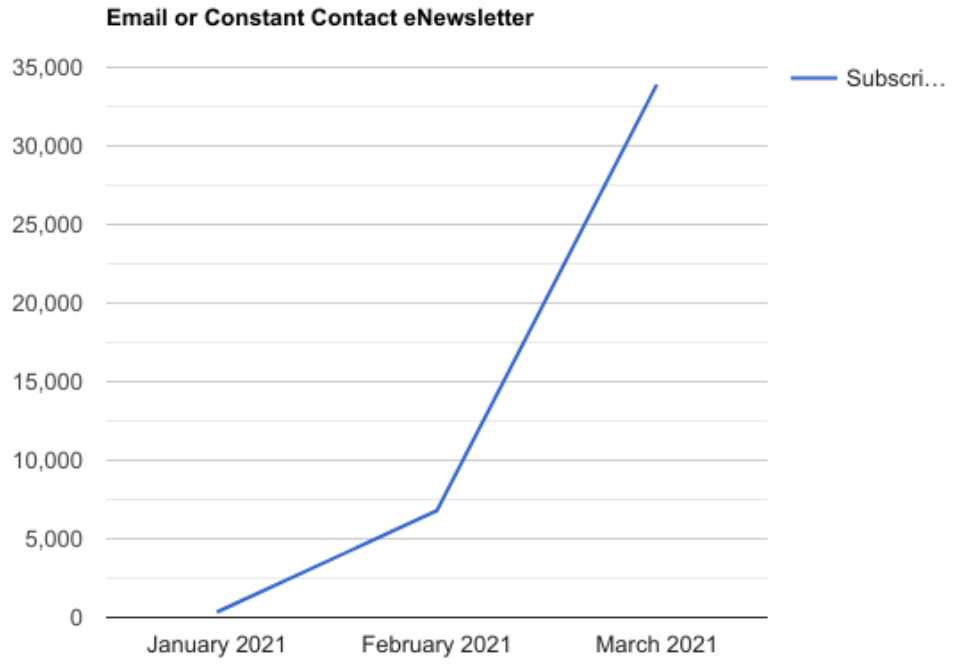
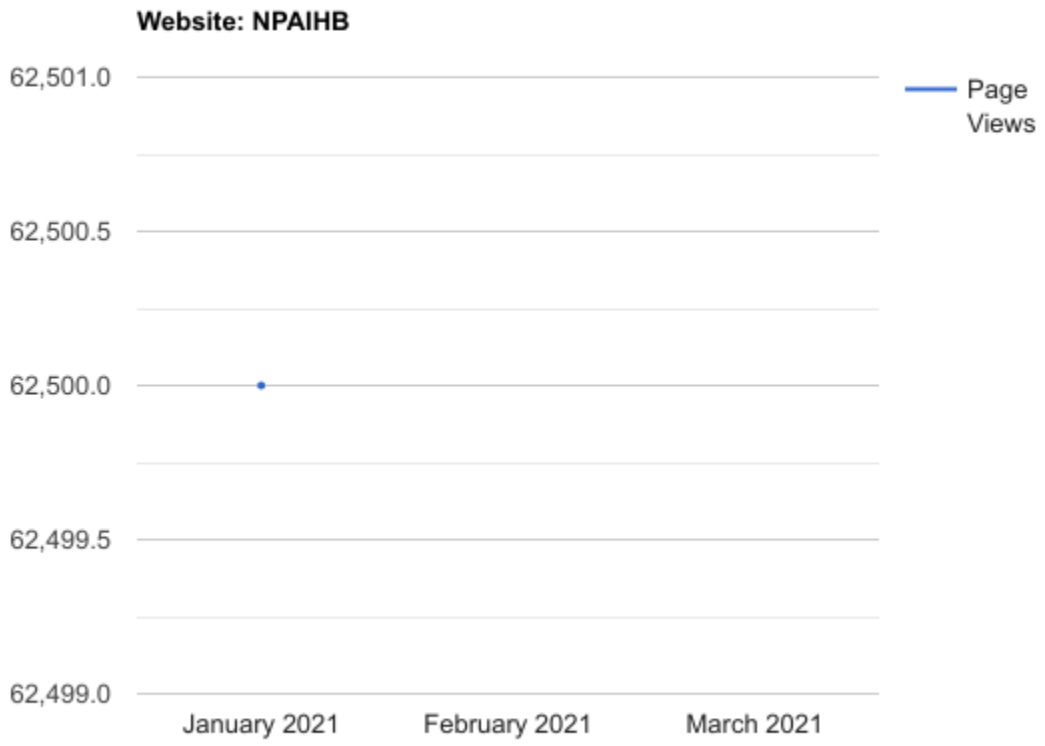


During this period, the NPAIHB utilized the following communication channels to inform the NW Tribes about emerging public health topics and strategies to improve healthcare delivery in tribal settings:

Email or Constant Contact eNewsletters		
Date	Campaign	Subscribers
01/26/2021	NTFSC eNewsletter	169
03/03/2021	Healthy Native Youth	2321
03/25/2021	Opioid Community (154-00)	132
03/25/2021	LGBTQ2S	67
03/01/2021	Indian Country ECHO	17202
03/31/2021	NPAIHB	8735



Websites				
Date	Campaign	Users	Page Views	Sessions
01/01/2021 - 03/01/2021	Indian Country ECHO	3,692	12,309	5,359
01/01/2021 - 03/01/2021	We R Native	33,600	76,607	36,700
01/01/2021 - 03/01/2021	Healthy Native Youth	3,961	10,986	5,900
02/28/2021	Hep C (100-72)	1,458	5,416	2,303
01/01/2021	NPAIHB	28,442	62,556	36,034



Capacity Building

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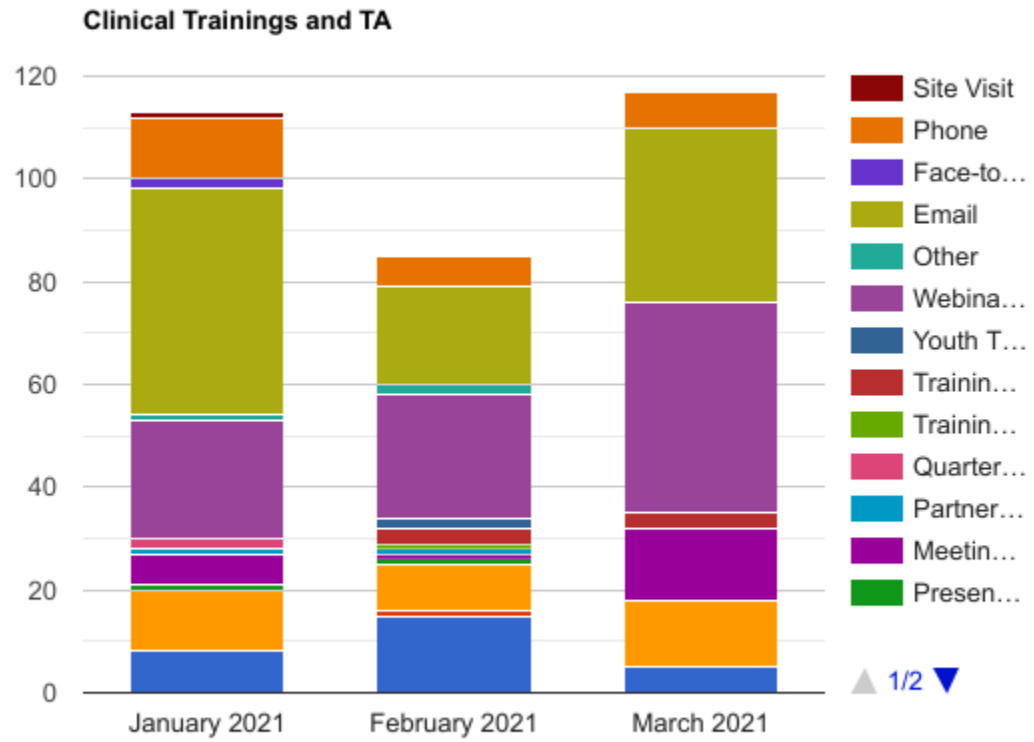
- TA on Healthcare management (Goal 1) = 10
- TA on IT assistance (Goal 1) = 12



Grant Writing

During this period, the NPAIHB researched health-related funding opportunities, disseminated funding announcements to member tribes, and educated federal agencies on strategies to ensure that federal funding opportunities align with the priorities, needs, and organizational capacities of the NW Tribes.

Date	Grant
01/19/2021	Opioid Supplement Monthly Call
01/22/2021	Native American Agriculture Fund: Food Sovereignty Initiatives
01/29/2021	SAMHSA Garrett Lee Smith Youth Suicide Prevention Grant for the NPAIHB THRIVE project
02/04/2021	TOR3
02/16/2021	TOR4 Consortium
02/28/2021	Behavioral Health ECHO
03/04/2021	Disaster sub-award environmental health assistance grant for Warm Springs.

Staff Development

During this period, the NPAIHB built 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.

- Total number of promotions = 2
- Total number of performance reviews = N/A
- Total number of staff hired and onboarded = 6
- Total number of IT helpdesk requests = 0

Staff Trainings	
Date	Description
01/28/2021	QPR
4/5/21	Preventing Harassment and Discrimination in the Workplace
4/5/21	Preventing Bullying in the Workplace

Youth Development

During this period, the NPAIHB helped develop tribal youth into future leaders in healthcare by making NPAIHB meetings and trainings accessible to youth, and by offering internships to interested students.

Date	Topic	Attendees
02/26/2021	2021 Youth Advisors Retreat	16
03/24/2021	Dissertation Committee - Lea Sacca	8
02/05/2021	NNACoE Student Learner Check-in	3
01/20/2021	We R Healers office hours	15
01/27/2021	We R Healers office hours Text Messaging	51
02/03/2021	We R Healers office hours Text Messaging	16
02/17/2021	We R Healers office hours Text Messaging	50
03/03/2021	We R Healers office hours Text Messaging	14
03/10/2021	We R Healers office hours Text Messaging	45
03/24/2021	We R Healers office hours Text Messaging	15
03/31/2021	We R Healers office hours Text Messaging	12
	Total	245

PARTNERSHIPS

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

During this period, the NPAIHB built and maintained effective, collaborative relationships with 58 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.

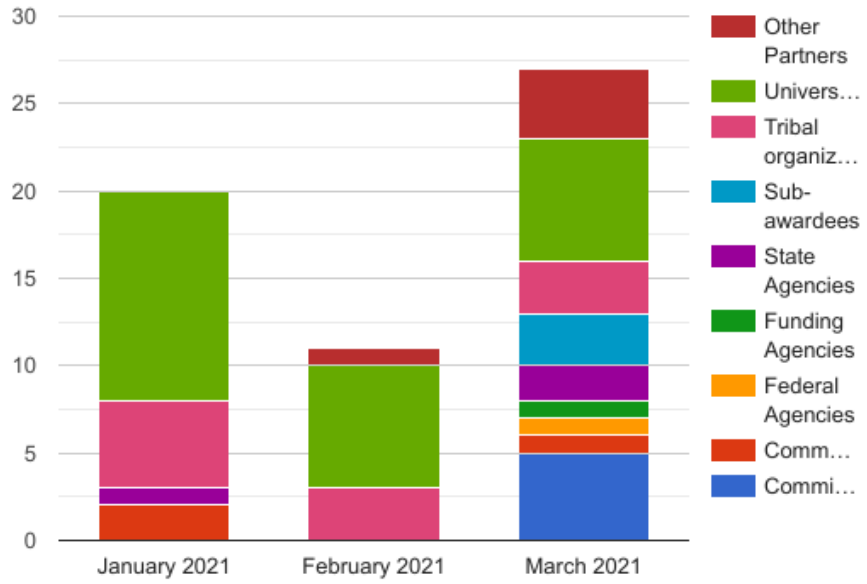
Partners

Date	Partner Name	Partner Type
01/06/2021	Oregon Health Science University	University
01/09/2021	Oregon Health Science University	University
01/14/2021	ITCA; ANTHC	Tribal Organization
01/14/2021	University of Texas School of Public Health	University
01/14/2021	University of Colorado mHealth Impact Lab	University
01/14/2021	ITCA; ANTHC	Tribal Organization
01/14/2021	University of Texas School of Public Health	University
01/16/2021	Oregon Health Science University	University
01/22/2021	ITCA; ANTHC	Tribal Organization
01/22/2021	University of Texas School of Public Health	University
01/22/2021	Oregon Health Science University	University
01/26/2021	University of Colorado	University
01/28/2021	ITCA; ANTHC	Tribal Organization

01/28/2021	University of Texas School of Public Health	University
01/30/2021	Oregon Health Science University	University
01/27/2021	Stronghearts native helpline	CBO
02/04/2021	University of Colorado mHealth Impact Lab	University
02/04/2021	University of Wisconsin (Social Media Adolescent Health Research Team)	University
01/06/2021	University of Washington	University
01/15/2021	The Wave	CBO
01/15/2021	Columbia River Intertribal Fish Commission	Tribal Organization
01/27/2021	Washington State Department of Agriculture	State Agency
02/10/2021	ChildTrends	Other
02/10/2021	Portland State University	University
02/17/2021	Navajo, PIMC	Tribal Organization
02/19/2021	Oregon Health Science University	University
02/25/2021	University of Colorado mHealth Impact Lab	University
02/24/2021	ITCA; ANTHC	Tribal Organization
02/24/2021	University of Texas School of Public Health	University
02/22/2021	Northwest Washington Indian Health Board	Tribal Organization
03/03/2021	Lines for Life	Other
03/04/2021	Behavioral Health Aide Education Program Monthly Meeting	Committee
03/04/2021	Northwest Indian College	Sub-Awardee
03/04/2021	didgwalic Wellness Center	Tribal Organization

03/04/2021	Northwest Indian College	University
03/04/2021	didgwalic Wellness Center	Urban Indian Clinics, Agencies, Sites
03/04/2021	Yellowhawk Tribal Health Clinic	Other
03/17/2021	University of Colorado mHealth Impact Lab	University
03/17/2021	National American Indian/Alaska Native Adolescent Sexual Health Work Group	Committee
03/17/2021	National Indian Child Welfare Association; National Indian Health Board;	CBO
03/17/2021	Department of Health & Human Services: IHS, OPA,	Federal Agency
03/17/2021	WA & OR Departments of Health and Education, Oregon Youth Authority;	State Agency
03/17/2021	Alaska Native Tribal Health Consortium; Inter Tribal Council of Arizona,	Sub-Awardee
03/17/2021	Northwest Portland Area Indian Health Board Healthy Native Youth Project	Tribal Organization
03/17/2021	University of Texas Health & Science Center at Houston; University of Iowa ATTC	University
03/17/2021	National Council on Urban Indian Health, Native American Youth and Family Center	Urban Indian Clinics, Agencies, Sites
03/18/2021	Healthy Native Youth Project Partners Work Group	Committee
03/18/2021	Alaska Native Tribal Health Consortium; Inter Tribal Council of Arizona	Sub-Awardee
03/18/2021	Northwest Portland Area Indian Health Board Healthy Native Youth & WYSH Projects	Tribal Organization
03/18/2021	University of Texas Health & Science Center	University

03/19/2021	Oregon Health Science University	University
03/30/2021	Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes Workgroup	Committee
03/30/2021	WA DOH	State Agency
03/14/2021	Northwest Native American Center of Excellence	Committee
03/14/2021	Oregon Health and Science University	University
03/24/2021	University of Texas School of Public Health	University
02/05/2021	Oregon Health Science University	University
03/01/2021	CDC Alzheimer's Disease Program Healthy Aging Branch (Proposed)	Funding Agency



Coalition, Alliance, or Workgroups

During this period, the NPAIHB actively contributed to 40 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.

Date	Title	Number of Attendees	Number of Tribes
01/11/2021	CHAP Advisory Workgroup	14	0
01/21/2021	HIV MetaECHO	14	0
01/25/2021	RWJF COVID ECHO group	12	0
01/26/2021	Native WYSE Choices - Advisory Board	12	0
01/20/2021	TECPHI CoP Data Practice Group Meeting	18	0
01/27/2021	CSTE AI/AN COVID-19 Mortality Workgroup	18	0
01/19/2021	Behavioral Health Committee at the NPAIHB QBM	10	4
01/29/2021	Healing of the Canoe	8	2
01/04/2021	Washington Dental Access Campaign mtg	8	0
01/04/2021	Oregon Dental Access Campaign	12	2
01/26/2021	ATNI	80	43
01/27/2021	NPAIHB Data Dashboards Meeting	2	0
01/13/2021	NPAIHB Data Dashboards Meeting	2	0
01/11/2021	NPAIHB Biostat Core	15	0
02/08/2021	CHAP Advisory Workgroup	10	16
02/12/2021	Impact of COVID19 on suicide among Tribes and Tribal communities	10	0

01/22/2021	Tribal Data Sharing Strategies Workgroup Meeting #1	18	0
01/27/2021	CSTE AI/AN COVID-19 Manuscript Workgroup Meeting	10	0
01/01/2021	Tribal Background and Moving Forward Meeting with Nine Tribes of Oregon	20	8
02/19/2021	University of Oregon President's Diversity Advisory Community Council Winter Meeting	20	0
02/17/2021	Native Advocacy Workgroup for Trans Health	6	0
02/26/2021	2021 Youth Advisors Retreat	16	0
02/11/2021	Oregon Dental Access Campaign	12	2
03/04/2021	Healthy Native Youth Project Partnership Workgroup Meeting	14	0
03/17/2021	National AI/AN Adolescent Sexual Health Work Group	40	1
03/18/2021	Healthy Native Youth Project Partnership Workgroup Meeting	10	0
03/30/2021	Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes Workgroup - WA DOH	9	0
03/19/2021	Meeting with Swedish Hospital System DEI	3	0
03/10/2021	SOGI Train the Trainer	6	1
03/17/2021	Native Advocacy Workgroup for Trans Health	7	0
03/26/2021	2S & LGBTQIA+ Publication Collaboration meeting	4	0
03/15/2021	Reg4 BHB Recovery & Wellness Subcommittee Meeting	10	0
03/17/2021	National AI/AN Adolescent Health Work Group	30	0

01/27/2021	Tribal Emergency Preparedness with OHA	15	5
02/10/2021	OR Tribal Emergency Response Coalition	17	3
02/24/2021	OR Tribal Emergency Response Coalition	17	8
03/03/2021	OR Tribal Emergency Preparedness Coalition - Honoring Tracy	15	6
03/10/2021	OR Tribal Emergency Preparedness Coalition	15	9
03/01/2021	WA State Opioid & Overdose Response Plan Workgroup Meeting	25	0
03/01/2021	Data Workgroup Meeting - WA State Opioid & Overdose Response Plan - Goal 4	15	0
	Total	599	110

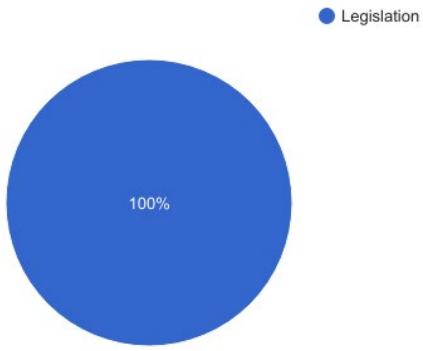
POLICY AND LEGISLATION

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

During this period, the NPAIHB facilitated 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.

During this period, the NPAIHB remained 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 assessed their impact on the Northwest Tribes.

Date	Title	Type
01/25/2021	Dental Therapy stakeholders meeting	Legislation
01/04/2021		Legislation



HEALTH PROMOTION

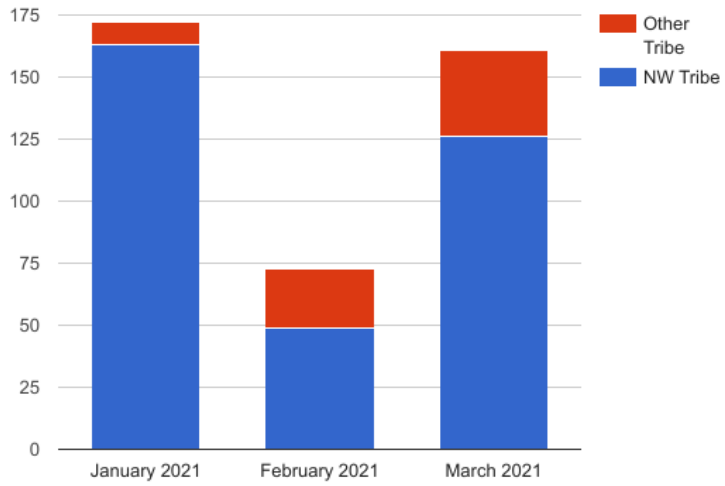
Support health promotion and disease prevention activities occurring among the Northwest Tribes.

During this period, the NPAIHB provided the following capacity building assistance (including training, technical assistance, and resource development) on priority health promotion and disease prevention topics.

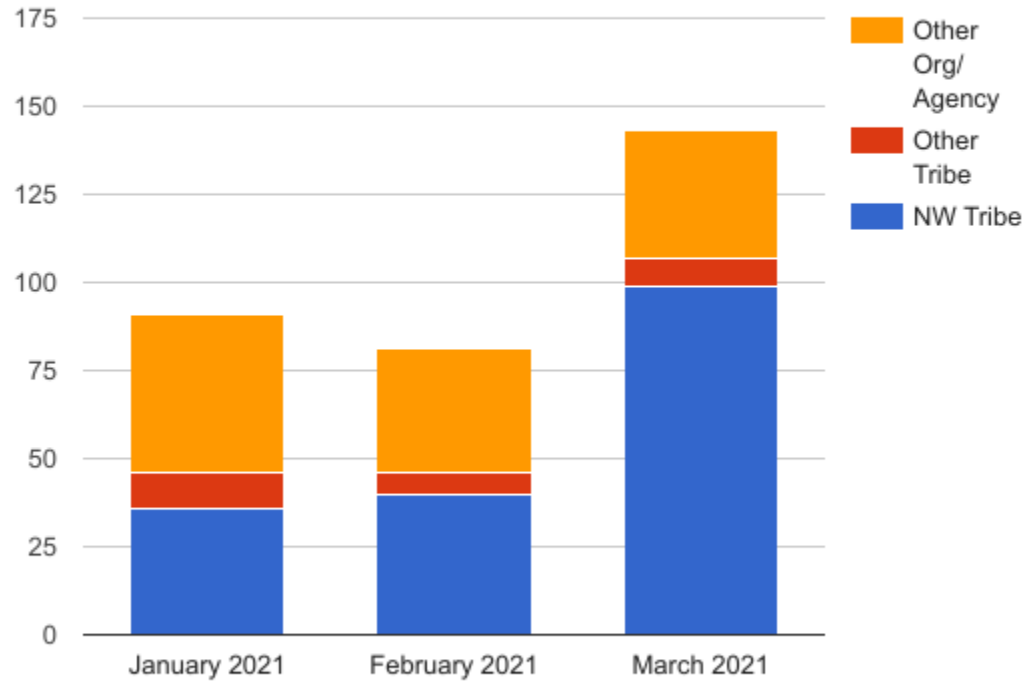
Cumulative Health Promotion Activities:

- Calls: 80
- Meetings (external): 38
- Number of presentations provided: 8
    - Number of presentation attendees: 418
- Number of trainings provided: 36
    - Number of training attendees: 561
- Webinar or Zoom: 188

Training on Health Promotion and Disease Prevention Topics



Technical Assistance on Health Promotion and Disease Prevention Topics



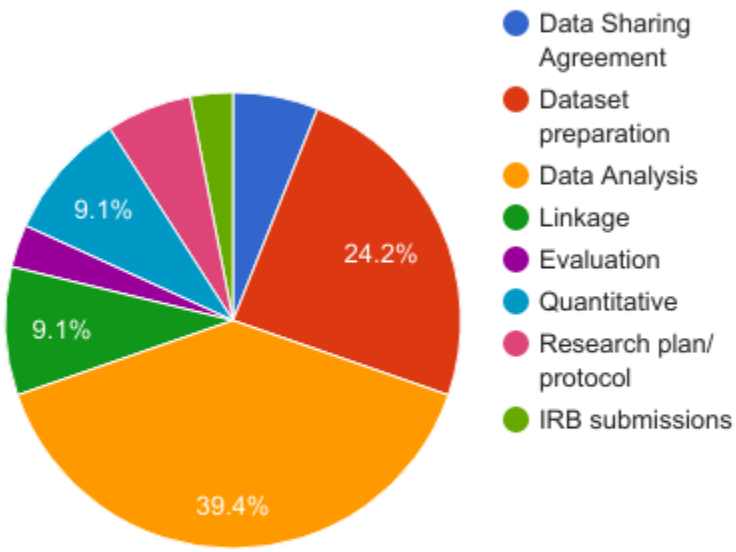
NW Tribal Site Visits

Date	Project	Tribe
01/07/2021	IHS Environmental Public Health (100-07)	Yakama Indian Nation
01/13/2021	ECHO Project (000-01), Hepatitis C Virus Treatment (100-72)	Lummi Nation
02/02/2021	NARCH 9: Asthma Management (127-73)	Yakama Indian Nation
02/27/2021	ECHO Project (000-01)	Lummi Nation
03/18/2021	ECHO Project (000-01)	Lummi Nation
03/20/2021	ECHO Project (000-01)	Lummi Nation

RESEARCH AND SURVEILLANCE

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

During this period, the NW Tribal EpiCenter responded 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. During this period, the NW Tribal EpiCenter assessed 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.

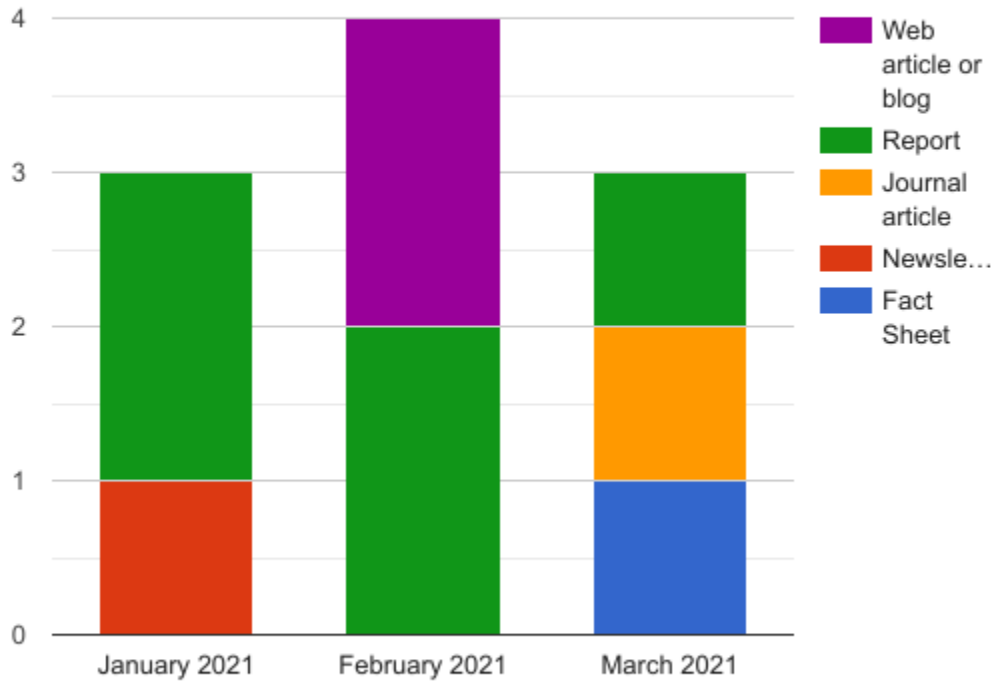


Reports, Articles and Publications

During this period, the NW Tribal EpiCenter communicated the results of its research, surveillance, and capacity building activities to appropriate stakeholders. This information was 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.

Date	Title	Citation
01/31/2021	Suicide surveillance pilot project summary	
01/31/2021	Sovereign Bodies, Sovereign Histories	https://soundcloud.com/two spirittalks/sovereign-bodies-sovereign-histories
01/26/2021	Washington Youth Sexual Healthcare (WYSH) Project Recruitment	
01/22/2021	Youth Access and Experience with Sexual Healthcare	
01/31/2021	WA DOH Semi-Annual Progress Report - TPP	
01/01/2021	Posted NPAIHB Opioid Data Sources Inventory on TECCONNECT (Opioid Group)	
02/01/2021	“It Starts with You”: Michael King, newly elected Two Spirit Tribal President	https://www.npaihb.org/it-starts-with-you/
02/28/2021	Completing the Circle	https://soundcloud.com/two spirittalks/completing-the-circle
02/14/2021	to love and mourn in the age of displacement: A Conversation with Alan	https://www.npaihb.org/alan-pelaez-lopez/

	Pelaez Lopez	
02/28/2021	Final Report	
02/16/2021	Idaho Opioid & Drug Overdose Data Brief	
03/30/2021	Racial Misclassification and Disparities in Neonatal Abstinence Syndrome among American Indians and Alaska Natives	
03/01/2021	Ometeotl / nya:wëh sgë:nö' / haa marúawe / Tēnā koutou katoa.	https://soundcloud.com/twospirittalks/ha-shli
03/01/2021	Distributed finalized Idaho Overdose Mortality Data Brief	



Portland Area IHS Institutional Review Board

During this period, the NW Tribal EpiCenter protected 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.

Epi Surveillance TA Requests

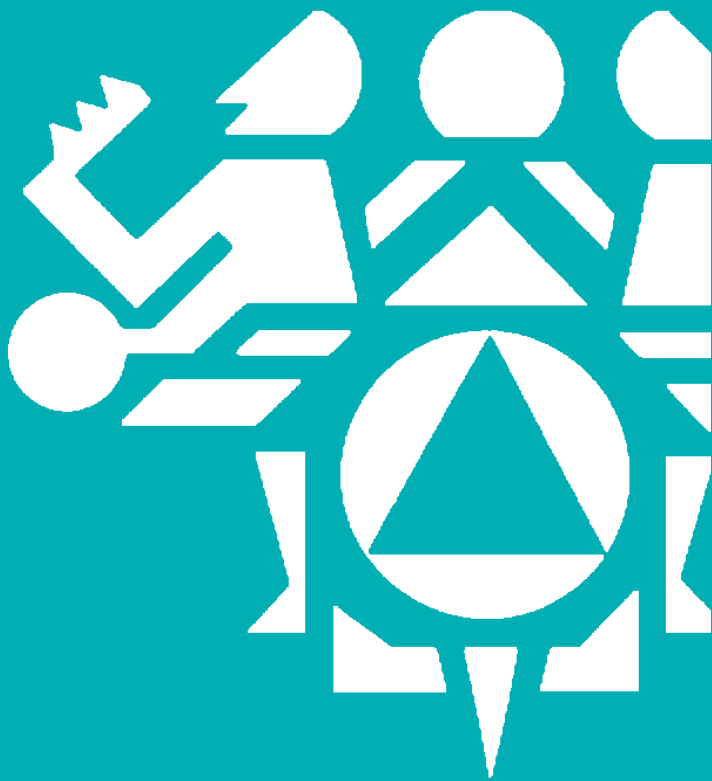
During this period, the NW Tribal EpiCenter provided 5 NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on epidemiologic skills and research methods.

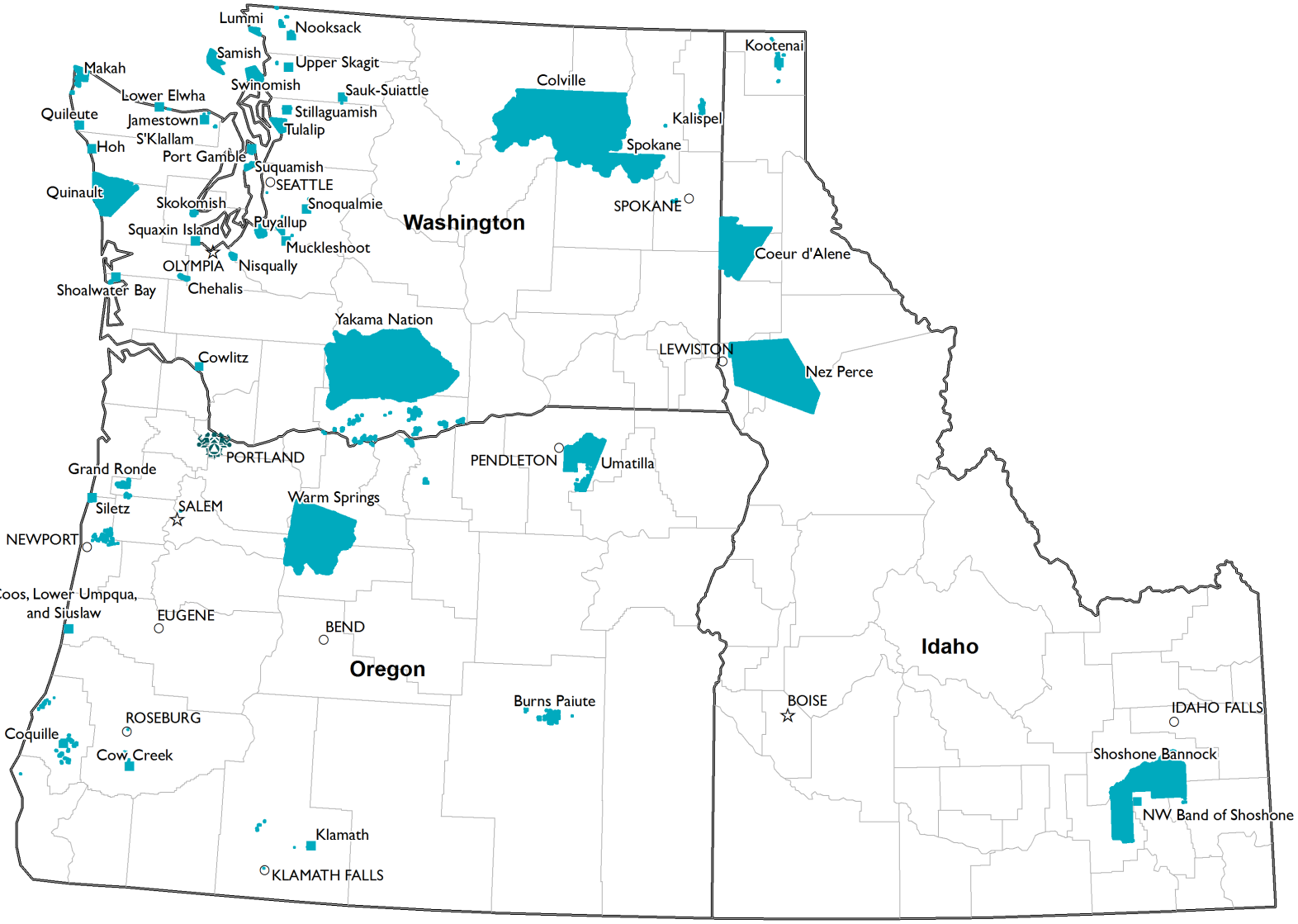
Date	Title	NW Tribes
01/14/2021	Intro to harm reduction	Lummi Nation
02/24/2021	Nisqually - 2SLGBTQ+ Affirming Environments Training	Nisqually Tribe
02/25/2021	Virtual MAT Waiver Training	Chehalis Tribe, Skokomish Tribe, Warm Springs Tribes, Yakama Indian Nation
03/10/2021	SOGI Train the Trainer	Cowlitz Tribes
03/15/2021	2SLGBTQ+ Affirming Environments Training	Nisqually Tribe

NPAIHB

Indian Leadership for Indian Health

2020 - 2025 Strategic Plan




Lummi
Nooksack
Samish
Upper Skagit
Makah
Swinomish
Sauk-Suiattle
Lower Elwha
Quileute
Jamestown
Stillaguamish
Tulalip
S'Klallam
Hoh
Port Gamble
Suquamish
SEATTLE
Quinault
Skokomish
Snoqualmie
Squaxin Island
Puyallup
Muckleshoot
OLYMPIA
Nisqually
Shoalwater Bay
Chehalis
Washington
Colville
Kootenai
Kalispel
Spokane
SPOKANE
Coeur d'Alene
Yakama Nation
Cowlitz
LEWISTON
Nez Perce
PORTLAND
PENDLETON
Umatilla
Grand Ronde
Siletz
SALEM
Warm Springs
NEWPORT
Coos, Lower Umpqua, and Siuslaw
EUGENE
BEND
Oregon
Idaho
Burns Paiute
BOISE
IDAHO FALLS
ROSEBURG
Coquille
Cow Creek
Shoshone Bannock
NW Band of Shoshone
Klamath
KLAMATH FALLS

Executive Summary

Since March of 2020, the COVID-19 pandemic has demonstrated the critical yet often invisible role of public health agencies in the Indian health system and the significant health disparities of American Indian and Alaska Native people. The long history of underfunding of the Indian health system, social determinants of health, and systemic racism are all contributing factors to the current health status of Native people. At the forefront of improving the health of Native people is fulfillment of the federal trust responsibility and treaty obligations to Tribal Nations. We are hopeful that President Biden's reaffirmation of the federal trust and treat obligations to Tribal Nations and increased funding will support and strengthen Tribes through the pandemic.

During this pandemic, our staff at the Northwest Portland Area Indian Health Board (NPAIHB) stepped up to the challenge like never before - doing the critical work of surveillance, contact tracing, clinical support, and health messaging - under exceptionally challenging conditions. This required immense creativity, flexibility, teamwork, technical knowhow, and dedication in service to our Tribes.

This 2020-2025 strategic plan will ensure that we continue to serve at the direction of Northwest Tribes. The plan was carefully and thoughtfully put together with input from our staff and Tribal Delegates. It reflects the passion, expertise, and dedication of tribal public health and health care professionals, who deliver culturally appropriate and high-quality health programs and services to our Northwest Tribes. It is these qualities and long-range vision that makes me feel assured of the NPAIHB's role as a national public health leader for the next 5, 10, and 50 years.

Next year marks the NPAIHB's 50th anniversary. A momentous milestone and opportunity to reflect upon how far we have come under the fearless leadership of our Tribal Delegates and look forward to the future that will grow from our organizational vision and guiding principles.

Laura Platero
Executive Director,
Northwest Portland Area Indian Health Board

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 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.

From left to right: Pauline Stearns, < photo bomb >, Tom Austin, Tom Siedl, Terry Smith, Mary Marschand, Shirley Palmer

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Our Vision:

Health and Wellness for the 7th Generation

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.

Nez Perce Men on Horseback - July 1906

Strategic Priorities

1

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

2

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

3

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

4

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

5

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

Administrative 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

Administrative Leadership

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.

2

Partnerships

Strengthen regional and national Partnerships to ensure tribal access to the best possible health 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 to promote health equity.

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.

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, and that the federal government is fulfilling their trust and treaty obligations to Tribal Nations.

3. 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.

Continues on next page...

3 ...Continued

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.

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 assuming 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).

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

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 principles 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.

Continues on next page...

4 ...Continued

Health Promotion

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

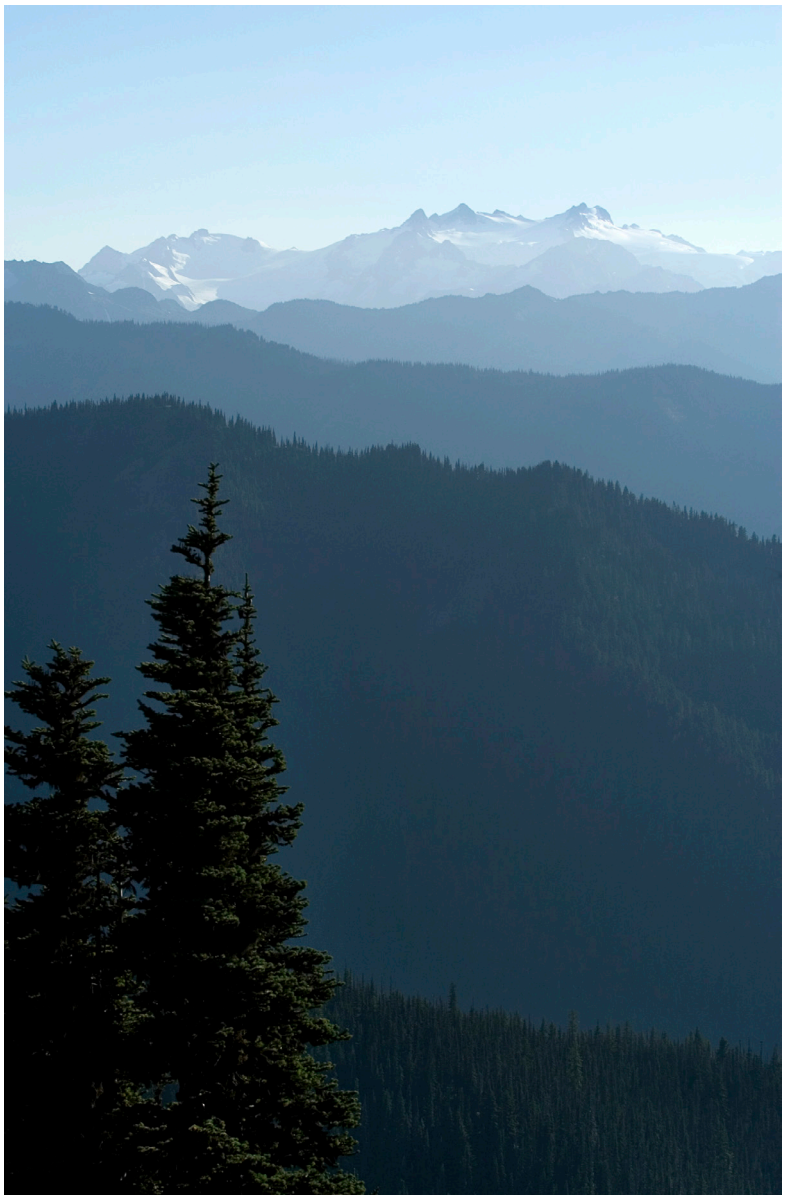
5. NPAIHB projects will facilitate regional planning and collaboration by developing and implementing intertribal action plans that address priority health topics, and by hosting regional trainings, meetings, webinars, Extension for Community Healthcare Outcomes (ECHO) trainings, and conference calls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

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;

Continues on next page...

5 ...Continued

Research and Surveillance

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

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

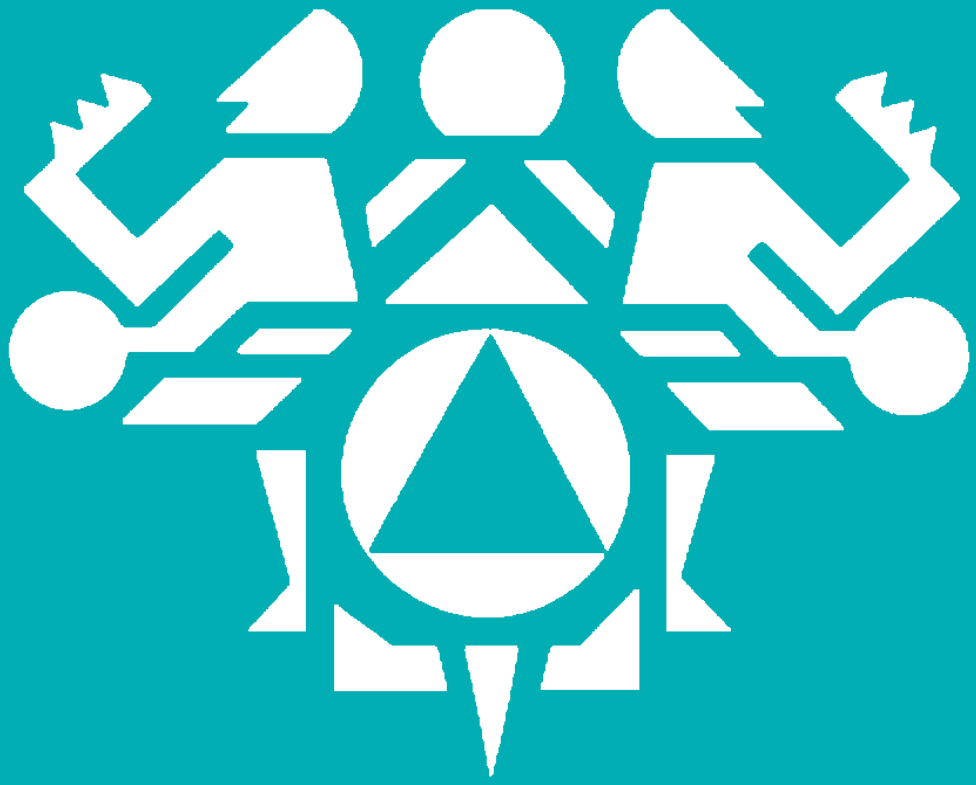
- Board leadership guide and manage organizational growth: Larger Board staff, Acquire own building
- Board staff create new avenues to share tribal health best practices and feature model programs in the Pacific NW
- QBM meetings are fully represented by NW Tribes and Youth Delegates, and are well-attended by other community stakeholders
- Thriving Board programs address our most vulnerable community members: maternal and child health, youth, elders, and veterans
- Board staff 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 works together to tackle challenging regional issues, including: Facilities construction, State-wide CHSDA, climate change, and environmental health

10-Year Organizational Goals

- Our Board successfully advocates for and receives full funding for health services at the State and Federal level
- Our Board inspires and prepares our Tribal Public Health workforce, including the next wave of Indian policy leaders
- Our EpiCenter has a robust research agenda that is Native-led and Native-staffed
- Our Board tackles challenging regional issues, including: building a Regional Specialty Referral Center(s) and/or IHS Hospital(s)
- Our Board is prepared to assume DHHS, IHS, State functions, when best for our Tribes or those services

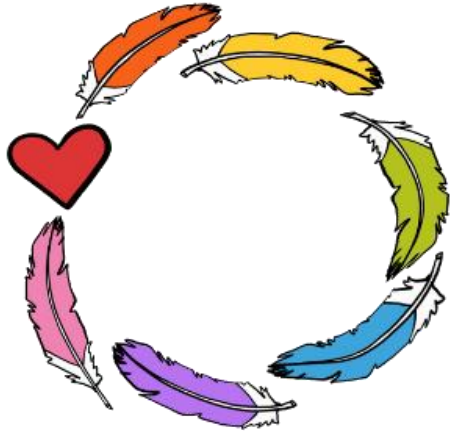
The People Spoke: This is their Vision

- 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 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.



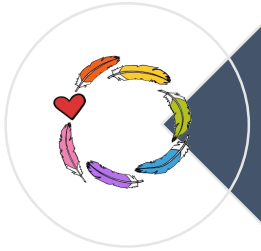
Northwest Portland Area Indian Health Board
2121 SW Broadway, Ste. 300
Portland, Oregon 97201
503.228.4185
www.npaihb.org

Paths (Re)Membered Project

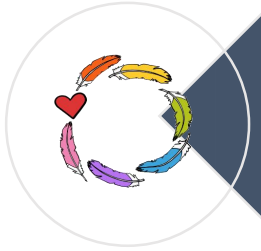


Itai Jeffries, PhD (they/them), Jessica Leston, MPH (she/her),
& Morgan Thomas (they/them)
Northwest Portland Area Indian Health Board

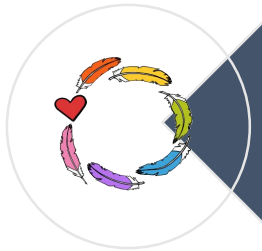
Logo by: Lorenzo Yazzie



Research and Data

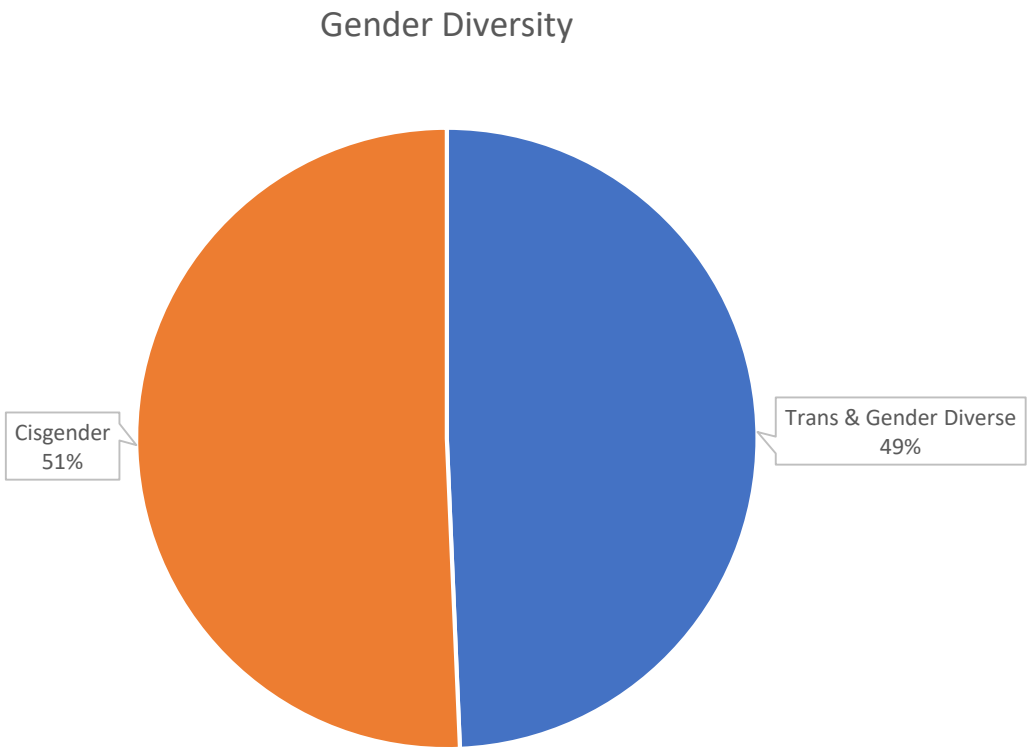


Community Engagement

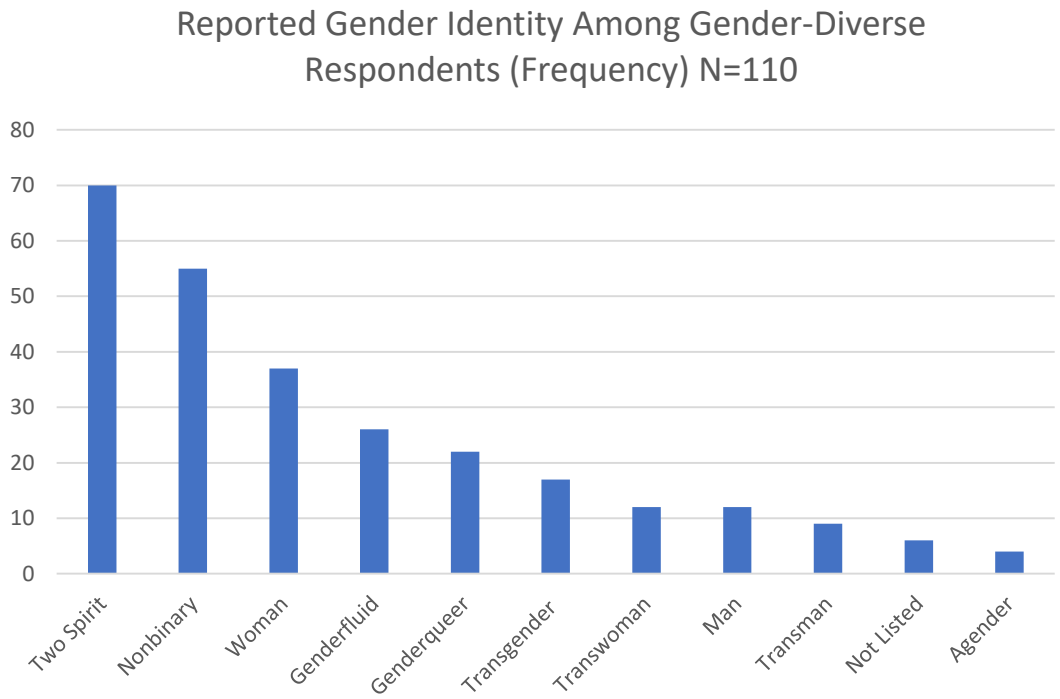


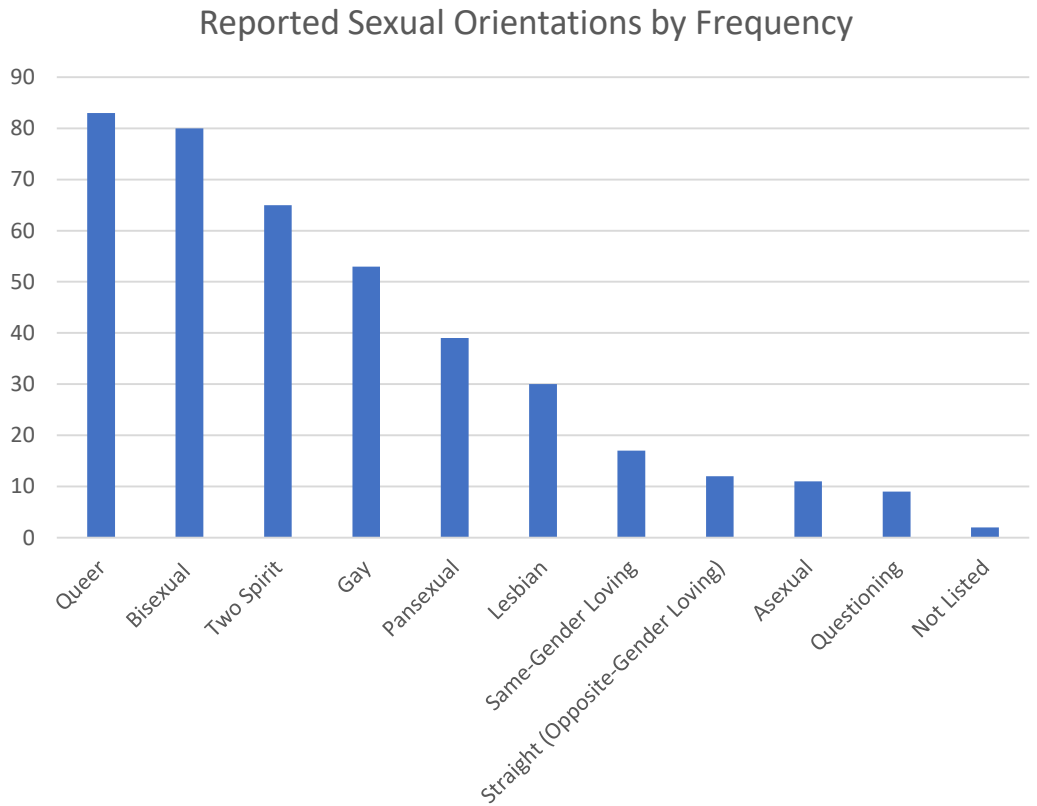
Advocacy

Two Spirit & LGBTQ+ Pride & Connectedness Survey



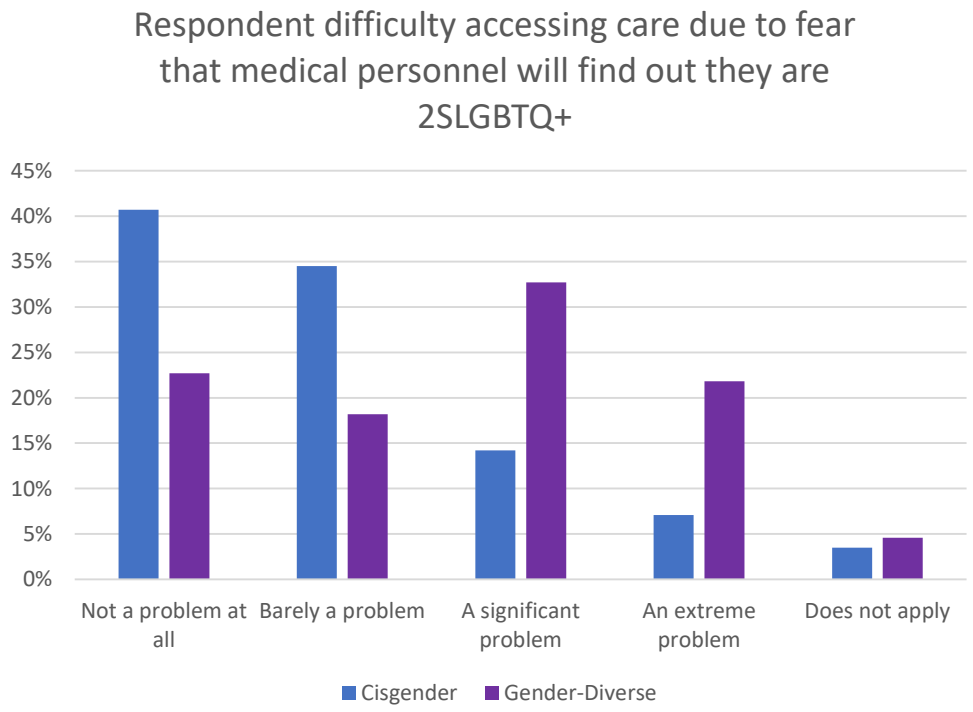
2SLGBTQ Pride and Connectedness Survey, NPAIHB 2020; N=223

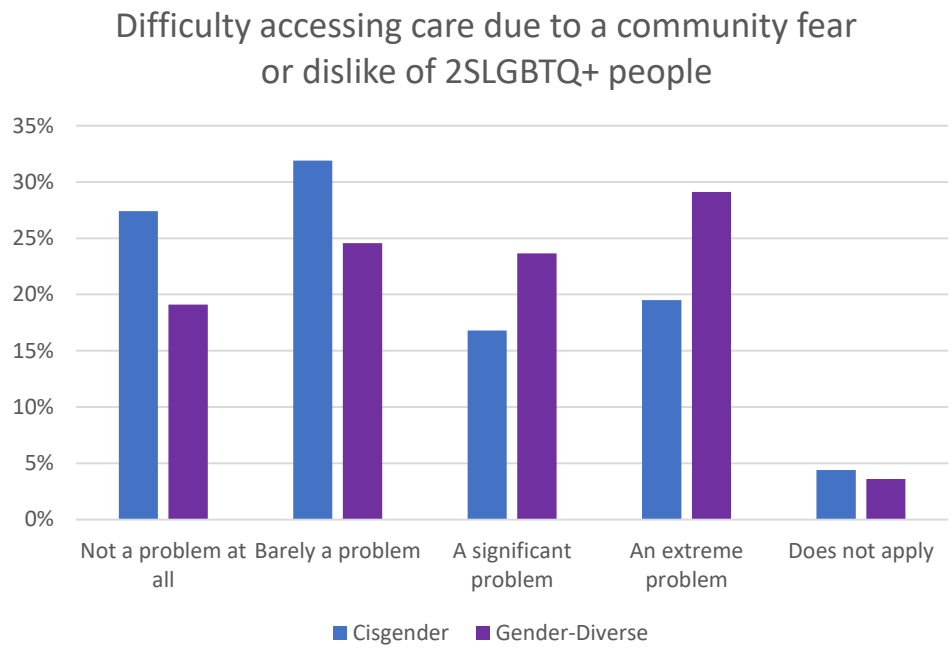




2SLGBTQ Pride and Connectedness Survey, NPAIHB 2020; N=223

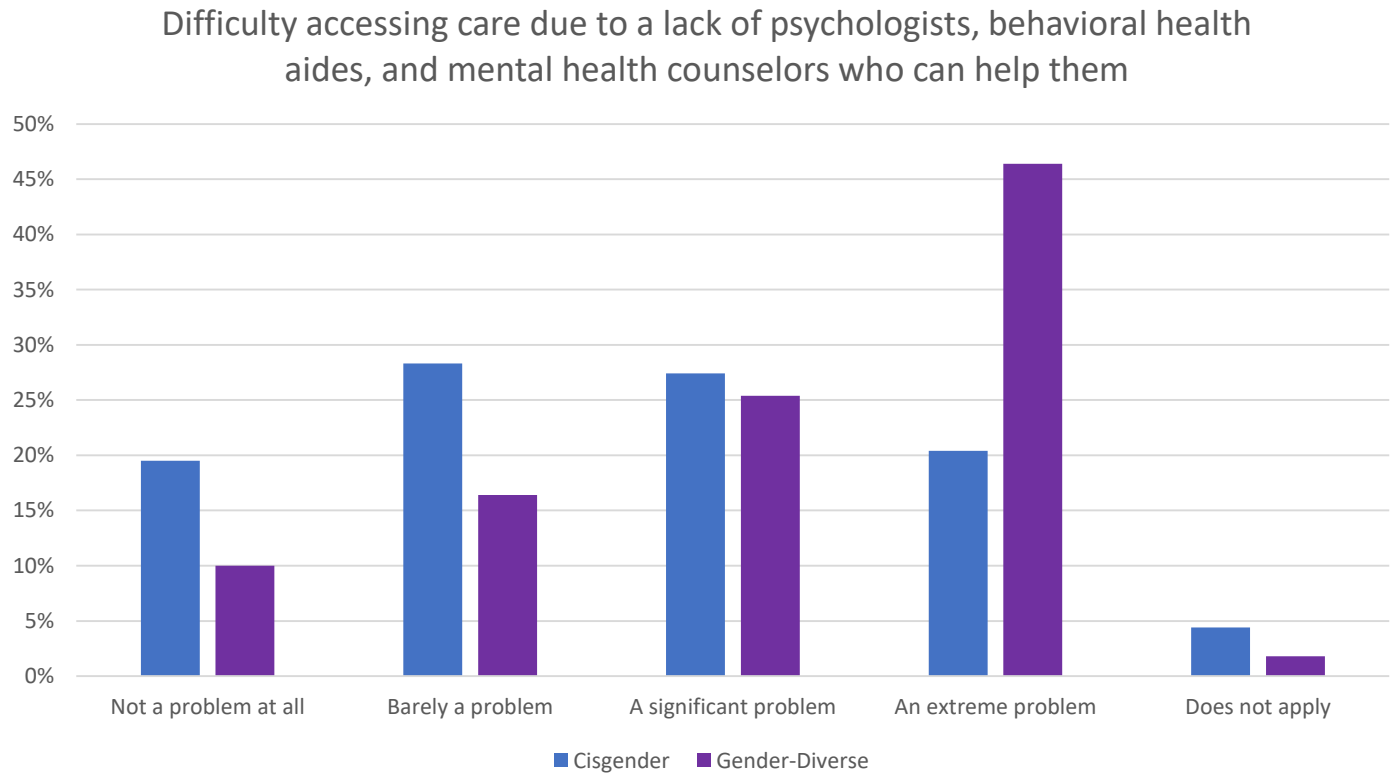
Gender-Diverse Indigenous people face significant barriers to healthcare access.





2SLGBTQ Pride and Connectedness Survey, NPAIHB 2020; N=223

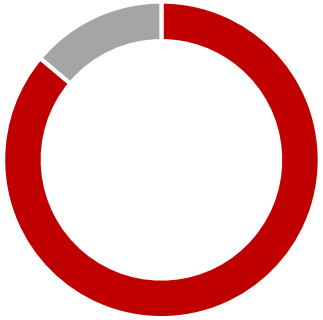
Gender-Diverse Indigenous people face significant barriers to healthcare access.



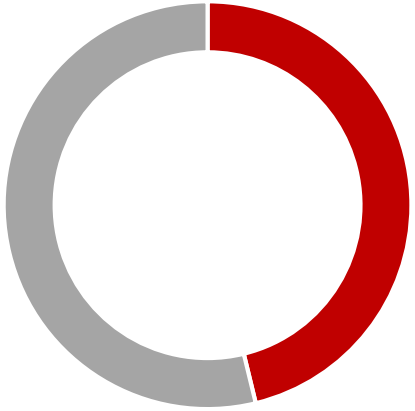
2SLGBTQ Pride and Connectedness Survey, NPAIHB 2020; N=223

Gender-Diverse Indigenous people face significant mental health challenges.

Over 86% of respondents have thought about suicide, wished they were dead, or wished they could go to sleep and not wake up at least once in their life.



Nearly half of respondents have attempted suicide at least once in their life.



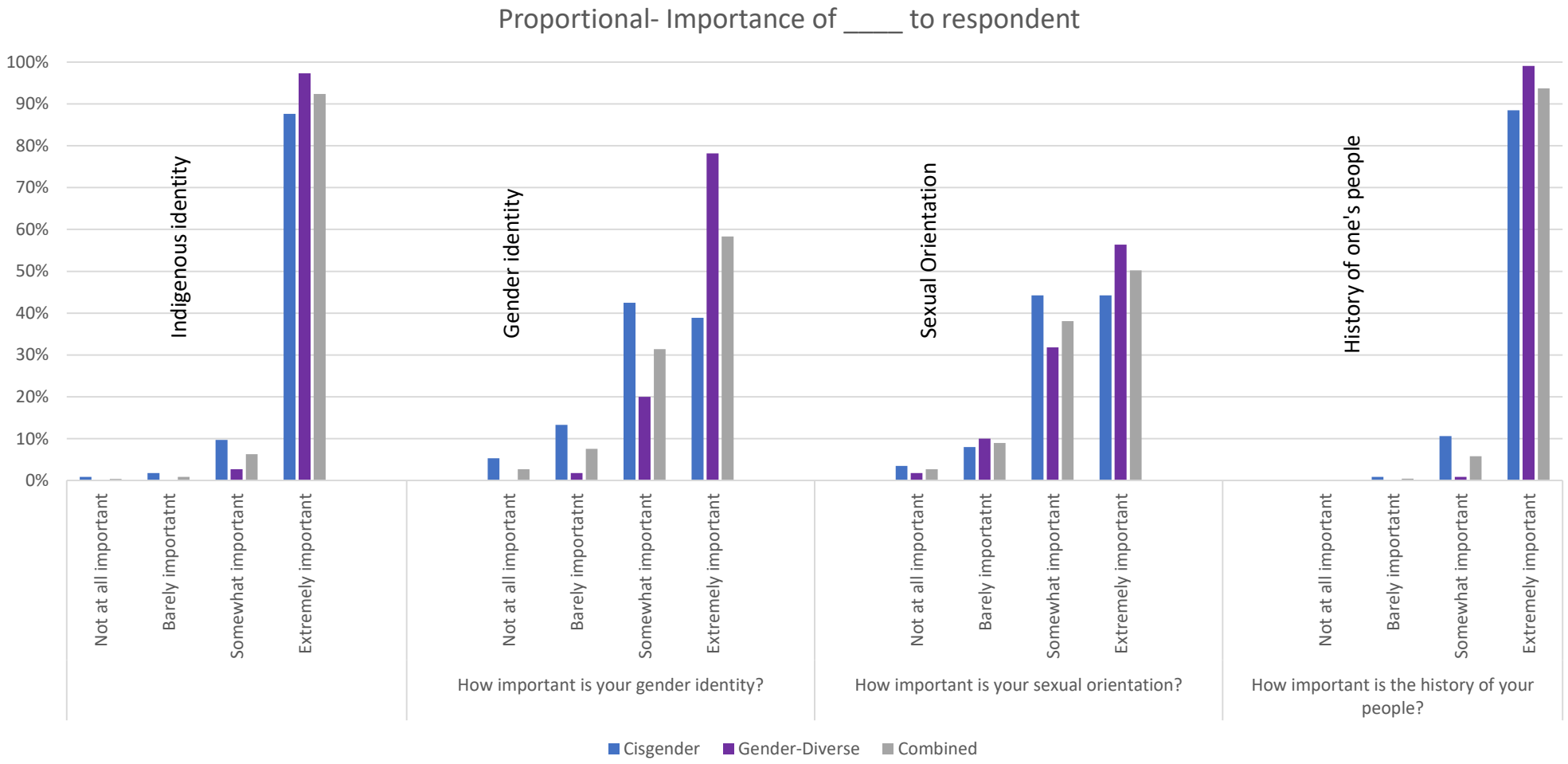
2SLGBTQ Pride and Connectedness Survey, NPAIHB 2020; N=223

Use of correct name and pronouns associated with a **56% decrease** in suicide attempts.

Trans youth who have socially transitioned have levels of anxiety and depression **comparable to their cisgender peers.**

Russell ST, Pollitt AM, Li G, Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. *J Adolesc Health*. 2018;63(4):503-505. doi:10.1016/j.jadohealth.2018.02.003

Gender-Diverse Indigenous people are significantly connected to their communities…



2SLGBTQ Pride and Connectedness Survey, NPAIHB 2020; N=223

Trans & Gender-Affirming Care Strategic Vision and Action Plan

bit.ly/2slgbtqstrategicplan

Native Trans Advocacy Workgroup:
Mattee Jim, Itai Jeffries, Lane Holcomb, Lanny McCanta, Rick Haverkate, Jessica Leston, Morgan Thomas

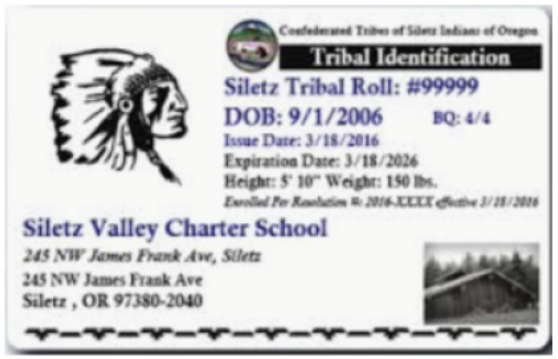
TABLE OF CONTENTS

Best Practice Care

- Clinical provider applies the latest electronic health records (EHR) solutions to meet the needs of gender-diverse patients.
- Provide culturally-attuned care to all Indigenous patients.
- Provide access to a continuum of gender-affirming care including gender-affirming medications and surgery.
- Routinely collect aggregate data on sexual orientation and gender identity (SOGI) and conduct meaningful analysis of that data for all patients.
- Ensure commitment to gender-affirming care in pharmacy.
- Ensure commitment to gender-affirming behavioral health care.
- Foster a clear understanding of the clinic's abilities to provide competent gender-affirming care as well as its current limitations, and be transparent with patients about each.

APPENDIX B:
EXAMPLE TRIBAL ID DOCUMENTS

Confederated Tribes of Siletz Indians



The Confederated Tribes of Siletz Indians does not include a gender marker on their Tribal ID Card.

Their Tribal Identification Request Form therefore does not need to ask about gender.

FORM # ENROLL-008

Confederated Tribes of Siletz Indians
Enrollment Department
201 SE Swan Ave
PO Box 549
Siletz, Oregon 97380-0549
Telephone: (541)444-8258 ● Toll Free: (800) 922-1399 ext. 1258
E-Mail: angelar@ctsi.nsn.us

- Enrollment Staff Use -
Rec'd: _____
By: _____

Entered: _____
By: _____

Siletz Tribal Identification (ID) Request

Please print clearly in blue or black ink

INSTRUCTIONS: If you are not able to come into the Enrollment office to have your Tribal ID issued in person, you can order it by submitting this form. If there is no photo/signature on file or your photo on file is over twelve (12) months old, complete this form to order a Siletz Tribal ID to be issued and it will be sent to you via Certified mail.

Siletz Tribal Member: _____ Roll#: _____

☐ 1. Updated Address: Submit an "Address & Contact Information Update" form

☐ 2. Height: _____ feet _____ inches Weight: _____ pounds

☐ 3. Digital Photo Specifications: Email to "angelar@ctsi.nsn.us"
- a. In color, no filters and clearly focused
- b. Plain white or off-white background
- c. Taken within the last six-months to reflect your current appearance
- d. Taken in full-face view directly facing the camera, no shadows on your face
- e. Both eyes open, neutral/smiling facial expression, no hats
- f. No sunglasses (even if tinted prescription glasses)
- g. Glare on clear glasses is not acceptable. Glare can be avoided by slight downward tilt of glasses, turning off the flash or removing the glasses.

☐ 4. Photo Verification: Submit a color copy of your State issued ID to confirm your identity

☐ 5. Signature: Sign within the box in front of a notary as this is what will be used on your ID card

_____
Date

COLVILLE TRIBES REPORT

THURSDAY APRIL 22ND, 2021

COVID STATS

- Total number of COVID-19 positives to date: 464
- Total number Hospitalizations: 21
- Total number of deaths: 7* tracked HHS Division
- Total number recovered: 456
- Total number of vaccines administered: 5508
  - LRCHC: 1161
  - Omak: 1396
  - Nespelem: 2451

SAN POIL TREATMENT CENTER

- 46 Bed Facility Adult Residential Substance Abuse Treatment Center
  - 23 Female / 23 Male beds
- Planned Opening
  - Estimated Date is September
- Tribe's Goals
  - Decrease Alcohol & Substance Abuse Deaths by 50%
  - Reduce Alcohol & Drug Recidivism Rate by 25%
  - Increase on-Reservation Employment by 25%

SAN POIL TREATMENT CENTER

- Construction Completion
  - Estimated May 13th
  - Take Possession & Facility prep by June
- Staffing
  - Focus on Professional Staff Recruitment
  - Staff Training
  - Community Job Fair planned for June for Para-Professional roles
- Marketing
  - Focus Initial Outreach and Relationship Building
  - Pre-launch Video's and Social Media Development
  - Web Landing Page

SAN POIL TREATMENT CENTER

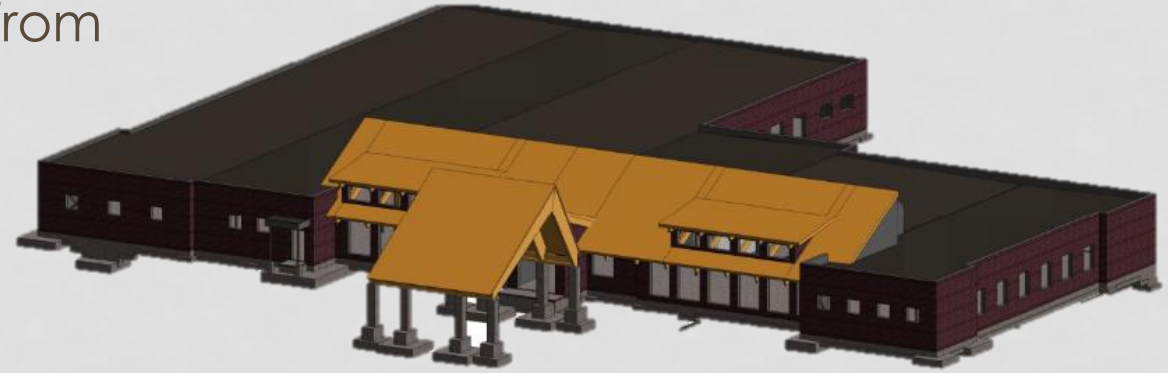
- Features
  - Ancillary Services for a Multidisciplinary Approach
  - Trauma Informed Treatment
  - Culturally Driven Approach with Cultural Specialists On-Site
  - Comprehensive Multidisciplinary Team of Experts
    - Substance Abuse Treatment, Mental Health, Western Medicine, and Traditional Healing
  - Focus on Health & Wellness
  - ADA Accessible Rooms
  - On-site Child Care & Family Engagement
  - 24/7 Resident Support and Activities

OMAK HEALTH CENTER

- Completed Joint Venture Process Post-Design with Submission of Approved Planning Documents to HIS
- Currently in the Operations Funding Negotiation Phase while Preparing for Site Prep
- Timeline:

OMAK HEALTH CENTER

- Jobs Created
  - 110 Staff Positions to Start
- Staff Retention
  - Perform at the Top of Licensure
  - Competitive Salaries
  - Ability to Transfer from Existing Facilities
  - Loan Repayment
  - Housing
- Clinic Design
  - Collaborative/Integrated Care Model
  - Patient Centered Medical Home (PCMH)
  - Tribal FQHC



OMAK HEALTH CENTER

Comprehensive Healthcare System with <u>Full-Service</u> Integrated Outpatient Clinic

- Primary Care Medicine
- Specialty Care Medicine
- Pharmacy
- Optometry
- Dentistry
- Radiology
- Laboratory
- Behavioral Health / Chemical Dependency
- Preventive Care Services
- OT/PT and Nutritional Services
- Medical Case Management

CONVALESCENT CENTER

- Enhanced Rate
  - Negotiated Between the Tribe, State of WA, and CMS
    - Spearheaded by Councilmember Andy Joseph with Support from DSHS and Empire Health Foundation
  - Provided the Ability to Bill at Higher Daily Rate for 10 years
  - Designed to Support
    - Raise Staff Pay Rates
    - Aid Recruitment
    - Improve Employee Retention
    - Provide for the Construction of a New Facility
    - New Services

CONVALESCENT CENTER

- New Services Planned or Implemented
  - Speech Pathology
  - OT/PT
  - Behavioral Health Support
  - Cultural Specialists/Programming
  - New Facility (within 3 years) – Site Selection has been Finalized
- Envisioned
  - On-site Helipad
  - Assisted Living Units
  - Co-located Dialysis Facility

The Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians

Health & Family Support Services

Presentation to the NPAIHB QBM on April 22, 2021

CTCLUSI: Who We Are

The Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians are made up of three tribes (four bands): two bands of Coos (Hanis Coos and Miluk Coos); the Lower Umpqua Tribe and the Siuslaw Tribe. Our ancestors were the aboriginal inhabitants of the South Central coast of Oregon. Our ancestral homeland is a vast region of 1.6 million acres, stretching from the Coastal Range on the east and the Pacific Ocean to the west. Our People have lived and flourished in these lands since immemorial.

CTCLUSI: Who We Are

Our ancestors welcomed the first Europeans to enter our lands. We maintained these peaceful relations for many years. Headmen from each of our three Tribes signed the Treaty of 1855, ceding our lands for certain compensation from the government. However, this treaty was never ratified and the promises were not kept. In 1954, the Coos, Lower Umpqua, and Siuslaw Tribes were terminated by Congress. It would take many years and a lot of hard work, but after 30 years we achieved Restoration on October 17, 1984.

CTCLUSI: Who We Are

Today we have 1,283 Tribal members spread throughout the United States. Just over half of our Tribal members live in Oregon. Additionally, we have large numbers of Tribal members living in Washington, Alaska, and California. Within our five-county service delivery area (Coos, Curry, Douglas, Lane, and Lincoln counties in Oregon) we have approximately 480 Tribal members.

Programs at CTCLUSI

Since Restoration, we have worked hard to establish programs and services for our people. Health & Family Support programs include:

- CTCLUSI Dental Clinic
- Purchased/Referred Care
- Community Health
- Behavioral Health/Peer Support
- Elders Programs
- Circles of Healing (domestic violence support and prevention)
- Youth Prevention Program

CTCLUSI: Our Staff

- Health & Family Support Administration team: 1 Interim Director and 1 Assistant Director
- Purchased/Referred Care: 2 PRC Specialists, 1 Benefits Specialist
- Community Health: 1 RN, 3 CHAs, 1 Tribal Navigator
- Family Support Services: 1 Prevention Activities Coordinator, 1 Peer Support Specialist, 1 Behavioral Health Coordinator, 1 TPEP Coordinator
- ICWA: 1 Lead ICWA Specialist, 1 ICWA Caseworker
- Dental: 1 Dentist, 1 Hygienist, 2 DHATs, 3 Dental Assistants, 1 Administrative Assistant, 1 DHAT Coordinator/Billing Specialist

Dental Health Aide Therapist (DHAT) Program

- In 2015, we partnered with the NPAIHB Native Dental Therapy Initiative to establish a pilot project for Dental Therapy in our clinic
  - Our first DHAT student left for training in Alaska in July 2016; our second student left in July 2017.
  - We are the final year of our 5-year pilot project with the Oregon Health Authority (OHA); the pilot will continue beyond this year, though, as we are attempting to get Dental Therapist licensure passed in the current legislative session.
  - Even with the occurrence of the COVID-19 pandemic, we have seen good success with the project: increased access to services and decreased wait time to see a provider.

Expansion of our Dental Clinic

When we started the DHAT program in 2015, our clinic was small, with one dentist and one hygienist working out of three operatories. We quickly identified a need for a larger clinic. We worked with the engineering team at IHS-PAO on a feasibility study for expansion of the clinic.

In July 2019, we broke ground on our clinic addition:

- Added 4 new operatories – total of 7 operatories
- Added 1,380 sf to the building and remodeled 1,414 sf of interior space

COVID-19 Modifications to the Dental Clinic

The project was completed in February of 2020. On March 12, 2020, we closed the Dental Clinic due to the pandemic and subsequently closed the remainder of Tribal services on March 17. All offices were re-opened on June 15, 2020; however, Dental did not begin seeing patients again until July 2020, to give us time to make safety modifications to our clinic:

- Made 3 operatories into closed/negative pressure operatories
- Purchased/obtained additional air-cleaning devices
- Purchased/obtained PPE, including PAPRs and N-95 masks
- Made upgrades to our HVAC system

Elders Activities Program

- Although our Elders Activities program has been closed during COVID-19, we are looking forward to once again having activities with our Elders. Components of our Elders Program:
  - Title VI Program – consortium with the Coquille Indian Tribe
    - Part A – meals/congregate meals and chore services
    - Part C – respite care services
    - Summer produce program
  - Elders Activities
    - Monthly Elders Luncheons
    - 1-2 Elders trips each year
  - Annual Elders Honors Day – co-hosted by CTCLUSI and the Coquille Indian Tribe

Elders Activities Program

Elders Activities Program

Thank You

Iliana Montiel
Interim Director of Health & Family Support Services
541-888-7526
imontiel@ctclusi.org

Veteran's Committee meeting notes, April 20, 2021

In attendance:

Debbie Jones, Suquamish
Nate Tyler, Makah
Andy Joseph, Colville Confederated Tribes
Sam Spino, Umatilla
Dan Delavan, VA Portland Health Care System
Terry Bentley, VA Office of Tribal Government Relations
Carrie Epperson, VA Seattle regional office
Amanda Gaston, staff
Veronica Smith, contractor
Candice Jimenez, staff
Dondi Head, staff

Minutes from the January 2021 meeting were reviewed.

Amanda Gaston presented on Caring Messages, a Suicide Prevention Intervention that will be launched in November 2021, utilizing text to share messages from and to Native veterans. The committee provided input on the avatars and logo that are under development. Amanda also asked for any volunteers to be a part of the project's advisory board. Interested veterans can email her at agaston-contractor@npaihb.org.

Veronica Smith provided a review of the recently passed legislation. The tribal advisory committee to the VA was discussed, and Terry Bentley said that the TAC would likely draw the members along the lines of the current IHS Area divisions, with three more at-large members for 15 total members.

Meeting was adjourned.

Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Notes

April 20, 2021

Start Time: 11:45 pm

Members Present: Cassandra Sellards-Reck, Kim Coombs

Staff Present: Andra Wagner

- Personnel update was reviewed.
  - _7___ new hires
  - _2___ new temps/interns
  - _2___ promotions
  - _0___ transfers
  - _0___ departures
  - 1 Recognition:
    - Jim Fry – 25 years of service
  - 1 Open Position – Compliance Manager

- Staff Trainings:
  - Annual Preventing Harassment and Discrimination in the Workplace Training – April 5th
  - Annual Preventing Bullying in the Workplace Training – April 5th

Adjourned at 12:00 p.m.

NPAIHB QBM Behavioral Health Committee Meeting on Tuesday 4.20 @ 1pm

Attendees:

- NPAIHB: Eric Vinson, Colbie Caughlan, Larissa Molina, Birdie Wermy, Tanya Firemoon, Candice Jimenez, Katie Hunsberger
- Cow Creek: Sharon Stanphill
- Digwalic Center: David Jefferson
- Cowlitz: Patty Kinswa-Gaiser
- Warm Springs: Caroline Cruz
- CTUIR/Yellowhawk: Martina Gordon
- Upper Skagit: Marilyn Scott
- Suquamish/Makah Veterans Resource: Lavada Anderson
- Karen Robey

Board check-in:

Birdie:

- BH ECHO: 4 faculty, training needs:
    - Orientation
    - Telehealth, telemedicine resources
    - What ways are other programs doing to engage youth during pandemic: provide onsite physical training (workouts)
    - Upcoming Trauma and addiction BH Session on May 27th
- Updated about webinars with Kauffman and Associates and Dr. Ursula Whiteside

Colbie

- April 30th Compassion Fatigue and May 6th Parenting Webinar – will attach to meeting minutes
- Crisis Text Line information
- updating THRIVE media materials soon
- Caring Text Intervention for youth

Participant check-in:

Warm Springs/Cow Creek

- Oregon Tribal Opioid Academy: June 15-17
- Trying to confirm presenters
- MACCBO credits will be offered for SUD and CPS certifications
- Looking at wellness: chair aerobics in between sessions
- Missing/murdered indigenous people/women

- Update on measure 110 in OR updates on opioid prevention and treatment in OR; CTUIR will present; Kristi Woodard will offer MHFA; emergency preparedness; roll out of OR Tribal BH strategic plan; art work activities
- Contacts for planning this Academy are at Lines for Life, Donna Libemday and Jorgette – Colbie will contact them to be able to stuff all mailings with NPAIHB Opioid stuff (maybe NARCAN) and Crisis Text Line stuff, maybe straws and glasses and camera protectors and CC holders?
- Colbie will email Caroline separately to help teach her how to use Breakout Rooms on Zoom for an ethics workshop that is 6hrs long so need NPAIHB staff to help co-host that for the academy
- Colbie will connect with representative from WA dept of Veterans Affairs so they can connect with Lines for Life and get some suicide prevention scarfs to L4L to be put in the swag bags

Upper Skagit

- Second gathering of wisdoms for elders
- Mentors for BHA students in June: getting flyer
- NPAIHB staff working hard on getting the curriculum completed with Heritage University and NW Indian College in order for new students to use this curriculum in to the fall
- Marilyn will be transitioning to retirement over the next couple of years so she will have other members of her tribe attending some of these meetings to mentor them to take over her duties over time

Cowlitz

- Starting Virtual groups for MAT and SUD programs
- Also starting virtual Positive Indian parenting group
- MAT stories/interviews from three tribes

Didgwalic Center

- May 18-19 dental clinic will start serving client
- Phase 2 building for Didgwalic has opened for staff and then slowly more MAT patients will be taken on by the wellness center
- Independent covid vaccine clinic
- Applying for funds to be able to start Phase 3 for Didgwalic

Suquamish/Makah Veterans Resource

- Makah: New memorandum for better telehealth
- Co-pays for tribal veterans; legislation push through
- Working on memorandum on governor's challenge on suicide
- More tribal health managers

- Also Heroes for Horses are VA vendors and that may be something to look at for amending the MOU for reimbursement purposes.

CTUIR/Yellowhawk

- Sober transitional housing is open
- Grand opening for horse arena
- Horse therapy program in June
- People being trained on becoming one with the spirit of the horse: billable hours: http://becomingonewiththespiritofthehorse.com/

NPAIHB Youth Committee – Meeting Minutes

April 2021

Participants: Lorinada (Lower Elwha Klallam Tribe), Jessie Adair (Stillaguamish Tribe), Cassy Sellards Reck (Cowlitz Indian Tribe)

Staff: Paige Smith, Katie Hunsberger

Meeting Notes:

Paige Smith – NPAIHB

- Updated on TYD
- Application for TYD are open. Ask the Tribal Delegates for support in recruiting.

Cassy Sellards Reck – Cowlitz Indian Tribe

- Giving fund
    - Unrestricted funds to help support the TYD
    - Enquire with their tribe to donate.
    - Reach out to Stephanie
    - Follow up.

- 2022-Youth are important.
    - Don't overlap events with canoe journey.
    - If things are safe, Create a space for the youth to participate in QBM summer 2022
    - Positively support the TYD and work these things out

Jessie Adair – Stillaguamish Tribe of Indian

NPAIHB Youth Delegate Application is Open

The Northwest Portland Area Indian Health Board is recruiting a new cohort of NPAIHB Tribal Youth Delegates. Below you will find the eligibility requirements and some helpful information about the program. Please forward it along to any AI/AN youth in OR, WA or ID that you think might be interested. If you have any questions, please reach out to Paige Smith: Psmith@npaihb.org.

- Applications closes: May 28, 2021
- If you or someone you know is interested in applying, please apply here.
- Youth Delegates represent the 43 Tribes in the Pacific Northwest (OR, WA, ID) and serve as the health policy-making body for the Northwest Portland Area Indian Health Board and its member tribes.

- Why should you apply to be a Youth Delegate? You will learn about health careers, governance structures, and policy. You will gain leadership skills and advocate for positive changes in health and wellness topics.
- To be eligible, you must be between the ages of 14-24. Must be an enrolled member or descendant of one of the 43 tribes in the NW. And must be able and willing to participate in (virtual) Delegate trainings, projects and activities.
    - **Youth Delegate webpage**: http://www.npaihb.org/youth-delegate/
    - **NPAIHB Tribal Youth Delegates:** https://youtu.be/YNqehVImiPg
    - **Sacred Roots, Sacred Youth: 2020 Tribal Youth Delegates**: https://youtu.be/yDKeu81K9Q0

Legislative and Resolutions committee Minutes

April 20, 2021

Attendees: Andy Joseph (Colville), Cheryle Kennedy (Grand Ronde), Ann Jim (ShoBan), Karen Robey, Lorinda Robideau, Rachel Edwards (Nez Perce), Kim Coombs, Greg Abrahamson

NPAIHB Staff: Sue Steward, Laura Platero, Itai Jeffries, Tom Becker, Veronica Smith, Jessica Leston, Amy Franco

The Legislative and Resolutions Committee discussed 12 resolutions.

The Committee reviewed 6 funding resolutions discussed:

1. **Strengthening Indigenous Health and Science Research: NW NARCH Program**

   NW tribal students and undergrad/grad students in pursuit of training can get funding. Now therefore, be it resolved, that NPAIHB supports the NW NARCH application designed to fund: 1) NW tribal high school students, and 2) undergraduate and graduate students in pursuit of sciences

2. **NW Tribal Food Sovereignty Coalition and Food Sovereignty Initiatives Project 2021 RFA NAAF Settlement Funding: Keepseagle v. Vilsack Litigation**

   Therefore be it resolved, that the NPAIHB endorses and supports efforts by staff of the EpiCenter, under the guidance of the ED, to pursue funding through the 2021 Native American Agriculture Fund.

3. **IHS Minority HIV/AIDS Fund Clinical Programs Support**

Now therefore be it resolved, that NPAIHB approves the Clinical Programs Project to continue to secure funding through IHS Minority HIV/AIDS funds for clinical program support through September of 2025. This is new funding.

4. **IHS MHAF to Support Ending the HIV Epidemic in Indian Country**

Funding of $1.5 million. Now, therefore, be it resolved that the NPAIHB supports applying for funding through IHS MHAF to support ending the HIV epidemic in Indian Country by helping to build a national strategic agenda.

5. **Native Dental Therapy Initiative- Funding Offered by NIHB for Education and Outreach to Enhance Policies Supportive of Dental Therapy**
   In 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.

6. **Native Dental Therapy Initiative –Implementation of Dental Therapy Offered by NIHB**
   In the amount of $25,000 to support the creation of an online treatment planning calibration course designed for dental therapists and their supervising dentists.

Action: Motion to approve all 6 funding resolutions: Andy Joseph (Colville), second Ann Jim (ShoBan), passed by unanimous vote to the Board for consideration.

7. **Call on Congress to Support Full or Increased Funding for FY 2022 Indian Health Service Budget**
   Two options for funding at $12.8 billion or the President's proposed FY 2022 budget increase.

   Andy Joseph: Want to support National Tribal Budget Recommendations at 12.8 billion; using COVID pandemic as example of where tribes would have been if listened to years ago and IHS funded at normal average rate compared to any other races in the US; Recommends Option 1

   Cheryle Kennedy: support for full funding; that's what we said that's what we need to do; supports option 1

   No one opposes on the committee moving forward with option 1

Action: Motion by Greg Abrahamson to approve of option 1; second by Andy Joseph; and all in favor to pass the resolution for Board's consideration.

The Committee reviewed 5 Policy Resolutions:

8. **Action by Unanimous Consent of the Governing Board Restatement of 403(b) Retirement Plan**
   IRS requirement – a complete restatement of the prior Plan to be effective on 1/1/2010.
   Question from Cheryle -has this gone through Personnel Committee? No.

9. **Article X (Amendments) of the NPAIHB Constitution and By-Laws-30 Days Notice**
   Hereby agrees to provide all duly appointed delegates a copy of the proposed changes to the constitution at least 30 days prior to the official vote on the proposed changes; and Executive Director directed to provide notice
   One change proposed by Greg - changing hereby to shall

10. **Support for Trans and Gender Affirming Care in IHS, Tribal, and Urban Indian Health Facilities--2021 Strategic vision and Action Plan**

Supports trans and gender affirming care in ITU 2021 Strategic Vision and Action Plan. Presentation will be conducted by Itai and Morgan tomorrow. Morgan Thomas – collaborate on clinics to implement goals

What time is presentation tomorrow? Noon on Thursday

11. **Option for Tribal Nations to Exempt their COVID Funds from Indirect Cost Rate Calculations**

    Andy: testified on this during HHS Annual Budget Consultation; don't want negative impact; tribes didn't cause epidemic; all this funding coming to tribes being used to offset impacts of the virus; definitely need to be exempt on this funding

    Cheryle: on how indirect cost rates are calculated, when PRC funds were CHS tribes could decide whether to treat them as pass through $$ vs. apply indirect rate; see it as same way

12. **Portland Area CHAP Certification Board**

    Supports development of the PACCB with federal baseline standards; supports finalization of recommended seating chart recommended by CHAP Board Advisory Workgroup

Action: Motion to approve remaining 5 policy resolutions: motion by Andy Joseph; second by Greg Abrahamson; all in favor, no opposition/abstentions to pass the resolution to the Board for consideration.

NPAIHB

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RESOLUTION # 21-03-01

Strengthening Indigenous Health and Science Research: NW NARCH Program

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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, the Northwest Native American Research Centers for Health (NARCH) is one of the NPAIHB programs working toward health promotion of regional tribes; and

WHEREAS, the NARCH program proposes to further science education programs for tribal high school, college, and graduate school students toward the benefit of tribal people; and

WHEREAS, the National Institutes of Health reports that AI/AN scientists receive only 0.2% of all funded research projects from that federal agency, compared to 67.3% for whites; and

WHEREAS, for the past 20 years AI/AN Bachelor's, Master's and PHD degrees in Science awards have demonstrated no increase. In 2019 AI/AN people were awarded fourteen (14) PhD degrees as compared to six hundred (600) for Hispanics and four thousand (4000) for whites; and

WHEREAS, training AI/AN scientists to address health issues of importance to tribes should be viewed as a priority concern; the interests of science starts in high school and before, and requires nurturing of these students to reach the goal of becoming independent scientists; and

WHEREAS, the NW NARCH program has sponsored a significant number of successful tribal graduate students in the sciences, including many who have worked at the Health Board; and

NOW, THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board supports the NW NARCH application designed to fund; 1) NW tribal high school students, and 2) undergraduate and graduate students, in pursuit of science research training through a grant from the National Institutes of Health.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NPAIHB

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RESOLUTION # 21-03-02

NW TRIBAL FOOD SOVEREIGNTY COALITION (NTFSC) and Food Sovereignty Initiatives Project
2021 RFA- NATIVE AMERICAN AGRICULTURE FUND (NAAF)
SETTLEMENT FUNDING: KEEPSEAGLE v. VILSACK LITIGATION

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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, NAAF is seeking proposals under the non-profit section of this RFA, a key focus area. NAAF seeks to augment existing work being done by others; leverage other food sovereignty or traditional foods investments already underway; and provide communities with additional resources to take next steps in their activities. These areas have been determined important, and of high interest among NW Tribal Food Sovereignty Coalition Members. These areas are also considered foundational concerns important to the underpinning of strong and sustainable food systems in Indian Country; and

WHEREAS, the Northwest Tribal Food Sovereignty Coalition, and the Food Sovereignty Initiatives Project have been successful in securing funds from NAAF for the past two years, and look to expand and strengthen business assistance and technical support to NW native food producers; and to strengthen

and support the local, regional, and intertribal food system to better respond to, and prepare for, food security needs in our region in consultation with nutritional professionals;

WHEREAS, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the *NW Tribal EpiCenter*; and

THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board endorses and supports efforts by staff of the *EpiCenter*, under the guidance of the Executive Director, to pursue funding through the ***2021 NATIVE AMERICAN AGRICULTURE FUND (NAAF) - SETTLEMENT KEEPSEAGLE v. VILSACK LITIGATION*** funding opportunity.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NPAIHB

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RESOLUTION # 21-03-03

Native Dental Therapy Initiative – Funding Offered by the National Indian Health Board for Education/Outreach to Enhance Policies Supportive of Dental Therapy

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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, Dental Health Aide Therapists (DHATs, also known as Dental Therapists) have been recognized as important mid-level providers in Tribal health programs; and

WHEREAS, Communicating information about NDTI project activities with a strong internet presence will benefit Tribal communities and enhance work toward policies supportive of Dental Therapy programs; and

WHEREAS, the National Indian Health Board is offering a funding opportunity of up to $25,000 for work to enhance policies supportive of dental therapy programs, and this funding opportunity permits a maximum indirect rate of 10%;

THEREFORE, BE IT RESOLVED that the Northwest Portland Area Indian Health Board 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 the National Indian Health Board 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.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NPAIHB

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RESOLUTION # 21-03-04

Native Dental Therapy Initiative - Implementation of Dental Therapy Offered by the National Indian Health Board

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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, Dental Health Aide Therapists (DHATs, also known as Dental Therapists) have been recognized as important mid-level providers in Tribal health programs; and

WHEREAS, the National Expansion of the Community Health Aid Program (CHAP) was recently approved by IHS which will enable more clinics nationwide to employ DHATs; and

WHEREAS, Dental Health Aide Therapists (DHATs, also known as Dental Therapists) are required to have their work supervised by a Supervising Dentist; and

WHEREAS, supervising Dentists and Dental Therapists must Dental Health Aide Therapists must agree on the treatment that is planned and completed for patients; and

WHEREAS, ensuring alignment of treatment philosophies and therefore treatment plans enables a stronger supervision relationship; and

WHEREAS, calibration activities have been shown to be effective at helping clinicians to align their treatment philosophies; and

WHEREAS, creation of an online treatment calibration activity requires contracting a company with this expertise; and

WHEREAS, 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, and this funding opportunity permits a maximum indirect rate of 10%.

THEREFORE, BE IT RESOLVED that the Northwest Portland Area Indian Health Board 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 the National Indian Health Board in the amount of $25,000 to support the creation of an online treatment planning calibration course designed for dental therapists and their supervising dentists, and related support for this training.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NPAIHB

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RESOLUTION # 21-03-05

Indian Health Service Minority HIV/AIDS Fund Clinical Programs Support

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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 Clinical Programs has provided support to Tribal, Indian Health Service, and Urban clinicians to expand American Indian and Alaska Native peoples' access to high-quality care since 2010; and

WHEREAS, NPAIHB's Clinical Programs objective is to work in partnership with Tribes and other collaborators to increase the health and wellness of American Indian and Alaska Native people; and

WHEREAS, NPAIHB'S Clinical Programs offer learning opportunities and environments where all levels of clinicians and staff serving American Indian and Alaska Native people can connect with peers, engage in didactic presentations, collaborate on case consultations, and receive mentorship from experts from across Indian Country; and

WHEREAS, the NPAIHB is in position to offer programing and apply for funding on a variety of no-cost services for Northwest Tribes aimed at expanding American Indian and Alaska Native peoples' access to high-quality care; and

NOW, THEREFORE, BE IT RESOLVED, that the Northwest Portland Area Indian Health Board approves the Clinical Programs Project to continue to secure funding through the Indian Health Service Minority HIV/AIDS Fund for Clinical Program support through September of 2025.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NPAIHB

Member Tribes of the Northwest Portland Area Indian Health Board:

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Umatilla Tribe
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RESOLUTION # 21-03-06

Indian Health Service Minority HIV/AIDS Fund to Support Ending the HIV Epidemic in Indian Country

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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, 700,000 lives, and at least 2,019 American Indian and Alaska Native lives, have been lost to HIV in the United States since 1981; and

WHEREAS, more than 1.1 million Americans, and at least 3,035 American Indian and Alaska Native people, are currently living with HIV; and

WHEREAS, in January 2020, NPAIHB enacted resolution #2020-10, "Support for Ending the HIV Epidemic in Indian Country" and

WHEREAS, at the Winter Convention of 2020, the Affiliated Tribes of Northwest Indians (ATNI) enacted resolution #2020-10, "Support for Ending the HIV Epidemic in Indian Country" and

WHEREAS, NPAIHB for over ten years, has been a primary implementing partner with Indian Health Service (IHS) and the Health and Human Services Minority HIV/AIDS Fund (MHAF); and

WHEREAS, the HHS Office of the Assistant Secretary for Health (OASH) awarded the IHS National HIV/HCV Program $1.5 million dollars to develop an HIV strategy for Indian Country.

NOW, **THEREFORE**, **BE IT RESOLVED**, that the Northwest Portland Area Indian Health Board supports applying for funding through the Indian Health Service Minority HIV/AIDS Fund to support Ending the HIV Epidemic in Indian Country by helping to build a national strategic agenda.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NPAIHB

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RESOLUTION # 21-03-08

Call on Congress to Support [Full or Increased] Funding for FY 2022 Indian Health Service Budget

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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, the IHS has been chronically underfunded as demonstrated by the disparity of federal health care spending of the IHS ($4,078 per person in FY 2019) compared to federal health care spending nationwide ($11,582 per person in FY 2019); and

WHEREAS, President Biden released the FY 2022 discretionary budget request which includes a 23.5% increase to the Department of Health and Human Services over the 2021 enacted level; and

WHEREAS, the President's discretionary budget proposal is intended to help combat the COVID-19 pandemic, improve public health infrastructure, and advance equity across the U.S.; and

WHEREAS, the President has stated his commitment to Tribal Nations and to fully funding the Indian Health Service (IHS); and

WHEREAS, the President's request for IHS FY 2022 budget includes a $2.2 billion increase over FY 2021 enacted level and a request for advance appropriations; and
WHEREAS, the proposed $8.5 billion for IHS in FY 2022 is $4.2 billion below the FY 2022 National Tribal Budget Formulation Workgroup Recommendation of $12.8 billion; and

WHEREAS, the National Tribal Budget Formulation Workgroup has requested full funding of IHS at $48 billion; and

WHEREAS, the federal government has a trust responsibility and treaty obligations to ensure that Tribes and American Indian and Alaska Natives are fully funded to meet their health care and service needs; and

WHEREAS, funding IHS in FY 2022 at [Option 1: $12.8 billion or Option 2: $8.5 billion] to address the growing health disparities and urgent health care needs of American Indian and Alaska Native people is in fulfillment of the federal government's treaty and trust obligations.

OPTION 1:
NOW THEREFORE BE IT RESOLVED, that the NPAIHB recommends that Congress support a $6.5 billion increase to the IHS FY 2022 budget over FY 2021 enacted level to fund IHS at $12.8 billion in FY 2022 and move IHS to full funding of $48 billion; and

OPTION 2:
NOW THEREFORE BE IT RESOLVED, that the NPAIHB recommends that Congress support the President's request of $2.2 billion increase to the IHS FY 2022 budget over the FY 2021 enacted level in FY 2021 to fund IHS at $8.5 billion in FY 2022; and

BE IT FURTHER RESOLVED, that the Northwest Portland Area Indian Health Board calls on Congress to support the President's request for advance appropriations for FY 2023.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NPAIHB

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RESOLUTION # 21-03-09

"Article X (Amendments) of the NPAIHB Constitution and By-Laws---30 Days-Notice"

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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, the NPAIHB Program Operations Manual Constitution and By-Laws was adopted in July 1996, and revised in October 1999 in order to govern the Board relating to development and implementation of Indian health legislation, regulations, policies, and programs; and

WHEREAS, since the last revisions to the Constitution and By-Laws over twenty years ago, the NPAIHB has not only grown its programs and policy advocacy capacity to better support the health care needs of the Northwest Tribes, but has faced an unprecedented public health pandemic requiring the Board to adapt to a more virtual environment; and

WHEREAS, the Constitution and By-Laws require some necessary revisions to better align with the vision and purpose of the Board and to authorize use of remote meetings; and

WHEREAS, Art. X, Sec. 1 requires the Delegates to agree to provide all Board members a copy of proposed changes to the Constitution and By-Laws at least 30 days prior to any vote on the proposed changes.

THEREFORE, BE IT RESOLVED, that the Northwest Portland Area Indian Health Board hereby agrees to provide all duly appointed delegates a copy of the proposed changes to the Constitution and By-Laws at least 30 days prior to the official vote on the proposed changes; and

BE IT RESOLVED, that the Executive Director shall provide notice consistent with Article X prior to the scheduled Board vote on any changes to the Constitution and By-Laws.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NPAIHB

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RESOLUTION # 21-03-11

Support for Trans Gender-Affirming Care in HIS, Tribal, and Urban Indian Health Facilities – 2021 Strategic Vision and Action Plan

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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 supports the health and wellbeing of all Native people, including those who are Two Spirit, lesbian, gay, bisexual, transgender, queer or another identity (LGBTQ+), and

WHEREAS, prior to contact with settlers, many tribal nations across the country and continent had long histories of respect and inclusion of those in their communities who might today identify as Two Spirit or LGBTQ+; and

WHEREAS, Two Spirit and LGBTQ+ individuals disproportionately experience refusal of care, discrimination, and insufficient provider knowledge in healthcare settings; and

WHEREAS, Two Spirit and LGBTQ+ individuals who fear discrimination or harassment in healthcare settings are more likely to postpone necessary treatment and report lack of access to care; and

WHEREAS, Two Spirit and LGBTQ+ individuals are important members of their communities who deserve access to appropriate health care in affirming environments; and

WHEREAS, Two Spirit and LGBTQ+ individuals experience health disparities including increased risk of anxiety, depression, HIV, exposure to violence, and suicidiality; and

WHEREAS, access to gender-affirming healthcare is critical and lifesaving for transgender individuals; and

WHEREAS, healthcare settings are uniquely positioned to affirm Two Spirit and LGBTQ+ identities; and

WHEREAS, Two Spirit and LGBTQ+ individuals thrive in settings which demonstrate respect and inclusion of their identities.

NOW THEREFORE BE IT RESOLVED, that Northwest Portland Area Indian Health Board supports the Trans and Gender-Affirming care in IHS, Tribal, and Urban Indian Health facilities – 2021 Strategic Vision and Action Plan.

BE IT FURTHER RESOLVED, that Northwest Portland Area Indian Health Board supports advocacy for the continued dissemination of, and implementation of the goals within, the Strategic Vision and Action Plan within the Northwest and throughout Indian Country over the next five years to ensure that our healthcare facilities and communities affirm all sexual orientations and gender identities.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

TRANS AND GENDER-AFFIRMING CARE in IHS/Tribal/Urban Facilities: 2020 Strategic Vision and Action Plan

Contributors: Jessica Leston, Rick Haverkate, Hannah Wenger, Frances Grimstad, James Conniff, Jennie Wei, Vikas Gampa, Morgan Thomas, Itai Jeffries, Mattee Jim, Lanny McCanta, Shane Ortega

Northwest Portland Area Indian Health Board
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Special thanks to our reviewers:
Hannah Glaser, Michelle Enfield, Emily Ashbaugh, Elton Naswood,
Robin Parker, Andrew Terranella, and Annabelle Allison.

STATEMENT OF INTENT

Note: We are aware that terminology is quickly changing and varies regionally and culturally. In this document, we use the phrase 'gender-diverse' to refer to Two Spirit, trans, genderqueer, nonbinary, agender, and other patients with gender identities other than cisgender. We include all identities and gendered ways of being held by Indigenous persons beyond the colonial gender binary. We use the term Indigenous where possible to refer to the original peoples of the Americas; however, we also use "Native" or "Indian" when referencing institutions like the Indian Health Service.

Since time immemorial, Indigenous cultures have appreciated complex and numerous concepts of gender identity. Occupation and settlement of North America by Europeans, however, violently interrupted the systems that supported much of that traditional diversity and acceptance. Today, Indigenous people who do not identify as cisgender face discrimination in workplaces, education centers, and healthcare settings (to name a few). In 2014, 37% of Indigenous transgender people postponed necessary medical care because they feared mistreatment as a transgender person. Of those who did access care, 50% reported having at least one negative experience related to their transgender identity. These experiences include refusal of gender-affirming care, having to educate providers about that care, and learning of the unavailability of gender-affirming care at their clinic.[1] The disparities faced by gender-diverse individuals, including increased levels of depression and anxiety, can be greatly minimized by reducing barriers to access of healthcare and by ensuring gender-diverse people are affirmed in their gender identities. Simply using a person's correct name and pronoun has been associated with a 65% decrease in suicidal thoughts in gender-diverse youth.[2]

Gender-affirming care refers to healthcare that affirms a person's gender identity and allows gender-diverse people to live more authentically. To be gender-affirming, providers must create positive and optimistic medical care systems, inclusive clinic environments, and patient support through effective and compassionate social gender transition. With appropriate planning and support, gender-affirming healthcare can be highly successful at all levels of the medical system, including primary care, behavioral health care, pharmaceutical care, Indigenous medicine, and various other specialties. If effectively applied, gender-affirming care becomes integrated throughout all clinical services. Incorporating holistic and affirming care with respect to both gender and culture, and welcoming clinical spaces for all patients ensures gender-diverse patients have access to the care they medically need and that they feel safe accessing that care.

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[1] *2015 U.S. Transgender Survey: Report on the Experiences of American Indian and Alaska Native Respondents. National Center for Transgender Equality (2015):* https://transequality.org/sites/default/files/docs/usts/USTS-AIAN-Report-Dec17.pdf

[2] *Russell ST, Pollitt AM, Li G, Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. J Adolesc Health. 2018;63(4):503-505. doi:10.1016/j.jadohealth.2018.02.003*

STATEMENT OF INTENT *CONTINUED*

This strategic plan supports the Indian Health Service (IHS), tribal, and urban Indian clinics (I/T/U) as they begin to provide gender-affirming care to their patients by emphasizing the following four goals:

1. **Develop and pass protective policies at the federal, tribal, and local levels;**
2. **Ensure affirming clinical environments for gender-diverse patients;**
3. **Ensure best practice care for Indigenous gender-diverse patients; and**
4. **Improve I/T/U health systems support for initiatives focused on the wellness of gender-diverse community members.**

These recommendations are not individual-level interventions. They are structural and community-level interventions to ensure the wellbeing of gender-diverse patients. We hope that the Northwest Portland Area Indian Health Board (NPAIHB), the various tribal nations in the Pacific Northwest, and partnering agencies use this plan to guide program planning, catalyze community outreach efforts, and foster a coordinated response to the health and wellbeing of gender-diverse members of our tribal communities.

The Native Advocacy Workgroup for Trans Health will work to annually revise and implement the policies of this strategic visioning document.

Note: We have focused here on support for gender-affirming initiatives. However, we realize many of these supports, including funding and trainings will also broadly address Two Spirit and LGBTQ+ health. We also recognize that recommendations put forth in this strategic plan could be adapted by non-healthcare organizations, including academic, social service, political, and business institutions. We consider commitments to features presented in this plan to be important for a wide spectrum of organizations seeking to serve better Indigenous gender-diverse individuals.

TABLE OF CONTENTS

GUIDING PRINCIPLES

The authors created the strategies and action plans outlined in this document with the following priorities and perspectives. These principles are upheld throughout this work:

Indigenous understandings and practices are integrated. Prior to colonization, Indigenous cultures and communities had diverse concepts of gender, many of which were accepting of—or in some cases required—a wide array of gender diversity. We center these diverse Indigenous concepts of gender identity and de-center the compulsory binary gender embedded in colonial culture in the following ways:

- We do not assume that a person identifies with their assigned sex at birth and do not assume a person seeking gender-affirming care wishes to "pass" as a gender opposing their assigned sex at birth.
- We recognize that some within our communities are also intersex, and we do not assume that sex assigned at birth is always binary, clear, or accurate.
- We do not assume all individuals use consistent pronouns or use pronouns at all. We recognize pronouns are themselves a construction of the colonizer's language.
- We recognize gender as "the mental, emotional, and social aspects of one's expression and identity rather than an individual's physical or biological makeup."[3] We prioritize healthcare that takes this holistic approach and emphasizes supporting an individual's authentic self-expression, and in many cases, social transition.
- We strongly encourage the integration of Indigenous healing practices in clinical settings. We also strongly encourage support for gender-diverse practitioners to provide these services.

Initiatives are led by gender-diverse people. Any initiative aimed at improving the clinical experiences and wellness of gender-diverse individuals must necessarily include those voices and individuals not only as consultants but in compensated, leadership roles. Current gender-diverse-inclusive initiatives include the following:

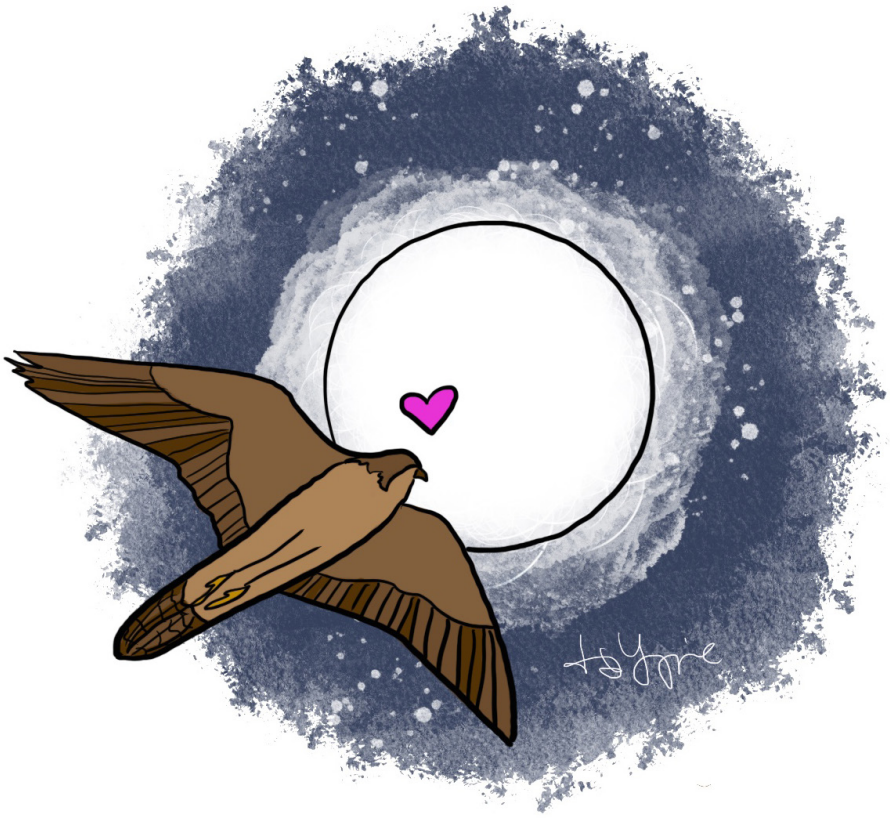
- The Native Advocacy Workgroup for Trans Health and the **IHS LGBTQ2S Workgroup** is involved in the creation, review, and implementation of this document.
- One initial step in this plan is the creation of a Gender-Affirming Care Advisory Council, including clinicians, community members, and youth which will serve to interpret and guide the work done in response to this plan.

[3] http://keinfoshop.org/zines/settler-sexuality.htm

GUIDING PRINCIPLES *CONTINUED*

Initiatives recognize Indigenous diversity in gender concepts, roles, and practices. This work begins with the recognition that tribes have always had diverse cultures, histories, and varied gender identity concepts, each of which also has had a unique history of colonization and has been altered in specific ways. There are also diverse historical and contemporary manifestations of acceptance of gender-diverse tribal members in various tribal nations and communities. Our recognition of tribal diversity includes:

- Offering sample policies for tribes to adapt as their needs demand.
- Creating protections for gender-diverse community members at the federal, state, and tribal levels.
- Identification of cultural leaders and wisdom/story-keepers to advise implementation of recommendations outlined in this document.



POLICY

Legislative and policy initiatives are needed to protect basic rights and access to comprehensive healthcare for gender-diverse community members and patients. This protection should include nondiscrimination policies that ensure healthcare access for all people regardless of gender identity or sexual orientation and the clinical adoption of best-practice guidelines for care, which provide access to quality healthcare for gender-diverse people. Listed below are existing and desirable policies at the clinical, tribal, state, and federal levels to aid in, assist with, and guarantee protections for gender-diverse individuals.

EXISTING POLICIES

Tribal Organizations

POLICY	ORGANIZATION	YEAR
Standing in Support of our Two Spirit Relatives in our Communities and Nations	National Congress of American Indians 2015	2015
Support for Quality Care and Improved Health Outcomes for Two Spirit and LGBTQ+ People	National Congress of American Indians; Affiliated Tribes of Northwest Indians; Northwest Portland Area Indian Health Board	2020
In Support of Native Students, Educators, and Community Members who Identify as LGBTQ2S	National Indian Education	2019

Tribal Policies

POLICY	TRIBE	YEAR
Hate Crimes Law Inclusive of Sexual Orientation and Gender Identity	Oglala Sioux	2020
Proclamation Establishing June as Pride Awareness Month	Tohono O'odham	2020
Same-sex Inclusive Marriage Laws	Lummi Nation (Note: Here is a list of same-sex marriage laws by tribe)	2019
Gender-Affirming Tribal ID Documents (Appendix B)	Confederated Tribes of Siletz Indians	2019

POLICY *CONTINUED*

Federal Policies

POLICY	YEAR	RELEVANT EXCERPT
Title VII – Civil Rights Act; IHS Policy Interpretation	1964; Includes sexual orientation and gender identity, by rule of Supreme Court in 2020.	"Title VII prohibits employment discrimination based on race, color, religion, sex and national origin."
Affordable Care Act	2010	"Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities."

State Policies

Please visit **Movement Advancement Project** for a map of nondiscrimination policies by state.

DESIRABLE POLICIES

Tribal Resolutions:

1. Nondiscrimination Ordinance (See **Tribal Equity Toolkit 3.0**)
2. Support for Quality Healthcare for Gender-Diverse People
3. **Gender-Affirming ID Documents & Enrollment Cards**

Clinic Guidelines and Statements:

1. Posted Nondiscrimination Statement: *"It is the policy of [Clinic Name] to treat all patients and not to discriminate with regard to race, religion, national origin, age, sex,* ***sexual orientation, gender identity*** *or expression, or disability."*
2. **Nondiscrimination Policy Including Sexual Orientation and Gender Identity**
3. **Best Practice Guidelines and Protocols for Trans & Gender-affirming Care**
4. Guidelines for SOGI Data Collection (See **Guidelines from Fenway Institute**)

Federal Policies:

1. IHS Nondiscrimination Policy
   Progress: Leadership briefing with Office of Management Services at IHS
2. IHS Guidelines and Protocols for Trans & Gender-affirming Care
   Progress: Leadership briefing with Office of Management Services at IHS
3. IHS SOGI Data Collection Policy
   Progress: Expect federal policy by December 2020.

BEST PRACTICE CARE FOR GENDER-DIVERSE PATIENTS

The University of California, San Francisco (UCSF), the Endocrine Society and the American Academy of Pediatrics developed guidelines that equip primary care providers and health systems with the tools and knowledge needed to meet the healthcare needs of gender-diverse patients. These best practice guidelines, developed in consultation with a medical advisory board, are updated regularly to reflect the most recent medical research and evolving best practices.

These guidelines include, but are not limited to, the following:

- recommendations for creating a safe and welcoming clinical environment;
- recommendations for physical examination of gender-diverse people;
- recommendations for prescribing femininizing and masculinizing hormone therapy;
- sexual and mental health considerations for gender-diverse people;
- recommendations for supporting a patient's social transition, including voice therapy, identity documents, and health insurance; and
- recommendations for gender-affirming surgical procedures and aftercare.

Any clinic can implement these guidelines, and they are appropriate for all clinic environments, including primary care, reproductive healthcare, behavioral healthcare, pharmacy, emergency departments, and other specialties. By following these guidelines, a clinic ensures the care it offers is in keeping with current best practices and remains updated as those practices continue to develop.

In addition to adopting these best practice guidelines, I/T/U clinics can implement the suggestions on the following page to best support gender-diverse patients.

Note: None of the above guidelines are specifically designed for Indigenous communities. They should be adapted to integrate cultural practices and Indigenous medicine.

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[4] https://transcare.ucsf.edu/welcome

[5] https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence

[6] https://pediatrics.aappublications.org/content/142/4/e20182162

BEST PRACTICE CARE FOR GENDER-DIVERSE PATIENTS *CONTINUED*

1. Clinical provider applies the latest electronic health records (EHR) solutions to meet the needs of gender-diverse patients.

- Include pronoun and name markers on patient records;
- Document **organ inventory within patient records**; and
- Implement appropriate **screening guidelines** based on organ inventory

Note: Roll out of SOGI-inclusive EHR in IHS beginning September 2020.

2. Provide culturally-attuned care to all Indigenous patients.

- Offer Indigenous medicine and culturally-specific services;
- Integrate these services into existing clinical services whenever possible;
- Ensure these practices are treated with parity alongside colonial medicine;
- Ensure patients can access Indigenous medicine services;
- Advocate for sustainable mechanisms to provide adequate pay to Indigenous cultural practitioners, whether through insurer reimbursement, revenue, or other sources not reliant on grants and without undue burden on the practitioners; and
- Provide culturally-attuned group- and community-level interventions such as the talking circle or sweat lodge, for gender-diverse youth and adults.
- Ensure providers of Indigenous medicine are trained in trauma-informed care.

3. Provide access to gender-affirming surgery and procedures directly or indirectly through clear, pre-screen referrals.

- Provide clear and transparent guidelines to patients regarding necessary documentation needed to access such treatments at the outset;
- Ensure that no patient is turned away or denied access based on ability to pay;
- Work to educate providers and purchase-and-referred care (PRC) specialists to create guidelines for gender-affirming care to be provided outside of the IHS/tribal system;
- Provide patients with guidelines to cover expenses for gender-affirming surgery;
- Provide access to an endocrinologist for hormone therapy in preparation for gender-affirming surgery;
- Protect reproductive sovereignty for gender-diverse patients; and
- Provide legal and social support services for gender-diverse youth, especially minors, who may struggle to have conversations about gender-affirming care with their parents and providers, or who may require other additional assistance related to social or legal support for transition.

BEST PRACTICE CARE FOR GENDER-DIVERSE PATIENTS *CONTINUED*

4. Routinely collect aggregate data on sexual orientation and gender identity (SOGI) and conduct meaningful analysis of that data for all patients.

- Include sexual orientation and gender identity fields on **patient intake forms**;
- Integrate these measures into clinical EHR;
- Ensure SOGI information capture is appropriate for youth of different ages;
- Train clinical providers to discuss SOGI during clinic visits when relevant to improve patient care and experience; and
- Create resource lists for front line staff with policies for legal name change and other non-medical transition-related services where available.

5. Ensure commitment to gender-affirming care within the patient pharmacy.

- Ensure a variety of gender-affirming medications are available on clinic pharmacy formulary to allow for patient choice;
- Integrate pharmacist into team of gender-affirming care clinicians;
- Advocate for gender-affirming medications to be included on national core formulary explicitly for gender-affirming use; and
- Ensure pharmacy staff use clients' correct names and pronouns when dispensing medication.

6. Ensure commitment to gender-affirming behavioral health care.

- Provide patient access to therapists, psychologists, and counselors with experience working with both Indigenous and gender-diverse patients;
- Ensure access to strengths-based behavioral health care for gender-diverse youth; and
- Initiate behavioral health referrals to gender-affirming providers as needed.

7. Foster a clear understanding of the clinic's abilities to provide competent gender-affirming care as well as its current limitations, and be transparent with patients about each.

- Support the free-flow of information about the current and pending status of national, state, and tribal policies;
- Publish protocols for I/T/U gender-affirming care and make those present and accessible within the clinic by request;
- Establish vetted referrals for services not currently provided within the clinic; and
- Be transparent about the specific limitations a clinic or provider may face in supporting gender-diverse youth, especially minors.

BEST PRACTICE CARE FOR GENDER-DIVERSE PATIENTS *CONTINUED*

8. Hire and train a patient navigator or social worker to coordinate gender-affirming care within and beyond the healthcare system.

- Support gender-diverse patients to navigate social, emotional, and physical wellness care. This can include finding medical, behavioral health, and other providers, assisting with name change and other legal needs, securing housing or employment, intimate partner violence services, emancipation, etc. (such as a Community Health Representative, Health Aide, or Centers for Medicare/Medicaid re-imbursable position);
- Support gender-diverse youth and their families through pre-pubertal, pubertal, and post-pubertal stages of gender-affirming care; and
- Recruit patient navigators and social workers who reflect the communities they serve.

9. Commit to integration of gender-affirming care across the continuum of clinical services.

- Institute a gender-affirming healthcare team in each clinic (may include primary care provider, endocrinologist, behavioral healthcare provider, front line staff, pharmacist, transitional medicine practitioner, and community health representative);
- Ensure a level of SOGI competency across clinical and human services staff;
- Ensure support for gender-diverse people with other health considerations, including HIV; and
- Integrate non-medical care at each clinic to include:
    - Access to Indigenous, gender-diverse-affirming voice therapists;
    - Access to pro-bono legal services to assist with ID documents, emancipation, and any other legal needs; and
    - Access to Indigenous practitioners with knowledge of the importance of pre-colonial gender systems.

ENSURING AFFIRMING ENVIRONMENTS

To safely and effectively access healthcare, gender-diverse patients need clinical environments in which they feel safe and accepted. Clinicians or medical directors are encouraged to take a quick survey to determine how affirming their clinic is for gender-diverse patients.

Based on a clinic's survey result, clinicians and/or medical directors can then use this online tool to identify actionable steps that will improve their clinic environment, making it more affirming for gender-diverse patients.

The Native Advocacy Workgroup for Trans Health will focus on the dissemination and implementation of these tools.

Our next steps are:

- Disseminate the checklist to clinics through regional and national meetings, face-to-face encounters, inclusion in clinical resource lists, and through Project ECHO;
- Ensure clinics can use and implement the suggested strategies by providing free print materials, pronoun buttons, and trainings to clinics;
- Use quality improvement/patient satisfaction surveys to begin to understand the needs of gender-diverse patients at I/T/U clinics (for instance, the IHS Consumer Satisfaction Survey);
- Integrate maintaining an affirming clinic environment into clinic policy;
- Set **national and public standards** for clinic affirmation.

IHS/TRIBAL/URBAN SYSTEMS SUPPORT

IHS, tribal, and urban Indian clinics need support to implement clinic-level changes in policy, affirming environments, and providing best-practice care. The following list avenues of potential support for I/T/U and partner agencies:

1. Locate grants and funding to support the needs of gender-diverse people.

IHS and partner agencies propose and support grants for gender-diverse health equity, explicitly funding initiatives that support:

- Access to behavioral healthcare for gender-diverse patients;
- Clinical training to create affirming clinic environments;
- Increased capacity of healthcare providers to offer gender-affirming care;
- Identify champion affirmative clinicians in each IHS region;
- Education of gender-diverse populations about medical and preventative care;
- Integration of Indigenous medicine; and
- Data collection to better understand needs of gender-diverse people, youth and adults.

2. Continue to support regular training on gender-affirming environments and care for all clinical staff. Clinical staff include healthcare providers, as well as intake, front-desk, transportation, and security staff.

- Prioritize support for and application of trainings intended to increase awareness of gender diversity and to promote gender-affirming care across the I/T/U system; and
- Include training on insurance access, coverage of gender-affirming care, and appeals.

3. Support the recruitment and retention of mental health providers who have experience with gender-diverse patients, both youth and adults.

- Train providers to provide trauma-informed and strengths/resiliency-focused care; and
- Integrate Indigenous methods of healing.

4. Support access to gender-affirming providers.

- Provide a patient-facing list of gender-affirming and Indigenous-affirming providers.

POTENTIAL PARTNERS

Note: We have deliberately prioritized organizations led by Indigenous and/or gender-diverse people and those which focus on Indigenous gender-diverse communities in the list below.

NATIONAL ORGANIZATIONS:

- National Congress of American Indians
- National Indian Health Board
- National Council of Urban Indian Health
- Association of American Indian Physicians
- National Indian Law Resource Center
- Native American Rights Fund
- Indian Health Service
- Transgender Law Center
- National Minority AIDS Coalition
- Office of Minority Health
- U.S. Department of Veterans Affairs - The Veterans Health Administration
- Health Resources and Services Administration
- The Fenway Institute

REGIONAL ORGANIZATIONS:

- Tribal Epidemiology Centers
- Indigenous Health Boards
- University of California, San Francisco
- Indiana University LGBTQ+ ECHO
- Trans Resource Centers Associated with State Universities

LOCAL AND COMMUNITY ORGANIZATIONS:

- Native Community-Based Non-Profits
- IHS/Tribal/Urban Clinics

APPENDIX A:
EXAMPLE CLINIC NONDISCRIMINATION POLICY

Oklahoma City Indian Clinic

Oklahoma City Indian Clinic Policies and Procedures

<table>
<tr><th colspan="3">LGBTQ2 Non-Discrimination and Transgender Healthcare Rights</th></tr>
<tr><td colspan="3">Ownership: Administration</td></tr>
<tr><td colspan="3">Applicable Departments: All Departments</td></tr>
<tr><td>Effective Date:
July 27, 2018</td><td>Last Review:
September 15, 2020</td><td>Last Board Review Date:
April 25, 2019</td></tr>
<tr><td>Last Policy Revision:
July 20, 2018</td><td>Approved By:
Janice Hixson, MD
Chief Medical Officer</td><td>Board Approval Date:
July 27, 2018</td></tr>
<tr><td>Last Procedure Revision:
September 15, 2020</td><td>Approved By:
Robin Parker
Director of Policy Development</td><td>Board Approval Not Required</td></tr>
<tr><td colspan="3">Reference / Regulatory Standard:
• AAAHC Chapter 1: A
• National Center for Transgender Equality www.transequality.org/know-your-rights/healthcare
• The Center of Excellence for Transgender Health (CoE) at the University of California - San Francisco Guidelines for the Primary and Gender - Affirming Care of Transgender and Gender Nonbinary People. http://transhealth.ucsf.edu/trans?page=protocol-00-00
• The Fenway Institute, Boston, MA http://doaskdotell.org/ehr/toolkit/
• Human Rights Campaign www.hrc.org
• Section 1557 of the Affordable Care Act (2010)</td></tr>
</table>

Purpose:
Studies have shown that transgender individuals may avoid seeking care due to prior discrimination in a health care setting. Providing a safe, welcoming, and culturally appropriate clinic environment is essential to ensure that transgender and gender diverse people not only seek care, but return for follow-up. Under the Affordable Care Act, it is illegal for any health care provider, health insurance company, health program or organization that receives any federal funding (including accepting Medicare or Medicaid payments for any patients) or is administered by a federal agency to discriminate against anyone because they identify as transgender or because they don't conform to gender stereotypes.

Policy:
Oklahoma City Indian Clinic (OKCIC) will provide a safe, welcoming and culturally appropriate clinical environment that does not discriminate against any person on the basis of gender identity, gender expression, sexual orientation, or transgender status. OKCIC will comply with all federal regulations to protect patient rights. All LGBTQ/Two- Spirit patients will be treated with respect, and according to their gender identity.

OKCIC promotes patient and family-centered care by allowing patients to be accompanied by a visitor(s) of their choice including, but not limited to, a spouse, domestic partner (including a same sex domestic partner), family members, or a friend, for emotional support during the course of their visit, except treatment areas where visitors are generally not allowed (i.e. dental operatory). Visitors designated by the patient or health care proxy, where appropriate, do not have to be legally related to the patient and patients are able to withdraw or deny such consent at any time.

Types of Prohibitive Discrimination by Health Care Providers:
It is illegal for health care providers that receive federal money to do any of the following based upon a patient's gender identity:

- Refuse to admit or treat the patient
- Force the patient to have intrusive and unnecessary examinations
- Refuse to provide services that are provided to other patients
- Refuse to treat a patient according to their gender identity, including providing access to restrooms consistent with the patient's gender identity
- Harass or refuse to respond to harassment by staff or other patients
- Refuse to provide counseling, medical advocacy or referrals, or other support services
- Isolate or deprive the patient of human contact, or limit patient participation in social or recreational activities offered to others
- Require the patient to participate in "conversion therapy" for the purpose of changing their gender identity
- Harass, coerce, intimidate, or interfere with the patient's ability to exercise their health care rights
- In every state, most insurance companies aren't allowed to exclude transition-related care

Definitions and Terminology:
OKCIC adopts the following definition of "family" for purposes of clinic-wide visitation policy:

- **Family:** Any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual. Members of "family" include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" includes a minor patient's parents, regardless of the gender of either parent. Solely for purposes of visitation policy, the concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same-sex parents, step-parents, those serving in loco parentis, and other persons operating in caretaker roles.

The following definitions are some commonly encountered terms, based on North American English language use. A detailed discussion of terminology in the context of the great diversity of transgender and gender nonconforming people encountered across cultures and languages is beyond the scope of these guidelines.

- **Cisgender:** A person whose gender identity and assigned sex at birth correspond (i.e. a person who is non-transgender) (cis = same side in Latin).
- **Cross Dresser / Drag Queen / Drag King:** These terms generally refer to those who may wear the clothing of a gender that differs from the sex, which they were assigned at birth for entertainment, self-expression, or sexual pleasure. Some cross dressers and people who dress in drag may exhibit an overlap with components of a transgender identity. The term transvestite is no longer used in the English language and is considered pejorative.
- **Cross-Sex Hormone Therapy:** The administration of hormones for those who wish to match their physical secondary sex characteristics to their gender identity.
- **Disorders of Sex Development (DSD):** Group of rare conditions where the reproductive organs and genitals do not develop as expected. Some DSDs include Klinefelter Syndrome and Androgen Sensitivity Syndrome. Sometimes called differences of sex development. Some prefer to use the term intersex.
- **Gender Affirming Surgery (GAS):** Surgeries used to modify one's body to be more congruent with one's gender identity. Also referred to as sex reassignment surgery (SRS) or gender confirming surgery (GCS). "Bottom surgery" is a colloquial way of describing gender affirming genital surgery
- **Gender Dysphoria:** Distress experienced by some individuals whose gender identity does not correspond with their assigned sex at birth. Manifests itself as clinically significant distress or impairment in social, occupational, or other important areas of functioning. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes gender dysphoria as a diagnosis. Gender dysphoria is not the same as gender nonconforming or being gay/lesbian.
- **Gender Expression:** The outward manner in which an individual expresses or displays their gender. This may include choices in clothing and hairstyle, or speech and mannerisms. Gender identity and gender expression may differ; for example a woman (transgender or non-transgender) may have an androgynous appearance, or a man (transgender or non-transgender) may have a feminine form of self-expression.

- **Gender Fluid:** Describes a person whose gender identity is not fixed. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more one gender some days, and another gender other days
- **Gender Identity:** A person's internal sense of self and how they fit into the world, from the perspective of gender. An internal sense of being a man/male, woman/female, both, neither, or another gender.
- **Gender Identity Data:** Includes chosen name, chosen pronouns, current gender identity, and sex listed on original birth certificate. Failure to collect and use gender identity data has several important repercussions, including difficulties in tracking the organ inventories and preventive health needs of transgender people, invisibility of gender and sexual minority populations to policy makers and researchers, and reduced patient satisfaction due to a failure to use chosen names and pronouns.
- **Gender Nonconforming:** A person whose gender identity differs from that which was assigned at birth, but may be more complex, fluid, multifaceted, or otherwise less clearly defined than a transgender person. Genderqueer is another term used by some with this range of identities.
- **Intersex:** Group of rare conditions where the reproductive organs and genitals do not develop as expected. Some prefer to use the term disorders (or differences) of sex development. Intersex is also used as an identity term by some community members and advocacy groups. (Avoid outdated term of Hermaphrodite)
- **LGBTQ2:** (Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), Two-Spirit Community) "Two-spirited" refers to a person who has both a masculine and a feminine spirit, and is used by some First Nations people to describe their sexual, gender and/or spiritual identity.
- **Nonbinary:** Transgender or gender nonconforming person who identifies as neither male nor female.
- **Sex:** Historically has referred to the sex assigned at birth, based on assessment of external genitalia, as well as chromosomes and gonads. In everyday language is often used interchangeably with gender, however there are differences, which become important in the context of transgender people.
- **Sexual Orientation:** Describes sexual attraction only, and is not directly related to gender identity. The sexual orientation of transgender people should be defined by the individual. It is often described based on the lived gender; a transgender woman attracted to other women would be a lesbian, and a transgender man attracted to other men would be a gay man.
- **SO/GI:** Refers to sexual orientation and gender identity data used to track and improve LGBT health outcomes.
- **They/Them/Their:** Gender neutral pronouns used by some who have a nonbinary or nonconforming gender identity.
- **Transgender:** A person whose gender identity differs from the sex that was assigned at birth. May be abbreviated to trans. A transgender man is someone with a male gender identity and a female birth assigned sex; a transgender woman is someone with a female gender identity and a male birth assigned sex. (Avoid the term trany as this is outdated and considered offensive)

- **Trans-masculine / trans-feminine:** Terms to describe gender nonconforming or nonbinary persons, based on the directionality of their gender identity. A trans-masculine person has a masculine spectrum gender identity, with the sex of female listed on their original birth certificate. A trans-feminine person has a feminine spectrum gender identity, with the sex of male listed on their original birth certificate. In portions of these Guidelines, in the interest of brevity and clarity, transgender men/women are inclusive of gender non-conforming or nonbinary persons on the respective spectrae.
- **Transsexual:** A more clinical term which had historically been used to describe those transgender people who sought medical intervention (hormones, surgery) for gender affirmation. Term is less commonly used in present day; however some individuals and communities maintain a strong and affirmative connection to this term.
- **Two-Spirit:** A contemporary term that connects today's experiences of LGBT Native American and American Indian people with the traditions from their culture (avoid outdated term of Berdache).
- **Ze/Hir/Hirs:** Gender neutral pronouns used by some who have a nonbinary or nonconforming gender identity. Pronounced zee/hear/hears

Procedures:
For the purposes of clarity and simplicity, the term transgender will be used throughout these guidelines to refer to transgender, gender nonconforming, and genderqueer people as a set, unless otherwise indicated. Non-transgender people will be referred to as such.

1. Oklahoma City Indian Clinic (OKCIC) has established a Diversity Council who is responsible for addressing LGBTQ/Two-Spirit health and healthcare inequities throughout the Clinic. The Council has developed a strategic plan to increase data collection, ensure highest quality of care, and collaborate with community groups to better serve gender diverse patients.
2. A transgender care team has been established in the Endocrinology Clinic. Patients will still maintain their PCP care team for all other medical services. The Prevention Specialist in the Public Health Department will serve as the Case Manager to navigate transgender services within and outside the Clinic as warranted.
3. OKCIC staff members should be aware of basic **terminology** used by the LGBTQ2 community. In addition to the terminology described in these guidelines (which are based on North American English language use), other local or individual terms may exist and also may change over time.
4. Each patient should be approached as an individual with no preconceptions. When addressing patients, avoid using gender specific terms like "sir" or "ma'am". Ask "How may I help you today?" as an alternative.
5. Patient privacy must be protected and discussions related to an individual's gender identity must be done privately. Never "out" someone without their permission. Once a patient's preferences are known, they should be referred to by their preferred (chosen) name and pronoun during the entire visit.

6. When conducting patient care, clinical staff should use a gender affirming approach. Gender affirmation is when an individual is affirmed in their gender identity through social interactions. This may also include using general terminology for body parts, or asking patients if they have a preferred term to be used.
7. Staff members are encouraged to foster an environment of accountability and not be afraid to politely correct a colleague if they use the wrong name and pronoun, or if they make insensitive comments. Creating an environment of accountability and respect requires everyone to work together.
8. Single-occupant gender neutral restrooms are available throughout the OKCIC campus for the comfort of gender diverse patients and visitors.
9. All patients are given an opportunity to communicate their Sexual Orientation / Gender Identity (SO/GI) preferences including preferred name, so that they may be addressed in the way they wish to be addressed. Preferred names are identified in RPMS/EHR with an asterisk to the right of the name. Preferred pronouns will be communicated to clinical staff through the use of Patient Flags in RPMS/EHR. Preferred pronouns include she/her/hers for transgender women and he/him/his for transgender men. Some individuals may identify outside of the gender binary and not identify strictly as male or female. They may prefer gender neutral pronouns that can include they/them/their or other, new pronouns such as ze/hir/hirs (pronounced zee/hear/hears). SO/GI data will be captured and recorded as follows:
    a. SO/GI data is entered into RPMS/EHR in the Patient Registration package.
    b. Data collected at the provider-level should be communicated to the Patient Registration Department for data entry.
    c. Registration staff will notify the Health Information Management (HIM) Director to set up a patient identity flag in the electronic health record that includes the patient's preferred name and pronoun.
    d. Clinical staff members are presented with the flag (dialog box) when accessing a patient's electronic health record to initiate care. The preferred name and pronoun should be used consistently in all conversations with or about the patient. The SO/GI information will also assist the care team in providing services and treatments that fit the patient's individual health care needs.
10. Gathering gender identity information by clinical staff is typically done using the two-step method:
    a. Gender Identity
        - Male
        - Female
        - Transgender Male
        - Transgender Female
        - Other _____
          (Identifies as Two-Spirit)
          (Not exclusively male or female)
          (Do not identify as male, female, or transgender)
    b. Sex assigned at birth (on birth certificate)

11. The patient's sex assigned at birth will be identified in the "Birth Sex" field in RPMS/EHR to ensure appropriate preventative health reminders are addressed. For example: an affirmed woman will still have a prostate gland and an affirmed man may still have his uterus and ovaries.

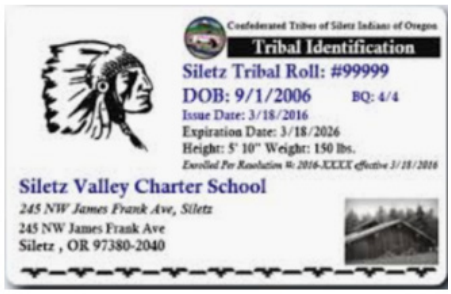
12. The "legal sex" gender marker may be identified in RPMS/EHR in the SO/GI section and must include the legal document source and effective date.

13. Health Level Seven (HL7) refers to a set of international standards for transfer of clinical and administrative data between software applications used by various healthcare providers. HL7 codes for "administrative gender" are separate and distinct from current gender identity and assigned sex at birth. Administrative gender data should only be used as necessary, such as for insurance billing purposes and should not be used for identifying, housing, or communicating with patients. As rules regarding insurance coverage for transgender individuals change, this use is expected to become obsolete.

14. Section 1557 of the Affordable Care Act (ACA) prohibits discrimination in health coverage and care based on sex, including discrimination based on gender identity or sexual orientation. That means that most insurers, including Medicare, Medicaid, and insurance companies that offer state and federal Marketplace plans, cannot deny or limit coverage simply because the treatment someone is receiving is related to their gender identity. For example, an insurance company cannot automatically deny coverage for transition-related care. If the plan covers a treatment for other people, the carrier cannot refuse to cover the same treatment simply because it is being used by a transgender individual, or because it is being used to treat transgender dysphoria. This law applies to Marketplace insurance plans in Oklahoma. Patients that believe a health insurance plan is violating their rights should be referred to the Senior Benefits Coordinator for assistance.

APPENDIX B:
EXAMPLE TRIBAL ID DOCUMENTS

Confederated Tribes of Siletz Indians



The Confederated Tribes of Siletz Indians does not include a gender marker on their Tribal ID Card.

Their Tribal Identification Request Form therefore does not need to ask about gender.

FORM # ENROLL-008

Confederated Tribes of Siletz Indians
Enrollment Department
201 SE Swan Ave
PO Box 549
Siletz, Oregon 97380-0549
Telephone: (541)444-8258 ● Toll Free: (800) 922-1399 ext. 1258
E-Mail: angelar@ctsi.nsn.us

- Enrollment Staff Use -
Rec'd: _____
By: _____
Entered: _____
By: _____

Siletz Tribal Identification (ID) Request

Please print clearly in blue or black ink

INSTRUCTIONS: If you are not able to come into the Enrollment office to have your Tribal ID issued in person, you can order it by submitting this form. If there is no photo/signature on file or your photo on file is over twelve (12) months old, complete this form to order a Siletz Tribal ID to be issued and it will be sent to you via Certified mail.

Siletz Tribal Member: _____ Roll#: _____

☐ 1. Updated Address: Submit an "Address & Contact Information Update" form

☐ 2. Height: _____ feet _____ inches Weight: _____ pounds

☐ 3. Digital Photo Specifications: Email to "angelar@ctsi.nsn.us"
- a. In color, no filters and clearly focused
- b. Plain white or off-white background
- c. Taken within the last six-months to reflect your current appearance
- d. Taken in full-face view directly facing the camera, no shadows on your face
- e. Both eyes open, neutral/smiling facial expression, no hats
- f. No sunglasses (even if tinted prescription glasses)
- g. Glare on clear glasses is not acceptable. Glare can be avoided by slight downward tilt of glasses, turning off the flash or removing the glasses.

☐ 4. Photo Verification: Submit a color copy of your State issued ID to confirm your identity

☐ 5. Signature: Sign within the box in front of a notary as this is what will be used on your ID card

_____
Date

Relationship to Tribal Member: ☐ Self ☐ Parent ☐ Guardian of Minor* ☐Guardian of Adult*
*Attach court or other legal documentation to show Guardianship/Power of Attorney

REQUIRED NOTARIZATION FOR SIGNATURE VERIFICATION

STATE OF _____

COUNTY OF _____

This instrument was acknowledged before me on _____ (date) by _____ (name of person).

Notary Public:

_____

Print Name: _____

My Commission Expires: _____

ADOPTED PER RESOLUTION 2015-266, 9/18/2015

The Confederated Tribes of Siletz Indians include "Nonbinary" as a gender option for individuals seeking to change their name on the tribal roll.

FORM # ENROLL-004

SILETZ TRIBAL OFFICE USE ONLY

RECEIVED DATE: _____ RECEIVED BY: _____

COMPLETE DATE: _____ POST #: _____

Confederated Tribes of Siletz Indians
Enrollment Department
201 SE Swan Ave
PO Box 549
Siletz, Oregon 97380-0549
Telephone: (541)444-8258 ● Toll Free: (800) 922-1399 ext. 1258

Request for Name Change

INSTRUCTIONS: To change your name on the Siletz Tribal Roll you must submit legal documentation (Marriage Certificate, Court Order, Divorce Decree, etc.) and a copy of your social security card showing your legal updated name. **Failure to provide these documents will result in no action being taken**.

NOTE: *For IRS tax purposes (per capita, etc.) it is important your name on the Tribal Roll and your Social Security Card match exactly.*

Siletz Tribal Roll #:_____

Change From (Current Name on Tribal Roll):

FIRST NAME	MIDDLE	LAST

Change To: (As listed on Social Security Card)

FIRST NAME	MIDDLE	LAST

Required documentation submitted:

☐ ORIGINAL* legal documentation showing my name change

☐ A clear COLOR COPY of my social security card showing the name change

*Originals will be returned via Certified mail after staff has made a copy for your request

I certify the above information is correct and current.

X _____ _____

Signature of Tribal Member/Guardian Date

Phone Number: _____

Email Address: _____

REVISED PER RESOLUTION 2017-075, 03/16/2017

APPENDIX C:
EXAMPLE GUIDELINES FOR GENDER-AFFIRMING CARE

Click each link to learn more:

UCSF Transgender Care Navigation Program

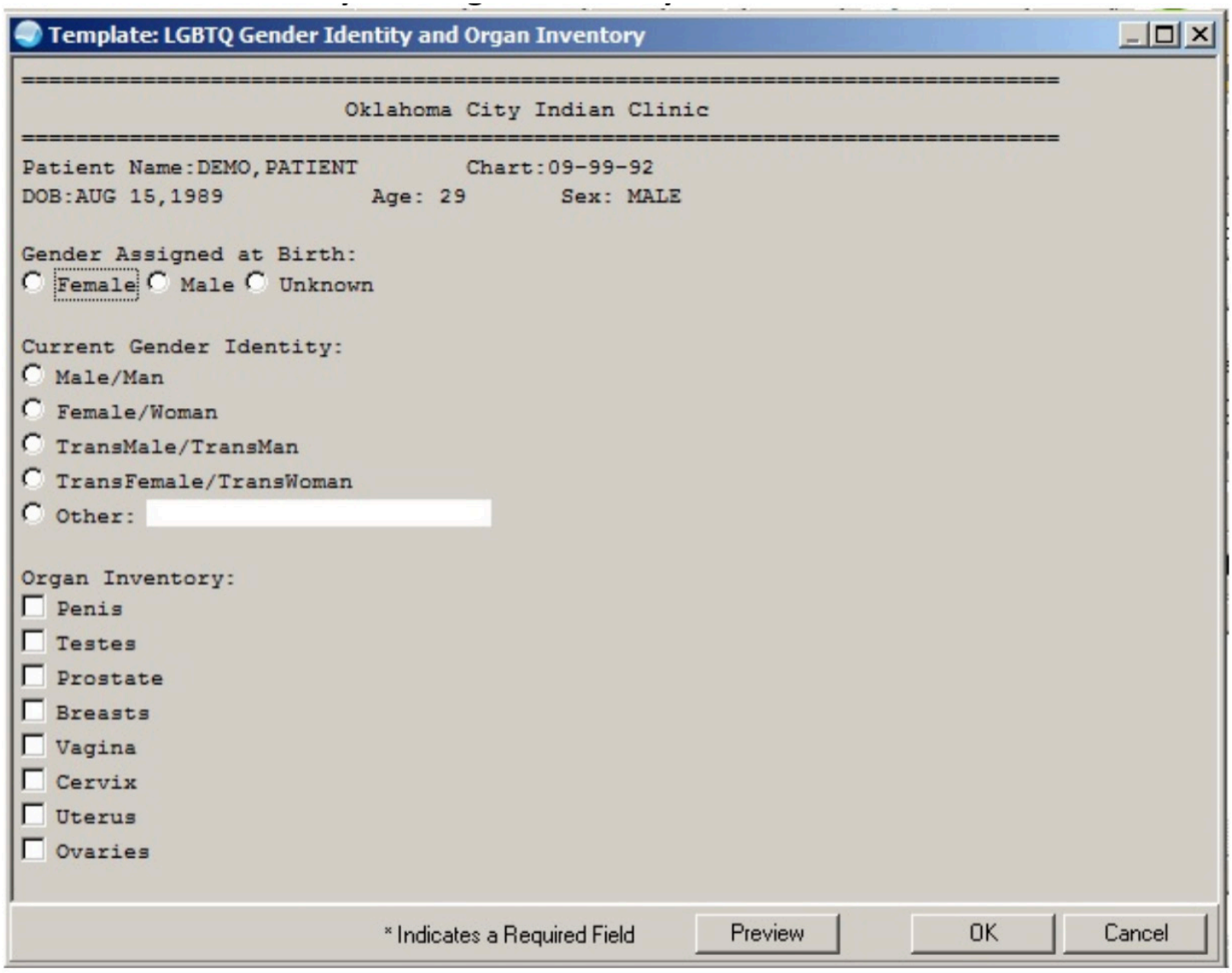
Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline

Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

World Professional Association for Transgender Health
(Note: Some of the language used by WPATH could be considered outdated.)

APPENDIX D:
EXAMPLE ORGAN INVENTORY IN EHR

Oklahoma City Indian Clinic



APPENDIX E:
SAMPLE QUESTIONS FOR INTAKE FORMS

Native Advocacy Workgroup for Trans Health

Sexual Orientation & Gender Identity Measures:

What is your sexual orientation? [Check all that apply.]

- ☐ Two Spirit
- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Pansexual
- ☐ Asexual
- ☐ Questioning
- ☐ Queer
- ☐ Not listed:_____
- ☐ Choose not to disclose

What is your gender identity? [Check all that apply.]

- ☐ Two Spirit
- ☐ Man
- ☐ Woman
- ☐ Trans man
- ☐ Trans woman
- ☐ Transgender
- ☐ Nonbinary
- ☐ Agender
- ☐ Genderqueer
- ☐ Genderfluid
- ☐ Not listed:_____
- ☐ Choose not to disclose

Please indicate your sex assigned at birth:

- ☐ Male
- ☐ Female
- ☐ or Are you intersex?
  - ☐ Yes
  - ☐ No

Additional Clinical Measures:

Name: _____
Last First Middle

Legal Name (if different from above): _____

Please indicate your pronouns: _____

Additional Clinical Measures *continued*:

I have:

- ☐ Ovaries
- ☐ Penis
- ☐ Prostate
- ☐ Vagina
- ☐ Chest tissue
- ☐ Uterus
- ☐ Cervix
- ☐ Testes

If relevant for care:

In the past three months, with how many partners have you been sexually active? _____

In the past three months, what kinds of sex did you have? [Check all that apply.]

- ☐ Receptive anal sex
- ☐ Insertive anal sex
- ☐ Receptive vaginal sex
- ☐ Insertive vaginal sex
- ☐ Receptive oral sex
- ☐ Insertive oral sex
- ☐ Stimulation using toys (dildo, butt plug, etc.)
- ☐ Stimulation using hands (fisting, hand job, etc.)

APPENDIX F:
SAMPLE CONSENT FORMS FOR HORMONE THERAPY

Consent Form – Testosterone

This form refers to the use of testosterone by persons who wish to become more masculinized as part of a gender transitioning process.

Your initials of the various statements on this form indicate that the risks as well as the changes which may occur as a result of the use of testosterone have been explained to you and that you understand them. If you have questions or concerns about this information, you are encouraged to take the time you need to ask for clarification, read, research, talk with staff, and think about the potential effects of this treatment before signing this document.

IF YOU DO NOT UNDERSTAND THIS INFORMATION, PLEASE STOP AND ASK FOR CLARIFICATION.

Please have the Legally Authorized Representative initial each section below to indicate that you understand and agree with the statements.

Masculinizing Effects

1. I/my child have been informed that the masculinizing effects of testosterone therapy may take several months to become noticeable and more than five (5) years to be complete.

I/my child understand that the following changes will be permanent:

- Hair loss at the temples and crown of the head, possibly male-pattern baldness
- Facial hair growth (beard, moustache)
- Deepening of my voice (lower voice pitch)
- Increased body hair growth (arms, legs, chest, back, buttocks, abdomen, etc.)
- Genital changes may be permanent (clitoral enlargement)

I/my child understand that the following changes are usually not permanent:

- Redistribution of fat to a male pattern (i.e., abdominal fat may increase while fat in the breasts, buttocks, and thighs may decrease)
- Increased muscle development
- Increased sex drive and energy levels. Possibly increased feelings of aggression or anger
- Acne, which may become severe and cause scarring without treatment
- Cessation of menstrual cycles (periods), suspended ovulation (maturing of ova/eggs), and genital changes (usually thinning of vaginal tissue leading to increased potential for easy damage, dryness, or yeast infections) may not be permanent

I/my child understand that there are some aspects of the body that will not be changed by testosterone:

- Breasts may appear slightly smaller due to fat loss, but will not substantially shrink
- Although voice pitch will likely drop, other aspects of speech will not become more masculine.

2. I/my child have been informed that it is not known exactly what the effects of testosterone are on fertility and that if the testosterone is stopped; it may or may not be possible to get pregnant in the future. I/my child have been advised to undergo gamete (egg) banking if this is a concern.
3. I/my child have been informed that brain structures are affected by testosterone and estrogen. The long-term effects of changing levels of one's natal estrogen through the use of testosterone therapy have not been scientifically studied and are impossible to predict. These effects may be beneficial, damaging, or both.
4. I/my child have been informed that everyone's body is different and that there is no way to predict what the response to hormones will be. I/my child have also been informed that the right dosage for me/my child may not be the same as for someone else and that in order to continue to receive hormone therapy at this clinic, the prescribed regimen of testosterone treatment must be followed.
5. I/my child have been informed that physical examination and lab tests will be needed periodically to monitor the effects of testosterone on the body and that this is required to continue therapy at this health center.

Risks of Testosterone and Prevention of Medical Complications

6. I/my child have been informed that the medical effects and safety of testosterone are not fully understood, and that there may be long-term risks that are not yet known.
7. I/my child have spoken to an affirming behavior health clinician (such as a psychiatrist, psychologist, or counselor) regarding the decision to pursue masculinizing therapy. Aside from starting masculinizing therapy, it is strongly recommended to engage in on-going psychotherapy because it may offer support as I/my child continue to develop gender identity, adjust to body changes, and negotiate relationships with other important people in my/my child's life.
8. I/my child have been informed and strongly advised not to take more testosterone than prescribed, as this increases health risks. I/my child have been informed that taking more will not make masculinization happen more quickly or increase the degree of change. Extra testosterone can be converted to estrogen, which may slow or stop masculinization.
9. I/my child have been informed that testosterone can cause changes that increase the risk of heart disease:
   - Decreasing good cholesterol (HDL), increasing bad cholesterol (LDL)
   - Increasing blood pressure
   - Increasing fat deposition around my internal organs

Risks of Testosterone and Prevention of Medical Complications (continued)

10. I/my child have been informed that the risks of heart disease are greater if people in the family have had heart disease, if I/my child am overweight, or smoke cigarettes.
11. I/my child have been informed that testosterone can increase the risk for diabetes by decreasing the body's response to insulin, causing weight gain, and increasing fat deposition around internal organs. I/my child have been advised that glucose levels will be monitored periodically while taking testosterone.
12. I/my child have been informed that testosterone may lead to liver inflammation and damage and that I/my child will be monitored for liver problems before starting testosterone therapy and periodically during therapy.
13. I/my child have been informed that testosterone can increase red blood cells and hemoglobin, and while the increase is usually only to a normal range for males (which does not pose health risks); a high increase can cause potentially life- threatening problems such as stroke and heart attack. I/my child have been advised that my/my child's blood will be monitored periodically while on testosterone.
14. I/my child have been informed that testosterone can be converted to estrogen by various tissues in the body, and that it is not known whether this increases the risk of ovarian cancer, breast cancer, or uterine cancer. I/my child have been advised that pelvic exams and regular cervical cancer screenings are strongly recommended unless there has been a removal of the ovaries, uterus, and cervix. Annual breast exams, monthly self-exams and annual mammograms after the age of 40 are highly recommended, even after chest reconstruction.
15. I/my child have been informed that testosterone can lead to the cervix and the walls of the vagina becoming more fragile, and this can lead to tears or abrasions that increase the risk of sexually transmitted infections (including HIV) from having vaginal sex. A frank discussion with the doctor about sexual practices can help determine how best to prevent and monitor for sexually transmitted diseases.
16. I/my child have been informed that the effects of testosterone therapy by itself will not provide protection from sexually transmitted diseases or HIV. Use of barriers and safer sexual practices are recommended to reduce chances of infections.
17. I/my child have been informed that testosterone therapy should not be relied upon to prevent pregnancy. Even with the cessation of periods, use of a barrier method of birth control is advised during sex where semen could enter the vagina or uterus.
18. I/my child have been informed that testosterone therapy can cause headaches or migraines. If frequent headaches or migraines occur, or if the pain is unusually severe, it is recommended to talk with the health care provider. I/my child have been informed that the masculinizing effects of testosterone therapy may take several months to become noticeable and more than five (5) years to be complete.
19. I/my child have been informed that testosterone therapy may cause changes in emotions and moods, including increased irritability, frustration and anger. I/my child have been advised that the providers can assist in finding support services and other resources to explore and cope with these changes.

Risks of Testosterone and Prevention of Medical Complications (continued)

20. I/my child agree that if I/my child have any adverse reactions or side effects to testosterone I/my child will inform the provider.
21. I/my child agree to tell the provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs, or medications I/my child might be taking. Sharing this information will help the provider to prevent potentially harmful interactions. I/my child have been informed that staff will continue to provide medical care, regardless of what information is shared with them.
22. I/my child agree to take testosterone as prescribed and to inform the provider of any problems or dissatisfaction I/my child may have with the treatment.
23. I/my child agree that physical examinations, blood tests and check-ups are needed on a regular basis to monitor changes and check for negative side effects of testosterone.
24. I/my child have been informed that there are medical conditions that could make taking testosterone dangerous. If the provider suspects I/my child may have any condition that could be dangerous, I/my child agree to be evaluated for it before the decision to start or continue testosterone therapy is made.
25. I/my child have been informed that I/my child can choose to stop taking testosterone at any time and that it is advised to do this with the help of the health care provider. I/my child also understand that the provider can discontinue treatment for clinical reasons. I/my child agree to follow a prescribed reduction plan if either of these situations occurs to reduce negative, potentially harmful side effects that may occur if I/my child suddenly stop taking testosterone.

All of the information above has been explained to my satisfaction AND (check only one):

☐ I/my child choose to begin testosterone therapy

☐ I/my child do not wish to begin testosterone therapy at this time.

SIGNATURES

By signing below, I acknowledge that I/my child have been provided the opportunity to have any questions answered to my satisfaction concerning the testosterone therapy. I believe I know enough to give informed consent for me/my child to take, refuse or postpone using the proposed medications. I understand and have had the opportunity to ask questions about the risks, benefits and alternatives, and consent to the treatment as discussed with my/my child's physician. I have no further questions. I understand that no guarantees have been made to me about the results of the process.

Signature of Patient	Printed Name of Patient	Date	Time
Signature of Legally Authorized Representative		Date	Time
Signature of Legally Authorized Representative		Relationship to Patient	
Witness' Signature		Date	Time
Practitioner's Signature	Printed Name of Patient	Date	Time

(I have explained to the above patient/legally authorized representative the nature of this process. In addition to the advising of the medically acceptable benefits and possible alternative modes of treatment, I have explained in lay terms the risks, benefits and alternatives which are or may be associated with this treatment.)

Interpreter Signature/Telephonic ID Number	Interpreter's Printed Name	Date	Time

Consent Form – Feminizing Hormones

This form refers to the use of estrogen and/or androgen antagonists (also called "anti-androgens" or "androgen blockers") by persons who wish to become more feminized as part of a gender transitioning process.

Your initials of the various statements on this form indicate that the risks as well as the changes which may occur as a result of the use of estrogen and/or androgen antagonists have been explained and that you understand them. If you have any questions or concerns about this information, you are encouraged to take the time you need to ask for clarification, read, research, talk with staff and think about the potential effects of this treatment before signing.

IF YOU DO NOT UNDERSTAND THIS INFORMATION, PLEASE STOP AND ASK FOR CLARIFICATION.

Please have the Legally Authorized Representative initial each section below to indicate that you understand and agree with the statements.

Feminizing Effects

1. I/my child have been informed that the feminizing effects of estrogen and androgen antagonists can take several months to become noticeable, several years to be complete, and that the rate and degree of change cannot be predicted.

I/my child have been informed that the following changes are permanent (they will not reverse, even if I/my child stop taking feminizing medications):

- Breasts may take several years to develop fully. There are natural variations in the size of breasts, and one person's breast development does not correlate with that of another person's. Even if estrogen therapy is discontinued, the breast tissue that has developed will remain. As soon as breasts start growing, it is recommended to start doing monthly self-exams and to have annual breast exams by a health care provider. It is not known if taking estrogen increases the risk of breast cancer. Also, there may be milky nipple discharge (galactorrhea). This can be caused by taking estrogen or by an underlying medical condition. It is advised to check with a doctor to determine the cause if you experience galactorrhea.

I/my child have been informed that the following changes are not permanent (they will reverse if I/my child stop taking feminizing medications):

- Skin may become softener
- Muscle mass decreases and there may be a decrease in upper body strength
- Facial and body hair growth may become less noticeable and grow more slowly, but it will not likely stop completely
- Male pattern balding may slow down, but it will probably not stop
- Redistribution of body fat to a more female pattern (i.e. abdominal fat may decrease while fat on the buttocks/hips/thighs may increase)

I/my child have been informed that there are some aspects of the body that will not be changed by feminizing medications:

- Beard/moustache hair may grow more slowly but will not go away
- Voice pitch will not rise and speech patterns will not become more feminine
- The laryngeal prominence (Adam's apple) will not shrink

2. I/my child have been informed that it is not known exactly what the effects of estrogen therapy are on fertility. Estrogen decreases hormones that support the size and function of testicles, and this may affect overall sexual functioning and fertility. The changes that may occur include:
   - Up to 40% shrinkage in size of the testicles
   - Decrease in testosterone production from the testicles
   - Sperm will still be present in the testicles, but may stop maturing which may cause infertility
   - If estrogen therapy is stopped, the ability to make healthy, mature sperm may or may not ever come back
   - The amount and quality of erections and ejaculation may decrease or stop entirely
   - Erections may no longer be firm enough for penetrative intercourse
   - There may be a decrease or loss of morning and spontaneous erections
   - Sex drive or libido may decrease

Risks Related to Estrogen

3. I/my child have been informed that the medical effects and safety of feminizing medications are not fully understood, and that there may be long-term risks that are not yet known.
4. I/my child have been informed that it is strongly advised not to take more estrogen prescribed, as this increases health risks.
5. I/my child have been informed that brain structures are affected by testosterone and estrogen. The long-term effects of changing the levels of one's natal testosterone through the use of estrogen therapy have not been scientifically studied and are impossible to predict. These effects may be beneficial, damaging, or both.
6. I/my child have been informed that estrogen can damage the liver, possibly leading to liver disease and that there is a slight risk of long-term estrogen use causing liver cancer. I/my child agree that while on estrogen therapy I/my child will be monitored for liver problems before and periodically during therapy.
7. I/my child have been informed that estrogen increases the risk of blood clots (thrombosis), which can result in:
   - Deep vein thrombosis
   - Pulmonary embolism (blood clot to the lungs), which can cause permanent lung damage or death
   - Stroke (blood clot to the brain), which can cause permanent brain damage or death
   - Heart attack (blood clot to the heart), which may cause death
   - Chronic leg vein problems

Risks Related to Estrogen (continued)

8. I/my child have been informed that the risk of blood clots while on estrogen therapy is much higher if I/my child smoke tobacco, especially if over the age of 35. The danger is so high that I/my child should stop smoking completely if estrogen therapy is started. The medical provider can offer options to assist with the process of stopping smoking if so desired or needed.
9. I/my child have been informed that estrogen may increase fat deposition around internal organs, which is associated with increased risk for diabetes and heart disease.
10. I/my child have been informed that estrogen may cause increased blood pressure. If I/my child have existing high blood pressure or develop high blood pressure, the doctor will work with me/my child to control it with diet and exercise and/or medications.
11. I/my child have been informed that estrogen may raise triglycerides.
12. I/my child have been informed that estrogen may increase migraine headaches and that this may be a reason to choose to stop taking estrogen or may be a reason for estrogen to be discontinued by the provider.
13. I/my child have been informed that estrogen may cause nausea and vomiting, similar to morning sickness in a pregnant woman. If I/my child experience nausea and vomiting that is severe and/or prolonged, it should be discussed with the doctor.
14. I/my child have been informed that estrogen increases the risk of gallstones and that if I/my child have abdominal pain that is severe or prolonged, it is recommended to discuss this with the doctor.
15. I/my child have been informed that it is not known if taking estrogen increases the risk of non-cancerous tumors of the pituitary gland (prolactinoma). While this is not typically life-threatening, it can damage vision and cause headaches and will be monitored for at least three years after starting estrogen.
16. I/my child have been informed that it can take six months to notice a decrease in hair growth while on spironolactone treatment.
17. I/my child have been informed that spironolactone affects the balance of water and salts in the kidneys, which may:
    - Increase the amount of urine produced, making it necessary to urinate frequently
    - Increase thirst
    - Reduce blood pressure
    - Rarely, spironolactone may cause high levels of potassium in the blood, which can cause changes to the heart rhythm and be life- threatening
18. I/my child have been informed that if feeling sick or unable to eat for any reason (e.g. diarrhea, vomiting, fasting for labs or surgery, etc.), I/my child should not take the spironolactone, as this may cause me/my child to become more easily dehydrated and develop high sodium levels, which can be dangerous. Skipping spironolactone for a few days will not substantially impact the effect it has on the body. Call the health care provider with any questions.
19. I/my child have been informed some androgen antagonists make it more difficult to evaluate the results of PSA (prostate- specific antigen), which may make it more difficult to monitor prostate problems. If I am over 50, I should have my prostate evaluated every year.

Prevention of Medical Complications

20. I/my child have spoken to an affirming behavior health clinician (such as a psychiatrist, psychologist, or counselor) regarding the decision to pursue feminizing therapy. Aside from starting feminizing therapy, it is strongly recommended to engage in on-going psychotherapy because it may offer support as I/my child continue to develop gender identity, adjust to body changes, and negotiate relationships with other important people in my/my child's life.
21. I/my child agree to take estrogen and other transition-related medications as prescribed and to inform the provider of any problems or dissatisfactions I/my child may have with the treatment. I/my child have been informed that the right dose or type of medication prescribed for me/my child may not be the same as for someone else.
22. I/my child have been informed that physical examinations and lab tests are required to check for negative side effects of feminizing medications and to continue good health care. This is required to continue hormone therapy through this health center.
23. I/my child agree to tell the provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs, or medications I/my child might be taking. Sharing this information will help the provider to prevent potentially harmful interactions. The staff will continue to provide medical care, regardless of what information is shared with them. I/my child have been informed that the risk of blood clots while on estrogen therapy is much higher if I/my child smoke tobacco, especially if over the age of 35. The danger is so high that I/my child should stop smoking completely if estrogen therapy is started. The medical provider can offer options to assist with the process of stopping smoking if so desired or needed.
24. Due to breast development with estrogen therapy, I/my child understand that it will be necessary to do monthly self-breast examinations, have an annual medical exam, and, once 40 or older, I will need to have an annual mammogram.
25. I/my child have been informed that there is a slight chance that taking estrogen will cause overgrowth of the prostate. Prostate cancer screening is recommended for people 50 years of age and older as well as in younger people if otherwise medically indicated.
26. I/my child have been informed that there are medical conditions that could make it dangerous to take estrogen or androgen antagonists. If the provider suspects I/my child may have any condition that could be dangerous, I/my child agree to be evaluated for it before the decision to start or continue hormones is made.
27. I/my child have been informed that I/my child can choose to stop taking feminizing medication at any time, and that it is advised to do this with the help of the doctor to make sure there are no negative reactions to stopping. The doctor may suggest to reduce or stop taking feminizing medication, or switch to another type of feminizing medication, if there are side effects or health risks that can't be controlled.

All of the information above has been explained to my satisfaction AND:

☐ I/my child choose to begin taking estrogen.

☐ I/my child choose to begin taking androgen antagonists (e.g. spironolactone).

☐ I/my child do not wish to begin taking feminizing medication at this time.

SIGNATURES

By signing below, I acknowledge that I/my child have been provided the opportunity to have any questions answered to my satisfaction concerning the use of feminizing medications. I believe I know enough to give informed consent for me/my child to take, refuse or postpone using the proposed medications. I/my child understand and have had the opportunity to ask questions about the risks, benefits and alternatives, and consent to the treatment as discussed with my/my child's physician. I have no further questions. I understand that no guarantees have been made to me about the results of the process.

Signature of Patient	Printed Name of Patient	Date	Time
Signature of Legally Authorized Representative		Date	Time
Signature of Legally Authorized Representative		Relationship to Patient	
Witness' Signature		Date	Time
Practitioner's Signature	Printed Name of Patient	Date	Time

(I have explained to the above patient/legally authorized representative the nature of this process. In addition to the advising of the medically acceptable benefits and possible alternative modes of treatment, I have explained in lay terms the risks, benefits and alternatives which are or may be associated with this treatment.)

Interpreter Signature/Telephonic ID Number	Interpreter's Printed Name	Date	Time

Consent Form – Puberty Blockers

Before considering a medication for your child to put puberty "on hold", there are several things you need to know. There are possible advantages, disadvantages and risks with pubertal blockers. We have listed them here for you. It's important that you understand all of this information before your child begins the medication.

Please read the following carefully and ask us any questions you may have. We want you to be very comfortable and sure of what pubertal blockers offer your child.

After your questions or concerns are addressed, if you have decided to proceed with the pubertal blocker medication for your child, both you and your child will need to sign this consent form.

What are the possible advantages of putting my child's pubertal development "on hold"?

For gender-questioning, gender-fluid, and transgender children, there are possible advantages to delaying or putting on hold changes brought on by puberty. First, blocking pubertal development can prevent potential distress that can result from body changes brought on by puberty. Second, the pause of pubertal development in gender-questioning children allows these children time to further explore and understand more about their gender identities and their bodies without distress associated with puberty changes. And, third, the pause of pubertal development may be especially beneficial to transgender girls (male to female) because transgender adult women who have undergone male puberty during adolescence are often unable to 'pass' as female because of certain irreversible body changes caused by male puberty (e.g., height, growth of Adam's apple, lower pitch voice, widened stature, etc.). Being unable to 'pass' as female in adulthood may increase their safety risk and pose challenges to their integrating into society.

How can the physical changes of puberty be put "on hold"?

The main way that the physical changes of puberty can be put on hold is by blocking the signal from the brain to the organs that make the hormones of puberty. These hormones are estrogen and testosterone. Estrogen is made by the ovaries. Testosterone is made by the testicles.

What are the different medications that can put "on hold" the physical changes of puberty?

These medications are called Pubertal Blockers. Lupron™ is given monthly. Histrelin acetate (Supprelin®, Vantas®) is a subcutaneous implant that delivers medication for one year. These medications are effective for both males and females. They can be started just after the early physical changes of puberty.

For young adolescents who identify as female (but are born with male bodies), there are alternative medicines that can block the effect of testosterone. The most common medication of this type is called spironolactone. There is a separate consent form for this medication. Spironolactone is not as effective at blocking puberty in these youth, but it is much cheaper in price than LupronTM or histrelin acetate.

CONTINUED

For young adolescents who identify as male (but are born with female bodies), there are several reversible medications that can be used to block periods. These medications are not as effective at blocking many of the physical changes that puberty leads to in these youth, but are cheaper in price than Lupron TM or histrelin acetate.

Every medication has risks, benefits, and side effects that are important to understand before starting. It is also important to know how they work. Please have the Legally Authorized Representative initial each statement on this form to show that you understand the benefits, risks, and changes that may occur for your child by taking these medications.

Medications for Blocking Puberty

I have been informed that puberty blockers are used to help temporarily suspend or put "on hold" the physical changes of puberty for my child. If not suspended, some of the physical changes of puberty are permanent.

I have been informed it can take several months for the medication to be effective. I know that no one can predict how quickly or slowly my child's body will respond to medication.

This medication is not specifically made for the purpose of blocking puberty in youth who may be gender-questioning, gender-fluid, or transgender and exploring their gender identity (they are not approved for this purpose by the Federal Drug Administration (FDA); however, pediatric endocrinologists (doctors who work with hormones and puberty), pediatricians, and behavioral health clinicians (for example, psychiatrists, psychologists, and counselors), may recommend these medications if it is determined that the physical changes of puberty need to be postponed. Puberty blockers (LupronTM) have been used to block puberty in children with a condition known as precocious puberty (when puberty starts too early) for many years.

I have been informed that the effects of the medication are not permanent. If my child stops getting the injections, in about six months my child's body will restart the changes of puberty at the developmental stage they were at when they started the hormone blocker.

I have been informed that by taking these medications, my child's body will not be making the hormones of puberty, testosterone or estrogen. At this time, I support my child in "putting on hold" the hormones and the changes that they cause in puberty.

I have been informed that by providing these medications to my child I am avoiding the potential distress that physical changes brought on by puberty may have on my child, allowing exploration of gender identity over time without the fear of irreversible physical changes occurring.

I have been informed that by providing these medications to my child I may be helping them avoid the need for surgeries and other treatments (e.g., mastectomies for transgender men, tracheal shaving or electrolysis for transgender women) that some may eventually seek to reverse the effects of an undesired puberty.

CONTINUED

I have been informed that especially with transgender girls (male to female) this may also improve their safety and integration into society when they are adults. This is because transgender women who have undergone male puberty are often unable to 'pass' as female because of irreversible changes that male puberty causes.

I have been informed that if my child identifies as female (but is born with a male body), my child can take spironolactone instead of puberty blockers to block the effects of testosterone. If we are interested in this medication, we can review and sign a separate consent form.

I have been informed that if my child identifies as male (but born with a female body), my child can take a different medication instead of puberty blockers to prevent a monthly period from occurring (which may be very distressing to them). If we are interested in this medication, we can review and sign a separate consent form.

I have been informed that if I have any concerns about these issues I can meet with a pediatric endocrinologist to help us explore this and other options.

I have been informed that it is strongly recommended that my child and our family follow up with a behavioral health clinician (for example, a psychiatrist, psychologist, or counselor) who is experienced in gender issues while my child is taking puberty blockers at a frequency determined by that clinician and how my child is doing at the time.

I have been informed that I can ask my child's provider and therapist for help advocating for my child.

Risks of Puberty Blockers

I have been informed that the side effects and safety of these medications are not completely understood. There may be long-term risks that are not yet known.

I realize there may be a stalling of typical adolescent cognitive or brain development while on these medications. Puberty hormones (testosterone and estrogen) usually help with cognitive development and aspects of emotional development in the adolescent brain. The long-term effects of puberty blocking medications on brain development in this population have not been formally studied.

I have been informed that my child's growth should not stop while on puberty blockers, but the rate of growth may be slower compared to the rate typically observed during puberty. This can be beneficial for young adolescents who identify as female (but are born with a male body) to achieve a typical female height. In young adolescents who identify as male (but are born with a female body), delaying the onset of puberty may actually slightly increase height (one of the reasons that girls are usually shorter than boys is because puberty is typically started earlier in girls).

CONTINUED

I have been informed that blocking puberty will stop further development of genital tissue (scrotal and penile tissue in natal males and vaginal tissue in natal females), and this may impact my child's options for future gender confirmation surgery (if these are desired). Different types of surgeries may be associated with different risks and outcomes, and if I am interested in learning more about this, I am encouraged to contact a specialist in these types of surgeries.

I have been informed that common side effects of being on puberty blockers include headaches, fatigue, insomnia, muscle aches, mood changes and emotional lability (possible mood swings), weight gain and allergic reactions. Male-identified adolescents (born with a female body) may also experience breast tenderness and vaginal bleeding and female-identified adolescents (born with a male body) may experience gynecomastia (benign breast tissue growth).

I have been informed that additional side effects and risks of injectable forms of puberty blockers include pain and rash near the area of injection.

I have been informed that additional side effects and risks of implantable forms of puberty blockers include site reactions near the area of implantation (for example, bruising, discomfort, itching, pain, soreness, swelling and tingling), pain immediately following the procedure, scarring, itching, formation of sterile abscesses and other suture-related complications. Some people experience difficulty with removal of the implant. Rarely, the medication can cause seizures in children.

Prevention of Medical Complications

I have spoken to an affirming behavioral health clinician (such as a psychiatrist, psychologist, or counselor) regarding the decision to pursue pubertal blocking medication for my child. I am aware that aside from starting pubertal blocking medications, it is strongly recommended that my child engage in on-going psychotherapy because it may offer support as my child continues to explore and develop their gender identity, adjust to their bodies, and negotiate relationships with peers.

I support my child taking puberty blocking medication as prescribed by their health care provider. I agree to tell my health care provider if my child has any problems or side effects or is unhappy with the medication.

I have been informed that my child needs periodic check-ups to make sure that my child is responding appropriately to the medication.

I have been informed that using these medicines to block puberty is an off-label use. I know this means it is not approved by the Food and Drug Administration (FDA) for this specific use. I know that the medication that is recommended for my child is based on the judgment and experience of our health care providers and is supported by the Society of Pediatric Endocrinology.

I have been informed that my child can choose to stop taking these medications at any time. I know that if my child decides to do so, we should stop the medications with the help of my health care provider.

My signature below confirms that:

- My child's health care provider has talked with me about:
  - The advantages and risks of puberty blockers for my child.
  - The possible or likely consequences of using puberty blockers.
  - Any potential alternative treatments.
- I understand that my child's health care provider has consulted with a pediatric endocrinologist about my child's situation and that the endocrinologist concurs that the puberty blockers are appropriate for my child.
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my child's health care provider. All of my questions have been answered to my satisfaction.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to give informed consent for my child to take, refuse, or postpone using puberty blocking medications
- My child is in agreement with this treatment and the signature of my child on the Child's Puberty Blocker consent form specifically for my child attests to this agreement.
- My signature attests that I consent for my child to begin puberty blockers.

Based on all this information:

☐ I want my child to begin receiving puberty blocking medication

☐ I do not wish my child to begin taking puberty blocking medication at this time.

SIGNATURES

By signing below, I acknowledge that my child and I have been provided the opportunity to have any questions answered to my satisfaction concerning the use of puberty blockers. I believe I know enough to give informed consent for my child to take, refuse or postpone using the proposed medications. I understand and have had the opportunity to ask questions about the risks, benefits and alternatives, and consent to the treatment as discussed with me/my child's physician. I have no further questions. I understand that no guarantees have been made to me about the results of the process.

Signature of Patient	Printed Name of Patient	Date	Time
Signature of Legally Authorized Representative		Date	Time
Signature of Legally Authorized Representative		Relationship to Patient	

CONTINUED ON NEXT PAGE...

SIGNATURES (CONTINUED)

By signing below, I acknowledge that my child and I have been provided the opportunity to have any questions answered to my satisfaction concerning the use of puberty blockers. I believe I know enough to give informed consent for my child to take, refuse or postpone using the proposed medications. I understand and have had the opportunity to ask questions about the risks, benefits and alternatives, and consent to the treatment as discussed with me/my child's physician. I have no further questions. I understand that no guarantees have been made to me about the results of the process.

Witness' Signature		Date	Time
Practitioner's Signature	Printed Name of Patient	Date	Time

(I have explained to the above patient/legally authorized representative the nature of this process. In addition to the advising of the medically acceptable benefits and possible alternative modes of treatment, I have explained in lay terms the risks, benefits and alternatives which are or may be associated with this treatment.)

Interpreter Signature/Telephonic ID Number	Interpreter's Printed Name	Date	Time

APPENDIX G:
SAMPLE PROTOCOL FOR HORMONE PRESCRIPTION

Note: This is a sample protocol only. Recommendations for these medications change frequently, more frequently than the updates to this document. Please verify hormone prescription protocols using the latest guidelines from WPATH, the University of California, San Francisco, or the Endocrine Society.

Follow up and lab schedule FTM

This is in addition to any other indicated lab monitoring based on other risks or disease states.

	All	Age > 30 or higher risk of CVD	Age > 40	Age > 50	Based on Risks/ Organs
Baseline	CBC, fasting CMP, BP	Lipids	chest/breast exam, Mammo if not s/p mastectomy		Pap[1] [2], STI screen[3], HCG if has uterus
2-3 mos p start or dose change	CBC, fasting glucose, ALT, Lipids, BP, Trough Total Testosterone			Approved By: Robin Parker Director of Policy Development	Board Approval Not Required
Q6 months	BP and exam				
Q12 months (stable dose)	CBC, fasting glucose, ALT, BP, Trough Total Testosterone	Lipids	chest/breast exam, Mammo if not s/p mastectomy	Consider osteoporosis screening if on testosterone > 5 yrs	Pap[1] [2], STI screen[3]

[1] Consider HPV testing if age > 30 or if significant emotional stress around pelvic exam so that q2-3 year screening may be done

[2] Let pathologist know if patient is on testosterone

[3] STI Screen = HIV, RPR, Hep A/B/C, GC/CT and consider Hep A/B vaccination

FTM Medication

Dose may be decreased after oophorectomy, but not in all cases

Medication	Start	Mid	Max
Testosterone cypionate	50 mg q 2 weeks	150 mg q 2 weeks	250 mg q 2 weeks
Testosterone enanthate	50 mg q 2 weeks	150 mg q 2 weeks	250 mg q 2 weeks
Androderm Patch	2.5 mg/patch qd	5 mg/patch qd	10 mg/patch qd
Androgel / Testim 1% gel	2.5 mg qd	5 mg qd	10 mg qd
Testosterone 5% cream (compounded)	0.25 g qd	1 g qd	2 g qd

[1] Adjust dose every 2-3 months to achieve desired changes and/or bring trough testosterone to lower half of male range

Follow up and lab schedule FTM

This is in addition to any other indicated lab monitoring based on other risks or disease states.

	All	Spiro	Flutamide	Age > 30 or higher risk of CVD	Age > 40	Age > 50	Based on Risks/ Organs
Baseline	CBC, CMP BP		G6PD, consider MetHgb level if G6PD deficient or smoker	Lipids	Mammo if high-risk family history	Digital rectal exam, Consider PSA if high risk	STI screen[1]
2-3 mos p start or dose change	CBC, ALT, Lipids, BP, Prolactin	K+, Cr	LFT, consider MetHgb if risks	Lipids			
Q6 months	CBC, ALT, BP, Prolactin, Consider Total Testosterone if inadequate feminization	K+, Cr					
Q12 months (stable dose)	CBC, ALT, BP, Prolactin	K+, Cr		Lipids		Digital rectal exam; Mammo if > 5 yrs on hormones or high-risk family history	STI screen[1], Pap smear [2] [3]

[1] STI Screen = HIV, RPR, Hep A/B/C, GC/CT and consider Hep A/B vaccination

[2] After vaginoplasty, do vaginal pap smear if history of genital warts and cervical pap smear if has neocervix

[3] Let pathologist know if patient is on estrogen

FTM Medication

Daily dose listed for oral preps; dividing bid recommended for those at risk of liver toxicity

Hormones [1] [2]

Medication/Orchi status	Start	Mid	Max
Premarin / Pre	2.5 mg	5 mg	10 mg
Premarin / Post	1.25 mg		5 mg
Estradiol / Pre	1 mg	4 mg	6 mg
Estradiol / Post	1 mg		4 mg
Estradiol valerate / Pre	10 mg q 2 weeks	10 mg q 2 weeks	20 mg q 2 weeks
Estradiol valerate / Post	10 mg q 2 weeks		20 mg q 2 weeks
Estradiol patch / Pre	0.1 mg/d biw	0.2 mg/d biw	0.3 mg/d biw
Estradiol patch / Post	0.0375 mg/d biw		0.2 mg/d biw

Anti-Androgens[3]

Medication/Orchi status	Start	Mid	Max
Sprinolactone[4][5]	50 mg qd	200 mg qd	500 mg qd
Flutamide[4]		125 mg bid	
Finasteride / Pre	2.5 mg qd	5 mg qd	5 mg qd
Finasteride / Post (androgenic alopecia)		1 - 1.25 mg qd	5 mg qd
Medroxyprogesterone (not routinely recommended)[4]	2.5 mg qd	5 mg qd	10 mg qd

Other

Medication/Orchi status	Start	Mid	Max
Aspirin if high risk CVD		81 mg qd	

[1] Adjust dose every 2-3 months to achieve desired changes; check testosterone levels if desired effects are not achieved at max doses

[2] Discontinue hormones 2-4 weeks prior to any major surgery to reduce the risk of thromboembolic events

[3] Spironolactone should be first-line anti-androgen

[4] Generally only used pre-orchiectomy

[5] Can be divided bid

NPAIHB

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

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

RESOLUTION # 21-03-12

"Option to Exclude All One-Time, Non-Recurring COVID-19 Funds from Direct Cost Base When Negotiating New Indirect Cost Rate"

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 Northwest Portland Area Indian Health Board 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 Northwest Portland Area Indian Health Board 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, American Indian/Alaska Native (AI/AN) people have been disproportionately impacted by COVID-19 with significantly higher rates of COVID-19 cases (3.5x), hospitalizations (5.3x), and deaths (1.8x) than non-Hispanic whites; and

WHEREAS, Tribes and Tribal Organizations that enter into contracts and compacts with the United States government operate programs funded under the Indian Self-Determination and Education Assistance Act are required to negotiate with the Secretary of Health and Human Services or other federal agencies an indirect cost rate for administrative costs associated with carrying out their contractual requirements; and

WHEREAS, Tribes and Tribal Organizations have received a historical level of one-time, non-recurring funding in Fiscal Years 2020 and 2021 to respond to the COVID-19 pandemic in order to help mitigate the health and economic impacts during this public health emergency; and

WHEREAS, the impact of such a large influx of one-time, non-recurring funding can destabilize and drive down indirect cost rates that are negotiated with the federal government in future years, and result in a decreased amount of contract support costs (CSC) payments provided to Tribes and Tribal Organizations in future years; and

WHEREAS, Treasury guidance explains that Tribes and Tribal Organizations may not apply their indirect cost rates to Coronavirus Relief Fund amounts, while at the same time such funds will significantly expand a tribal program's direct cost base—this will cause tribal indirect cost rates to drop (and therefore CSC payments to decrease) unless both the direct and indirect pool amounts increase proportionately; and

WHEREAS, this will result in large swings in CSC payments made to Tribes and Tribal Organizations when their indirect cost rates are driven down by COVID-19 funds and when indirect cost rates swing back up in future years without the COVID-19 funding; and

WHEREAS, this will wreak havoc on ISDEAA contractors who rely on CSC payments to support the administrative costs in carrying out their contractual requirements with the United States government.

THEREFORE, BE IT RESOLVED that the Northwest Portland Area Indian Health Board calls on the Indian Health Service and Office of Management and Budget to issue instructions permitting Tribes and Tribal Organizations to exclude all one-time, non-recurring COVID-19 funds from their direct cost base when negotiating new indirect cost rates; and

BE IT FURTHER RESOLVED, that the Northwest Portland Area Indian Health Board calls on the Indian Health Service to convene the Contract Support Costs (CSC) Workgroup to update its Indian Health Manual, Part 6 – Services to Tribal Governments and Organizations, Chapter 3 – Contract Support Costs (CSC), also referred to as the "CSC policy" to develop a provision to address such one-time funding anomalies on a permanent basis.

CERTIFICATION

The foregoing resolution was adopted by the Board of Directors at the April Quarterly Board Meeting, held virtually April 20, 2021 – April 22, 2021, with a quorum present.

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

ATTEST:

Greg Abrahamson, NPAIHB Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Indian Leadership for Indian Health

Washington Tribes Cancer Prevention and Screening Opportunity

An Intergenerational Approach to Cancer Screening and Prevention

The Northwest Tribal Comprehensive Cancer Program (NTCCP) is partnering with the Fred Hutchinson Cancer Research Center to apply for a one-year grant funding opportunity from the National Cancer Institute. This grant will be used to support current evidence-based interventions being implemented by the NTCCP. The overarching goal of this grant is to strengthen partnerships between the NCI-Designated Cancer Center Fred Hutch and the Northwest Tribal Cancer Coalition to increase opportunities for community outreach and engagement to better support cancer control among Washington Tribes.

Proposed activities are open to direction and feedback from Washington Tribes, but may include:

Intergenerational Cancer Intervention: Promoting breast cancer screenings and HPV vaccinations

- Media Campaign/Education
  - Developing materials to promote breast cancer screening and breast cancer educational materials for Tribal communities
- Promoting Breast Cancer Screening
  - Working with tribal programs to connect Tribes to mammogram vans or imaging centers who do not currently have access to mammography services
- Promoting HPV Vaccinations
  - Developing materials and media to promote HPV vaccinations for youth
  - HPV is cancer prevention
- Promoting intergenerational cancer prevention
  - Supporting tribes to coordinate mammogram clinics in conjunction with youth HPV vaccinations

There may be different levels of Tribal participation, depending on Tribes interest and capacity:

- Providing consultation to develop targeted messaging
- Receiving promotional materials to support cancer screening and HPV vaccination uptake
- Support to establish partnerships with mammogram vans or services

Application is due May 13th, 2021

Anticipated implementation timeline: September 2021 - September 2022

Washington Tribes interested in partnering, providing a letter of support or requesting more information may sign-up here: https://www.surveymonkey.com/r/W67R2WX

A project staff member will contact you to answer any questions or listen to any feedback you may have.

Envisioning cancer-free Tribal communities

www.npaihb.org/cancerproject

www.cancerconsortium.org

FRED HUTCH / UNIVERSITY OF WASHINGTON

CANCER CONSORTIUM

HEALTH NEWS & NOTES

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

April 2021
Policy Issue

Publication of The Northwest Portland Area Indian Health Board

Nation to Nation: Deb Haaland

M. Jonas Greene
Pueblo of Laguna
Communications Manager

On March 15, 2021, Deb Haaland became the first Native American Cabinet Secretary. As the Senate confirmed Ms. Haaland to lead the Interior Department, congratulations and praise soared over Native social and news media. Tribal members, communities, and Native organizations across the nation have rallied behind her confirmation since President Biden announced her as his nominee on December 17, 2020. The Northwest Portland Area Indian Health Board sent a **letter of unequivocal support** of Haaland's nomination on February 17, 2021.

Haaland sat before the Senate Committee on Energy and Natural Resouces during her two days of confirmation hearings in February. At times during **the hearings**, Haaland defended her position of support for aggressive action on climate change and even one accusation that she is anti-hunting. Montana Senator Danes asked, "Why should congress believe you will expand and protect our shooting opportunities on public lands?" I'm a Pueblo woman," Haaland answered. "We've been hunting on public lands for centuries. My dad and grandparents and brother, they all hunt. I myself was fortunate to harvest an oryx from the White Sands Missile Range, which fed my family for about a year. I respect the sportsmen and the anglers."

Deb Haaland @DebHaalandNM · Feb 24

Thank you to the Senate Energy Committee for the discussion and questions over the past two days during my confirmation hearings. I thank you for your time and If confirmed, I will listen to all of the people represented by members of this Committee and this Congress.

BOARD & STAFF

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Cheryle Kennedy, Vice Chair,
Confederated Tribes of Grand Ronde
Greg Abrahamson, Secretary, Spokane Tribe
Shawna Gavin, Treasurer, Confederated Tribes of Umatilla
Greg Abrahamson, Secretary, Spokane Tribe
Kim Thompson, Sergeant-At-Arms, Shoalwater Bay Tribe

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Mike Feroglia, Business Manager
Eugene Mostofi, Fund Accounting Manager
Nancy Scott, Accounts Payable/Payroll
James Fry, Information Technology Director
Jamie Alongi, IT Network Administrator
Jonas Greene, Communications Manager
Andra Wagner, Human Resources Manager

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Candice Jimenez, Health Policy Specialist
Liz Coronado, Health Policy Specialist
Lisa Griggs, Program Ops & Exec. Assistant
Katie Johnson, EHR Intergrated Care Coordinator

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Ashley Thomas, NW NARCH Program Manager
Barbara Gladue, Oregon Tribal Public Health
Improvement Manager
Birdie Wermy, Behavioral Health Manager
Bridget Canniff, PHIT/Injury Prevention Project Director
Breastfeeding/Native CARS Project Manager
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Nancy Bennett, WA Tribal Public Health Improvement Project
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Initiative Director & WEAVE FS Project Manager
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Rosa Frutos, Cancer Project Coordinator
Ryan Sealy, Environmental Public Health
Project Scientist
Shawn Blackshear, Senior Environmental Health Scientist
Stephanie Craig Rushing, PRT, MSPI, Project Director
Sujata Joshi, IDEA-NW Project Director
Tam Lutz, Maternal Child Health Program Director
Ticey Mason, Dental Project Director
Tom Becker, NARCH Project Director
Tom Weiser, PAIHS, Medical Epidemiologist, assigned to NWTEC
Tommy Ghost Dog, Jr., weRnative Project Coordinator

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Dove Spector, NDTI Project Specialist
Kaitlyn Hunsberger, BHA Student Support Coordinator
Miranda Davis, NDTI Project Director
Pam Johnson, NDTI Project Manager
Tanya Firemoon, TCHP Project Specialist

GRANTS MANAGEMENT

Amy Franco, Grants Management Specialist
Tara T. Fox, Grants Management Specialist

Nation to Nation: Deb Haaland (continued)

Ms. Haaland, a Laguna Pueblo tribal member and former U.S. representative for New Mexico's 1st congressional district (2019-2021), has her work cut out for her. The Department of Interior will have many other challenges under Haaland, including taking a central role in President Biden's ambitious plan to get to 100% clean electricity by 2035. There's the review of the many Endangered Species Act protections rolled back by the Trump administration. In addition to the management of American Indian affairs and wildlife conservation, the Department of Interior manages 507 million acres of public land, 476 dams, 348 reservoirs, and the seabed and submerged land off of the American coastline (Outer Continental Shelf) rich in marine wilderness and oil resources.

Since her confirmation, Secretary Haaland has issued a new Secretarial Order to prioritize action on climate change. She has also revoked orders of the former administration that she called "inconsistent with the department's commitment to protect public health; conserve land, water, and wildlife; and elevate science" **in a recorded statement**.

"A voice like mine has never been a Cabinet secretary or at the head of the Department of Interior," Haaland wrote on her Twitter account. "**Growing up in my mother's Pueblo household made me fierce. I'll be fierce for all of us, our planet, and all of our protected land. I am honored and ready to serve**."

"The historic confirmation of Secretary Deb Haaland is not only monumental for Indian Country, but shatters the glass ceiling for Native women legal professionals, like myself. Mich gayis Secretary Haaland for your fierceness that has paved the way for Native women in leadership."

Elizabeth J. Coronado, JD (Chukchansi)
NPAIHB Health Policy Specialist

"This is an unprecedented and monumental day for all first people of this country. Words cannot express how overjoyed and proud we are to see one of our own confirmed to serve in this high-level position. It's a wonderful feeling that we can now refer to her as Madam Secretary. Today's historic confirmation sets us on a better path to righting the wrongs of the past with the federal government and inspires hope in our people, especially our young people. It gives us a seat at the table to offer a new and different perspective from a person that has experienced the reality of adversities and challenges of growing up on what federal officials refer to as 'Indian' reservations."

Jonathan Nez,
President of the Navajo Nation

Chair's Notes

Nickolaus D. Lewis
Lummi Nation
NPAIHB Chairman

I think we are seeing the light at the end of the tunnel, and I am hopeful for what the future brings for our communities. The last 13 months have been hard, yet through all of the challenges we have seen people pull together and support each other over and over again. Thank you for all you do for our people. So much has happened since our January 2021 meeting, I want to focus first on the unprecedented funding to Indian Country by President Biden's administration with the additional $6 for the Indian Health Service (IHS) under the American Rescue Plan Act of 2021. This almost doubles our FY2021 budget, the funds are available until they are spent and includes:

- $2 billion for lost third-party revenue
- $500 million for additional health care services, including Purchased/Referred Care
- $140 million for information technology, telehealth, and the IHS Electronic Health Record
- $420 million for mental health and substance abuse prevention and treatment activities
- $600 million for construction, maintenance, equipment, and other related activities for COVID-19 response
- $240 million for public health workforce and other related activities
- $600 million for necessary expenses to plan, prepare for, promote, distribute, administer, and track COVID-19 vaccines and other related activities
- $1.5 billion for COVID-19 testing, contact tracing, and other related activities
- $10 million for the delivery of potable water
- No less than $84 million for Urban Indian Organizations

While we are waiting for the results of the consultation on these funds, we have another financial proposal to analyze as President Biden just released his FY 2022 budget. It includes an additional $2.2 billion for the Indian Health Service. This proposal takes IHS up to approximately $8.4 billion, which is $4.4 under the National Tribal Budget Workgroup's FY 2022 recommendation. We have started virtual visits with our representatives recently, and we will continue our advocacy. One of the things I have noticed in working with the Biden administration is that senior leadership is showing up at the table to talk, and they seem to be listening to tribal voices. I am encouraged to learn that HHS Secretary Xavier Becerra showed up at the National Tribal Budget Formulation Workgroup consultation in April, and that Acting HHS Director Norris Cochran and CDC Director Rochelle Walensky attended the HHS Secretary's Tribal Advisory Committee (HHS-STAC) meeting in February.

I am humbled to report that I have been given the opportunity to serve our people at the national level as the Vice-Chair of the National Indian Health Board (NIHB), and I will be the national at-large rep for NIHB on SAMSHA TTAC and CMS TTAG. These opportunities are meaningful to me because I believe that our work at the national level brings to light the good work that is going on at the local level. Your work in responding to COVID-19, the strong work that your health programs and the Board are doing in expanding the CHAP program to the lower-48, innovations that we see in your clinics in addressing prevention, intervention, treatment, and after care of substance use disorder, and the focus on traditional and cultural ways in healing and health that we see in our communities, all serve as examples we can share when we advocate for additional resources at the national level. Thank you for all you do to take care of our people. Please always know that I am available to listen, and help where I can.

Nickolaus Lewis
Chair, Northwest Portland Area Indian Health BoardCouncilman,
Lummi Indian Business Council

Biden Administration Undertakes Consultation With Tribal Nations

Elizabeth J. Coronado, JD (Chukchansi)
Health Policy Specialist

Within the first week of office, President Biden issued Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships directing his executive departments and agency heads to develop a plan of action to implement the directives of Executive Order 13175.[1] This Presidential Memorandum reaffirms the federal government's commitment to fulfil the trust and treaty obligations to Tribal Nations and to conduct regular, meaningful, and robust consultation.[2] Although this Memorandum reaffirms the policy directive in Presidential Memorandum of November 5, 2009, President Biden further directs his Executive Branch to not only "includ[e] Tribal voices in policy deliberation that affects Tribal communities" but to listen to Tribal Leaders.[3]

Since the execution of the Presidential Memorandum in January, the Biden Administration has conducted tribal consultation across the many agencies of the federal government, including Department of Health and Human Services (HHS) and Office of Management and Budget (OMB).

HHS Tribal Consultation Policy Background

The HHS Tribal Consultation Policy was initially developed with Tribal input in 2004, and signed in 2005. The most recently revised Tribal Consultation Policy was signed in 2010 by Secretary Kathleen Sebelius as a result of President Obama's 2009 Executive Memorandum. Tribal Leaders agreed to put on hold further revisions to the Policy under the Trump Administration.

HHS Tribal Consultation

HHS conducted tribal consultation for Region 10 on March 25, 2021. Through a pre-recorded video, Secretary Becerra committed to advancing American Indian and Alaska Native health priorities, honoring tribal sovereignty, and including tribal voices in policymaking. Tribal leaders on behalf of the Northwest Portland Area Indian Health Board (NPAIHB) urged HHS to honor tribal leaders requests in order to advance the health status of American Indian and Alaska Native people; to hold HHS' Agencies, Offices, Centers, Operating Units, and Regional Offices accountable to the provisions of the HHS Tribal Consultation Policy; and to mandate that states hold sincere and effective consultation with Tribal Nations. The HHS Office of Intergovernmental and External Affairs (IEA) is collating comments received during consultation and will issue a report on HHS plan of action to implement the directives of EO 13175 by the end of the month. IEA will collaborate with the Secretary's Tribal Advisory Committee (STAC) on comments received on the Tribal Consultation Policy.

Historical OMB Tribal Consultation

Because of their role in implementing and overseeing the President's agenda and budget, OMB is a crucial partner to Tribal Nations. The OMB has five main functions including, budget development, oversight of agency performance and financial management, federal regulatory coordination and review, clearance of agency testimony and legislative proposals, and clearance of Presidential Executive Orders and memoranda.[4] Tribal Leaders have been stalled in their policy efforts and funding requests by OMB without any true and effective government to government consultation.

On April 2 and April 5, 2021, OMB engaged in consultation for the first time with Tribal Nations. OMB acknowledged Biden's commitment to honor tribal sovereignty and to fulfill the federal trust and treaty obligations. In addition, OMB recognized that there is much work that needs to be done to rectify the type of engagement with Tribal Nations that historically has not happened. Tribal Leaders had a number of requests to OMB, including a dedicated Indian desk within OMB; a tribal advisory committee; a detailed cross for federal funding that specifies whether grant funding reaches Tribal Nations; and commitment to ongoing, meaningful consultation. The comments received during tribal consultation will help inform OMB's plan of action to engage in meaningful tribal consultation.

This initial consultation with OMB is the first step towards this Administration truly honoring tribal sovereignty by Tribal Leaders having a voice with senior leadership and participating with the highest levels across the Executive Branch.

HHS Annual Tribal Budget Consultation – FY 2023

The HHS agencies heard consistent requests from Tribal Leaders, such as the need to fully fund the Indian Health Service at $48 billion, non-competitive funding opportunities across the agencies, exempting the one-time COVID-19 funds from indirect cost rate negotiations, and the challenges of recruiting Indian Health Care Providers across the Indian health care system. Councilman Joseph and Councilwoman Sampson specifically addressed NPAIHB policy priorities, including but not limited to, increased funding for Community Health Aide Program expansion and Purchased Referred Care and the need for additional services and supports for tribal elders living in their homes and communities.

On the last day, Secretary Becerra conducted a roundtable discussion on Tribal Leaders' policy priorities. Councilwoman Sampson spoke to Secretary Becerra on a handful of NPAIHB's policy priorities, including reversing Medicaid policies that are inconsistent with the objectives of the Affordable Care Act, honoring Tribal Leaders' requests, and expansion of self-governance and self-determination models across HHS agencies.

"Final word . . . test me" stated Secretary Becerra during his address to Tribal Leaders at the Annual Tribal Budget Consultation on April 7, 2021.

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[1] *Presidential Memorandum On Tribal Consultation and Strengthening Nation-to-Nation Relationships, Daily Comp. Pres. Docs., DCPD No. 202100091 (JAN. 26, 2021).*

[2] *Id.* | [3] *Id.*

[4] *Office of Mgmt. and Budget,* **https://www.whitehouse.gov/omb/** *(last visited Apr. 9, 2021).*

Brief Summary of Mental & Behavioral Health Legislation (Northwest & National)

Candice Jimenez, MPH
Confederated Tribes of Warm Springs
Health Policy Specialist

In understanding the landscape of mental and behavioral health resources in the Northwest, and across the nation, is to know that there exist historic and systemic impacts on tribes and communities of color; a chasm between meeting needs and current resources that are sustainable, accountable, responsive and appropriate for each community they serve. When appropriate and consistent health interventions are brought together in a people first approach, there is less need for more intensive services or even hospitalization that can further harm youth, adults and families in those experiences. Further, the challenge may not exist in accessing services rather in how the services are being engaged with the people they are meant to serve, and how it benefits them in the long term across generations from youth to elders. As we collectively continue forward during a global pandemic, we are beginning to see positive changes that recognize the need for behavioral and mental health services that call on systemic reform which acknowledge the ongoing under-resourced nature of the system and recognizes expertise from the communities themselves, such as those who offer peer support, lead with traditional and cultural knowledge along with the healing nature of ceremony for one's mental and behavioral health. In this light, here we will take a brief look at local and federal legislation that focuses on these areas as we move forward in 2021 during a time where the current national administration seeks to build better relationships with tribal nations via tribal consultation, and for many agencies, a first-time occurrence.

Here's a brief look at current and pending legislation impacting mental and behavioral health services in the Northwest:

Idaho

- SB 1125 – To establish provisions regarding recognized state crisis care and suicide hotlines, to provide for mobile response teams, to provide for a suicide and mental health crisis access fund, to provide for a suicide and mental health crisis access fee, to provide for the use of the fee, to provide auditing and reporting requirements, and to provide a fee implementation deadline.
- HB 233 – Seeks to add a new section to the Child Mental Health Services Act; the addition would prevent parents from losing custody of children for seeking services for children in mental health facilities under certain conditions.

Oregon

- HB 2086 – Appropriates moneys to Oregon Health Authority to undertake specified steps to address needs of individuals with behavioral health disorders for services, treatment and housing. Declares emergency, effective on passage.
- HB 2314 – Requires Oregon Health Authority to study and make recommendations to interim committees of Legislative Assembly, no later than September 15, 2022, for legislative changes needed to increase access to behavioral health services for all Oregonians and particularly to Oregonians in rural areas and to medically underserved populations.
- HB 2381 – Modifies laws relating to youth suicide intervention and prevention to include children under 10 years of age and creates a Youth Suicide Intervention and Prevention Advisory Committee to advise the Oregon Health Authority on the development and administration of strategies to address suicide intervention and prevention for children and youth [10 through] who are 24 years of age or younger.

- HB 2949 – Requires Mental Health Regulatory Agency to establish program to improve Black, indigenous and people of color mental health workforce, including pipeline development, scholarships for undergraduates and stipends for graduate students, loan repayments and retention activities.
- HB 3377 – Establishes Addiction Crisis Recovery Fund. Prescribes uses of fund. Establishes Office of Intervention and Engagement in Oregon Health Authority to oversee expansion of substance use disorder treatment and peer services. Establishes Office of Behavioral Health Workforce Development in Oregon Health Authority to oversee recovery workforce development. Requires Oregon Health Authority to increase payments for reimbursement to addiction treatment providers for services provided to medical assistance recipients.
- Learn more about these bills and more at the OR House Committee on Behavioral Health led by Representative Tawna Sanchez (Shoshone-Bannock, Ute, Carrizo), Chair at https://olis.oregonlegislature.gov/liz/2021R1/Committees/HBH/Overview

Washington

- SB 5195 – Concerning prescribing opioid overdose reversal medication.
- SB 5412 – The authority shall conduct its oversight of the community behavioral health system in a manner that is aware of, nurtures, and protects significant relationships in the life of behavioral health system clients. These relationships may involve family, friends, and others who play a significant role.
- SB 5328 – An act relating to clubhouses and peer-run organizations for persons with mental illness; a clubhouse is a member organization where people living with mental illness can find fellowship, hope, opportunity, and recovery. Clubhouse programs offer vocational training, wellness programs, employment opportunities, participative community, and an end to isolation for persons whose lives have been severely disrupted by mental illness.

Recent Federal legislation (American Rescue Plan)

With President Biden's March 11 signing into law of the American Rescue Plan Act of 2021, a $1.9 trillion COVID-19 relief package emerged, there includes a number of provisions that affect health systems and provisions including across Indian Country. The law allocates $3.5 billion for block grants addressing behavioral health disorders and several million more for other behavioral health programs and workforce issues. Specifically, the law allocates:

- $1.5 billion for mental health block grants
- $1.5 billion for substance use disorder block grants;
- $420 million in grants to clinics participating in the Certified Community Behavioral Health Clinic program;
- $100 million in behavioral health workforce education and training grants;
- $80 million for grants to health professional schools, academic medical centers, local government and other nonprofits for training in evidence-based strategies to decrease behavioral health disorders among health care personnel;
- $40 million in grants to health care providers for programs promoting good behavioral health among their personnel;
- $30 million in grants for local governments, nonprofits, and health organizations for overdose prevention and harm reduction programs, including needle exchanges and naloxone distribution;
- $20 million for an education campaign directed at health care personnel and first responders to encourage identification and prevention of behavioral health disorders; and
- Over $100 million to programs addressing community-based and child and adolescent mental health.

In addition, the law creates a new optional Medicaid covered service. For the five years following enactment, states can cover mobile crisis intervention services for individuals experiencing a mental health or substance use disorder crisis. The law provides $15 million for planning grant funds for states to develop a mobile crisis service program, and provide enhanced FMAP for states that implement such a program. The law also directs $80 million to pediatric mental health services.

If you have any questions on current federal legislation related to mental and behavioral health, please reach to Candice Jimenez at cjimenez@npaihb.org – thank you!

Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group – 2021 Medicaid Priorities

Veronica Smith, MBA
Health Policy Consultant

Is Your Clinic Properly Reimbursed for Services by Medicaid Managed Care?

Tribes across the country have reported challenges being properly reimbursed by Medicaid Managed Care Organizations (MCOs). These reports have led the CMS Tribal Technical Advisory Group (CMS-TTAG) to add a recommendation its 2021 priorities. CMS-TTAG has recommended that CMS issue a State Health Official (SHO) letter informing all 50 states that compliance with the Indian provisions of the Medicaid Managed Care Rule (42 C.F.R. § 438.14) is a condition of approving any State Plan Amendment or waiver, and a condition of payment in state contracts with MCOs. CMS-TTAG is also recommending that MCO's deem all Indian health care providers as in-network providers, regardless of whether or not they have entered into a network provider agreement.

The National Indian Health Board is partnering with CMS-TTAG and hosting a MCO roundtable on May 19, 2021 from 9:30am – 2pm. The draft agenda includes:

- Overview of the Indian Provisions of the Medicaid Managed Care Rule
- Best practices in implementing managed care in Washington State
    - Presenters: Vicki Lowe (Jamestown S'Klallam, AIHC) and Jessie Dean (WA HCA)
- Overcoming challenges in implementing Medicaid Managed Care with CA, MS, and TX
    - Presenters: Tribal and state representatives
- Developing an Indian Managed Care Entity
    - Presenters: Michael Collins (Warm Springs), Sharon Stanphill (Cow Creek) Jason Stiener (Oregon Health Authority), Casey Cooper (CEO, Cherokee Indian Hospital Authority), and North Carolina Department of Health Services

Attendees to the roundtable will include tribes, state Medicaid Directors, and MCOs. Please share this meeting information with your office staff, your ideas and experiences make a significant contribution to moving this policy priority forward.

What is the Status of the 4-Walls Limitation?

The 4-Walls Limitation prohibits Indian Health Care Providers (IHCPs) from billing the Medicaid program for services provided outside the physical four walls of a health care facility. This includes many services that have been provided for years at off-site locations as a part of wraparound services. Tribes had been given a grace period until January 31, 2021 to work with their states and enroll in state Medicaid programs as Tribal Federally Qualified Health Centers (T-FQHCs), and for state governments to submit State Plan Amendments (SPAs) and agree to pay tribes at the all-inclusive rate (or encounter rate) for services provided by T-FQHCs. To date, only nine states have filed SPAs. Tribes were given an **11th hour extension** to the 4-Walls Limitation grace period on January 15, 2021, and enforcement is now scheduled to begin after October 31 2021. CMS-TTAG has advocated for a legislative fix to the 4-Walls Limitation, and recent legislation (**H.R. 1888, Improving Access to Indian Health Services Act**) provides that fix, along with providing 100% FMAP for Urban Indian Health Programs.

If you have questions about the upcoming MCO roundtable or the 4-Walls Limitation, please feel free to contact me at **vsmith-contractor@npaihb.org**

Administration's FY 2022 Budget Request Includes Funding Increases for Tribal Programs

Cindy Darcy
DC Policy Strategist

The Biden-Harris Administration released the outline of their discretionary spending priorities in the FY 2022 budget request. (Mandatory spending and details will be forthcoming.) The overview is available here: **https://www.whitehouse.gov/wp-content/uploads/2021/04/FY2022-Discretionary-Request.pdf**

Following the document's overall summary, the summaries of federal agencies' requested funding are listed by department, with the Department of Health and Human Services beginning on page 10. The budget request reads in most relevant part, "To begin redressing long standing health inequities experienced by American Indians and Alaska Natives, the [Administration's FY 2022] discretionary request includes an increase of $2.2 billion in the Indian Health Service."

Given the $6.1 billion increase to IHS that was included in the American Rescue Plan Act (Public Law 117-2), that essentially doubled funding for IHS, on top of the $6.236 billion that was enacted in the final FY 2021 omnibus appropriations and COVID-19 relief Act (Public Law 116-160), we may be looking at a requested FY 2022 funding level of $14.5 billion for IHS!

The Administration's FY 2022 budget request puts the emphasis on discretionary spending for domestic programs like education, health care and environmental protection, while essentially maintaining funding for defense spending. The discretionary request proposes $769 billion in non-defense discretionary funding in FY 2022, which is a 16% increase over the FY 2021 enacted level. A total of $753 billion is requested for national defense programs, which is a 1.7% increase.

The budget request also recommends the following:

- a total of $133.7 billion, a 23.1% increase over the FY 2021 enacted level, for the Department of Health and Human Services.
- $6.5 billion for a proposed Advanced Research Projects Agency for Health within the National Institutes of Health to pursue research in cancer, diabetes, Alzheimer's and other diseases.
- $10.7 billion, an increase of $3.9 billion over the FY 2021 enacted level, to address the opioid epidemic through support research, prevention, treatment, and recovery support services to populations with unique needs, including Native Americans, older Americans, and rural populations.
- $670 million within HHS to help reduce the number of new HIV cases, while increasing access to treatment, expanding the use of pre-exposure prophylaxis (also known as PrEP), and ensuring equitable access to services and supports.
- $7.4 billion for the Child Care and Development Block Grant program, an increase of $1.5 billion over the 2021 enacted level.
- $11.9 billion for Head Start, a $1.2 billion increase.
- increases of more than $600 million over the FY 2021 enacted levels for a range of tribal programs in the Department of the Interior, including for education, clean energy development, tribal law enforcement and tribal court programs.
- $3.6 billion to advance water infrastructure improvement efforts for community water systems, schools, and households, and to improve drinking water and waste water infrastructure, including in tribal communities.
- $153 million for CDC's Social Determinants of Health program to support states and territories to improve health equity and data collection for racial and ethnic populations.
- $900 million to address poor housing conditions in tribal areas.
- $1 billion for Department of Justice Violence Against Women Act programs, which is nearly double the FY 2021 level.

As noted above, the Administration's proposals for mandatory spending programs and tax policies, as well as more details about domestic discretionary spending, are not expected until late spring. However, with the submission of today's FY 2022 discretionary spending request, House and Senate Appropriations Subcommittees may begin writing their appropriations bills.

2020 Trans and Gender-Affirming Care Strategic Vision and Action Plan

Itai Jeffries, PhD (Yèsah/Occaneechi)
they/them/ya'll
Co-Manager
Paths (Re)Membered

Jessica Leston (Tsimshian)
she/her/hers
Clinical Programs Manager

Morgan Thomas
they/them
Co-Manager
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Prior to colonization, concepts of gender identity in Native communities were diverse and the acceptance of gender diversity was high. Two Spirit people, "whose behaviors or beliefs may be interpreted by others to be uncharacteristic of their sex," were often expected to take on roles as medicine people, mentors, teachers, and healers.[1] This practice of diverse gender acceptance in Native communities has been dramatically altered through colonization and the forced assimilation process. However, the history of Native acceptance of Two Spirit and LGBTQ identities remains in the teachings and wisdom of Native ancestors and Two Spirit Elders living today.

Over the past year, the Paths (Re)Membered Project has worked on a variety of projects to support the health of Two Spirit and LGBTQ+ (2SLGBTQ+) people. (We use Two Spirit and LGBTQ+ or 2SLGBTQ+ throughout this briefing to refer to individuals who identify as gender-diverse (not cisgender) or have a minority sexual orientation.) Paths (Re)Membered activities have included founding a **Trans & Gender-Affirming Care ECHO**, publishing monthly **podcasts** and blog posts, hosting regular community events and trainings for staff and partners, working with northwest tribes to build capacity for affirming environments in clinics and community spaces, and completing a 2SLGBTQ+ Pride and Connectedness Online Survey.

In a Pride and Connectedness Survey, completed in September 2020, we observed a number of widely reported barriers to healthcare access experienced by 2SLGBTQ+ people, with gender-diverse people reporting greater barriers than their cisgender peers. The most commonly reported barriers include lack of healthcare providers (especially behavioral healthcare providers) adequately trained to offer gender-affirming care and fear that providers would find out clients were 2SLGBTQ+.[2] The 2015 U.S. Transgender Survey also found that 37% of AI/AN transgender individuals postponed necessary healthcare appointments because they were afraid of mistreatment by healthcare providers.[3] However, advances in gender-affirming care and our knowledge of affirming clinical environments make it possible for all clinics to offer 2SLGBTQ+ clients the care they deserve.[4][5]

In January of 2020, NPAIHB Delegates approved the resolution "Support for Quality Care and Improved Health Outcomes for Two Spirit and LGBTQ+ People." In response, the NPAIHB Paths (Re)Membered Program founded the Native Advocacy Workgroup for Trans Health and worked with them to collectively create a Strategic Vision and Action Plan focused on Trans & Gender-Affirming Care in Indian Health Service, Tribal and Urban Clinics (I/T/U).

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[1] Jacobs, S.E. (1997). Two-Spirit People: Native American Gender Identity, Sexuality, and Spirituality. University of Illinois Press.
[2] Jeffries, Itai, Leston, Jessica,Thomas, Morgan, and Kaylee Trottier. "Two Spirit and LGBTQ+ Pride and Connectedness Survey." Unpublished. 2020.
[3] 2015 U.S. Transgender Survey: Report on the Experiences of American Indian and Alaska Native Respondents. National Center for Transgender Equality (2015): https://transequality.org/sites/default/files/docs/usts/USTS-AIAN-Report-Dec17.pdf
[4] UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at transcare.ucsf.edu/guidelines.
[5] Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. The Journal of adolescent health : official publication of the Society for Adolescent Medicine, 63(4), 503–505. https://doi.org/10.1016/j.jadohealth.2018.02.003

In its role creating the **Strategic Vision and Action Plan**, NPAIHB listened and consulted with stakeholders including 2SLGBTQ+ community members, healthcare providers, policymakers, and community and program leaders. The authors of the 2020 Trans and Gender-Affirming Care Strategic Vision and Action Plan upheld principals to ensure that:

1. Initiatives are integrated with Indigenous Traditional Understandings and Practices
2. Initiatives are led by gender-diverse people
3. Initiatives recognize Indigenous diversity in gender conceptions, roles and practices

Gender-affirming care refers to healthcare that affirms a person's gender identity and allows gender-diverse people to live more authentically. To be gender-affirming, providers must create positive and optimistic medical care systems, inclusive clinic environments, and patient support through effective and compassionate social gender transition. With appropriate planning and support, gender-affirming healthcare can be highly successful at all levels of the medical system, including primary care, behavioral health care, pharmaceutical care, Traditional Indigenous Medicine, and various other specialties. If effectively applied, gender-affirming care becomes integrated throughout all clinical services. Incorporating holistic and affirming care with respect to both gender and culture, and welcoming clinical spaces for all patients ensures gender-diverse patients have access to the care they medically need and that they feel safe accessing that care.

This strategic plan supports the I/T/U clinics as they begin to provide gender-affirming care to their patients by emphasizing the following four goals:

1. Develop and pass protective policies at the federal, tribal, and local levels;
2. Ensure affirming clinical environments for gender-diverse patients;
3. Ensure best practice care for Indigenous gender-diverse patients; and
4. Improve I/T/U health systems support for initiatives focused on the wellness of gender-diverse community members.

These recommendations are not individual-level interventions. They are structural and community-level interventions to ensure the wellbeing of gender-diverse patients. We hope that the NPAIHB, various tribal nations in the US Pacific Northwest, and partnering agencies use this plan to guide program planning, catalyze community outreach efforts, and foster a coordinated response to the health and wellbeing of gender-diverse members of our tribal and urban communities. The dissemination of this strategic plan will guide I/T/U clinics, ensuring they have the strategies and support they need to fully implement these guidelines and to offer 2SLGBTQ+ clients a welcoming space and the care they need to be healthy. It will further guide policy and tribal leaders as they work to ensure programs and policies developed in Indian Country are affirming for 2SLGBTQ+ clients and community members.

For more information about the Strategic Vision and Action Plan or to learn more about the NPAIHB Paths (Re)Membered Program, please contact Morgan at **mthomas@npaihb.org** or 850-748-3458.

Environmental Health Policy in Indian Country

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Shawn Blackshear, RS, MS
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Holly Thompson Duffy, MPH
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Environmental Health Policy in Indian Country

Cultural practices, laws, and policies related to the intersection of the environment and people have ancient origins with written documentation. Environmental health policy arose through the era of industrialization with an emphasis on sanitation and worker safety. Early practitioners' work profoundly influenced our understanding of environmental-related illness, none more influential than Dr. John Snow in his 1854 epidemiological investigation of the cholera outbreak in London and the implication of the Broad Street water pump as the source of disease. We can trace the modern field of environmental health back to the mid-20th Century and the 1962 publication of Rachel Carson's "Silent Spring." The advent of the EPA in 1970, the energy crisis in the 70s, visible smog in cities, and a series of deadly environmental disasters – the 1969 Cuyahoga River fire, Love Canal, the Exxon Valdez Oil Spill, and others - resulted in monumental environmental health legislation such as the Clean Air Act, Clean Water Act, and more. The increased public awareness of the intersection between the environment and health ignited the modern-day environmental justice movement, exemplified by the Dakota Access Pipeline protest movement to protect significant cultural and ecological resources for the Standing Rock Sioux Tribe. Weaved throughout the Pacific Northwest, laws associated with salmon, shellfish, and waters have long been a battle for Tribal rights and environmental health. Presently, environmental regulation and public health protection are fundamentally integrated and inseparable.

The Environmental Public Health (EPH) Program at the NPAIHB started in February of 2020 after the program's assumption from the Portland IHS under P.L. 93-638. Since that time, the EPH Program has secured additional funding from the CDC and the EPA and is actively funding tribal environmental health projects. The major approaches for addressing tribal environmental health issues include assessment, monitoring, providing training, health education, advocating for equitable environmental health policies, and assisting tribes with policy development.

Because environmental health involves the natural environment and the built environment, there are a multitude of laws, policies, and jurisdictions that may be involved in addressing issues and services. Environmental health services associated with the natural environment can include environmental quality monitoring of air, water, soil; pollution control; land use, zoning, and permitting; environmental hazards from natural disasters; and climate change. The majority of governmental environmental health work is associated with the built environment, which includes the following operations: retail and institutional food safety, drinking water quality, sanitary waste management, indoor air and indoor environmental quality, safety and emergency preparedness in facilities, school and child care health and safety, environmental infection prevention in health care, and occupational health and safety.

Environmental Health Policy in Indian Country

Due to the complexity of laws and jurisdictions associated with environmental health, we have adopted a collaborative governance model that involves shared responsibility and decision-making across organizations to include Tribes, NPAIHB, and appropriate federal agencies. Our ultimate goal is to develop and strengthen tribal public health capacity and infrastructure to support tribal environmental health programs' development and management.

Environmental health policy is often fractured and can be overwhelming. Many codes and regulations may be rightfully or wrongfully applied and enforced in Indian country. The table below is not exhaustive but includes the primary list of federal agencies and laws that define environmental public health policy on tribal lands:

Agency	Code or Law	Role	Regulatory Authority for Tribes	Tribal Authority
IHS	25, 42, & 45 CFR	Responsible for providing direct medical and health services to federally recognized Tribes	No Regulatory Authority	Tribes have the authority to regulate health and safety, including licensing and permitting of businesses.
CDC	42 CFR	Supporting tribal public health capacity building to reduce disparities, prevent the spread of infectious disease, conduct investigations, and research	No Regulatory Authority	Tribes have Public Health Authority (quarantine, infectious disease control).
FDA	21 CFR	To safeguard public health by ensuring food safety, security and preventing the spread of foodborne illness through retail food establishments	No Regulatory Authority on Tribal Lands	Tribes have the authority to regulate retail food and manufacturing/processing on tribal lands.
NIGC	25 CFR	Regulations to ensure the construction and maintenance of the gaming facility, and the operation of that gaming, is conducted in a manner that adequately protects the environment and public health and safety, pursuant to the Indian Gaming Regulatory Act	Yes	Tribes adopt codes according to their license and have the authority to ensure compliance through attestation.
OSHA	29 CFR	Assures safe and healthful working conditions to prevent occupational health and illness through inspections and application of standards	Yes	Tribes can enact policies, but the Federal OSHA retains primacy
EPA	40 CFR	Covers all environmental protection laws to protect the land, water, and air; includes the SDWA, CWA, CAA, TSCA, RCRA, FIFRA, and many other laws	Yes	Tribes can enact policies and seek primacy through EPA; otherwise, EPA has primacy.
BIA	25 CFR	To understand, protect and improve the integrity and security of the land, human health and safety, and cultural resources	Yes	Tribes can assume authority through P.L. 93-638. BIA land leases and environmental regulations are complex and can involve multiple parties.

Environmental Health Policy in Indian Country (continued)

Environmental health practitioners may be involved in other policy arenas in Indian Country such as health care accreditation surveys based on CMS policies, HUD-NAHASDA policies for healthy housing, and ACF health and safety policies for Head Start and child care centers.

While the environmental health political and regulatory landscape in Indian Country is saturated with many agencies often having vague and politically focused intentions, the ultimate regulatory authority for environmental public health in tribal communities resides with each Tribe itself. We encourage all Tribes to adopt and enforce their own policies to protect and enhance environmental health, retaining the legal protection of their lands, resources, and people. After all, who would you prefer to have the ultimate legal authority: the ever-rotating Rolodex of federal employees that shifts at least every four years with the changing political tides or the people who have been stewards of the land consistently and responsibly since the beginning of time?

The EPH team is available to work with Tribes on anything related to environmental health policy. Please email us at ehteam@npaihb.org should you have any questions, concerns or needs that we can assist you with.

FAQ: Washington Youth Sexual Healthcare (WYSH) Grant

Celena McCray, MPH
(Navajo)

WYSH Project Manager

NPAIHB's WYSH project is recruiting 4-6 federally-recognized Washington State tribes to fund youth sexual health services, strengthen linkages and referrals to youth sexual health services, and educate youth about sexual health services.

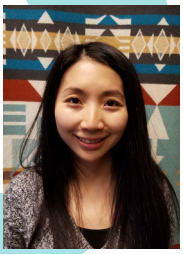
WYSH GRANT FAQ

Who is eligible for WYSH funding?	*Local I/T/U (Indian Health Service, Tribal and Urban) clinics, Tribal Health Departments, school-based health programs and youth engagement programs who have a bi-directional impact on youth and their access to and experience with sexual healthcare. Recipients must represent and/or provide services to one or more of the 29 federally-recognized Tribes in Washington.*
Can only federally-recognized tribes apply?	*The entity applying doesn't have to be a Tribe, if they can show partnership/collaboration with an I/T/U.*
Can multiple programs under one tribe/organization apply?	*One application will be funded per WA Tribe/Organization.*
What does the application entail?	*There are 3 sections of the application, a brief project narrative (no more than 2 pages), detailed budget justification, and workplan description.*
How long is the funding?	*Subcontracts can be extended for up to 2 additional one-year periods; up to 3 years total, contingent on available funding. The total term of the contract shall not exceed three (3) years.*
What is the total amount available for this grant?	*$65,000 - $100,000 per year, including indirect costs.*

Who should I contact if I have any questions?

WYSH Project Manager: Celena McCray at cmccray@npaihb.org or 503-416-3270. TA available every Tuesday and Thursday from 11 AM-12 PM until May 24th.

A Call for Targeted Suicide Prevention Interventions during the COVID-19 Pandemic – Trends in Suicide-related Emergency Department Visits during the COVID-19 Era



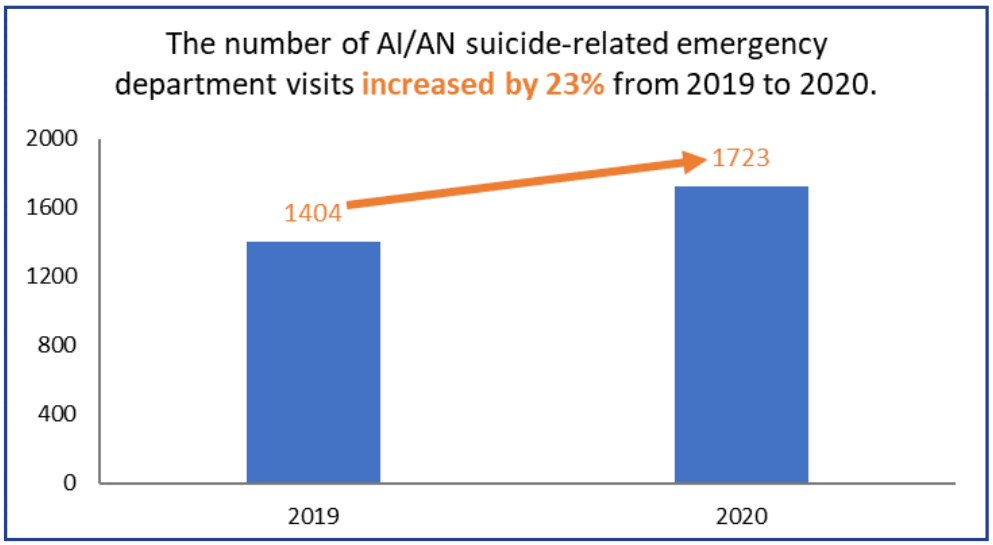
Chiao-Wen Lan, PhD, MPH

Improving Data & Enhancing Access (IDEA-NW) Epidemiologist

Sujata Joshi, MSPH

Improving Data & Enhancing Access (IDEA-NW) Project Director

The COVID-19 pandemic has resulted in negative mental health impacts among adults and children, including increases in anxiety and fear, loss, sense of isolation, and disrupted access to mental health services. American Indian and Alaska Native (AI/AN) communities in our region experienced a higher burden of suicide before COVID-19, and there are concerns that this burden has worsened during the pandemic. This article examines trends in suicide-related emergency department (ED) visits among Washington AI/AN communities during the first year of the COVID-19 pandemic.



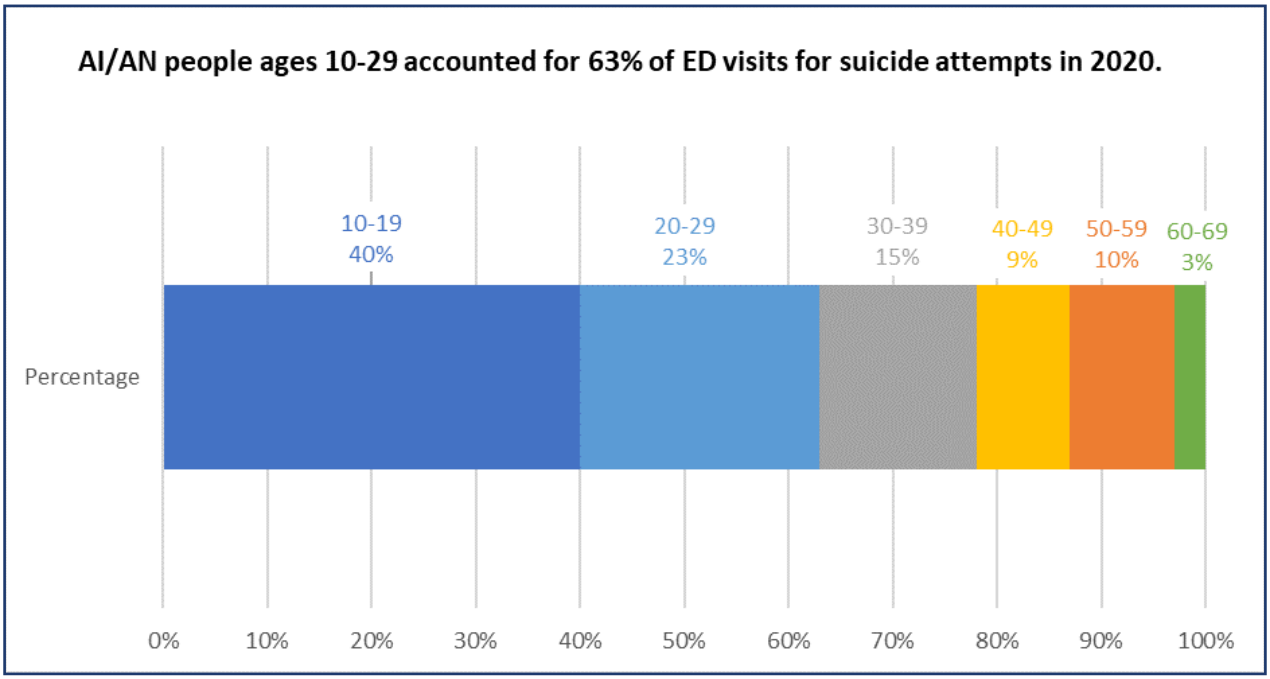
In Washington, the total number of **suicide-related ED visits** **among AI/AN people went up by 23% during the COVID-19 pandemic in 2020 compared to pre-pandemic** in 2019.

AI/AN **suicide ideation ED visits** **increased by 24% in 2020** compared to 2019. The ED monthly rate of suicide ideation for AI/AN reached its highest in May 2020, which was over 24% higher than the pre-pandemic monthly average.

The number of **suicide attempt ED visits** **among AI/AN increased by 17% in 2020** compared to 2019. The rate of suicide attempt ED visits reached its highest in September 2020, which was 45% higher than the previous year monthly average in 2019.

In Washington, AI/AN people ages 10 to 29 accounted for 63% of suicide attempt ED visits in 2020. The highest increase between 2019 and 2020 was seen in three age groups: ages **10-19, 30-39, and 50-59**. **The number of suicide attempt ED visits among AI/AN adults ages 50-59 doubled from 2019 to 2020.**

There was a higher percent increase for suicide ideation seen among AI/AN women compared to AI/AN men (7% vs. 2%). Alarmingly, there was a 29% increase in ED visits for suicide attempts among AI/AN women between 2019 and 2020. The data presented do not represent the full burden of suicide-related health care visits among AI/AN in Washington, but only those that presented at emergency departments in 2019 and 2020. Further, these data may undercount suicide-related ED visits by roughly 28% due to the misclassification of AI/AN people in emergency department data.



Key Considerations

There is a pressing need for innovative and age-appropriate mental health support for adults and youth. The extent of the pandemic's impact on mental health among adults and youth may depend on many vulnerability factors. These data suggest that AI/AN females in particular need tailored and targeted prevention interventions, especially among those10-39 and 50-59 years of age.

- Data Source: Analyses are based on information reported to the Rapid Health Information NetwOrk (RHINO), the syndromic surveillance program at the Washington State Department of Health.

Suicide-related, suicide ideation, and suicide attempt ED records were identified using validated CDC definitions for syndromic surveillance data. For more information or additional data, please contact the IDEA-NW project at ideanw@npaihb.org.

COVID-19 Mental Health Resources:

- Text NATIVE to 741741 for free, 24/7 crisis counseling from the Crisis Text Line
- Lines for Life: 24/7 free, confidential, and anonymous help get help https://www.linesforlife.org/get-help-now/
- National Suicide Prevention Lifeline Coping during COVID-19 https://suicidepreventionlifeline.org/current-events/supporting-your-emotional-well-being-during-the-covid-19-outbreak/
- American Foundation for Suicide Prevention: Mental health and COVID-19 https://afsp.org/mental-health-and-covid-19
- Approved Suicide Prevention Apps:
  - Stay Alive: Grassroots Suicide Prevention App
  - ReMinder Suicide Safety Plan on the App Store
  - My3 application

OHSU and NPAIHB Team up to Create Powerful PSAs in Response to COVID

COVID Communications Team

OHSU and NPAIHB Team up to Create Powerful PSAs in Response to COVID

We know films are a powerful tool to tell Indigenous stories and communicate important teachings to tribal people. To address the disproportionate impact of COVID-19 on tribal communities, the Northwest Native American Center of Excellence (NNACoE) and the Northwest Portland Area Indian Health Board (NPAIHB) teamed up to limit the spread of COVID-19 in tribal communities through innovative digital health technologies and tribal expertise.
The partners produced a series of Public Service Announcements (PSAs) to help keep Indigenous people safe during the pandemic, focusing on the informational needs and cultural values of Native people. According to Jonas Greene, Communications Manager at the NPAIHB, "It is imperative that we prevent, prepare, and respond to the pandemic in ways that meet the unique needs of our NW Tribes."

While our communities have been deluged with COVID-related messages, to truly resonate with our people, they must reflect the nuances of AI/AN culture and feature AI/AN subjects. Together, in partnership with A Twilight Dawn Productions, Buffalo Nickel Creative, and NW Tribes, we are producing powerful PSAs to help share those teachings:

- Clinical perspectives on protecting ourselves and our communities through vaccination: **https://www.youtube.com/watch?v=ypdIV7OdI1Y**
- Protecting our children through vaccination: **https://youtu.be/uSG_h7UGVxs**
- Traditional practices and COVID-19: **https://youtu.be/npsIO7OhdEM**
- Staying connected while being physically distant: **https://youtu.be/TunV6AUFs-g**
- Exercising safely: **https://youtu.be/Dr8EJUZ_c1M**
- Importance of wearing masks, even after vaccination (in production)
- Resilience and strength of Tribal communities during the pandemic (in production)

As Indigenous people, it is our role to learn from those who came before us and nurture those who come next. We dance, we pray, we share, we adapt, we protect. We thrive and carry on for those who came before us. Thankfully, we can now vaccinate adults and elders with confidence, knowing that getting vaccinated is the best way to protect our community and the quickest way to end the pandemic!

Until we return to normal: Get vaccinated when it's your turn. Continue to practice masking and social distancing outside. Avoid crowded settings and wash your hands regularly.

The Northwest Portland Area Indian Health Board is a non-profit tribal advisory organization that serves the forty-three federally recognized tribes of Oregon, Washington, and Idaho. **www.npaihb.org**
Follow the Northwest Native American Center of Excellence's Visual Stories page for future PSAs in the series. The NNACoE works to sustainably address the health care needs of all people by increasing the number of AI/ANs in the U.S. health professions workforce.
See: **https://blogs.ohsu.edu/researchnews/2020/11/20/ohsu-center-and-partners-release-first-native-health-psa-with-cares-act-funds/**

NPAIHB Health & Wellness During the Pandemic

Birdie Wermy, MPH
(S. Cheyenne)

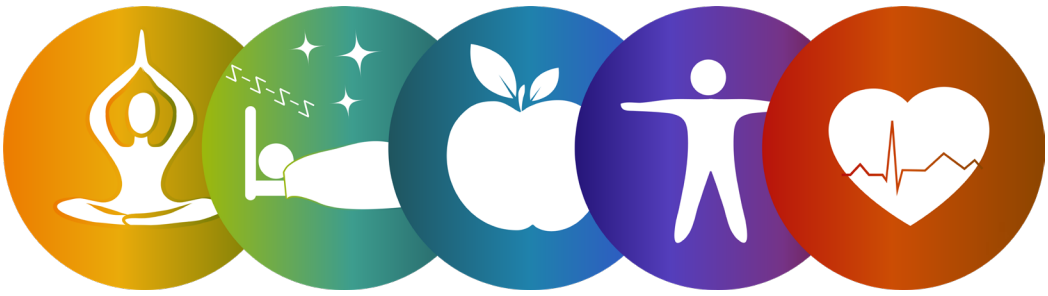
Behavioral Health Project Manager &
Wellness Committee Co-Chair

We can all agree 2020 was a hard and challenging year. Our world and daily life as we once knew it, was shut down in the blink of an eye. Our favorite restaurants were closed, the movie theaters were shut down and the gyms were closed – to avoid the spread of the Coronavirus. We all had to adjust to working from home, teaching our children from home and in some cases, becoming an in-home daycare for our children while trying to maintain a household and normal schedule. For some of us, this was a blessing in disguise. No more driving and sitting in traffic, more time with our families and children, more home cooked meals and more time to focus on our health and wellness.

The Northwest Portland Area Indian Health Board (NPAIHB) employees receive 30 minutes per day of paid Wellness time, and a full hour if combined with their lunch break. Employees use Wellness time to participate in running, walking, lifting weights, cycling, yoga, CrossFit, and other activities.

During the pandemic the Wellness Committee came up with ideas on how to engage staff virtually through weekly Craft Circle meetings, Wellness Wednesday Workouts with Erik and most recently Yoga w/ Ashley on Thursdays. A few of these activities included participation from our member Tribes as well as our family, children and friends. Our goal was to engage with others the same way we would've if we were in the office. We had a number of participants ranging from 5 -10 staff, family and friends on any given night. We also held our very first Virtual Summer Challenge which began on June 21st 2020 and extended through to the end of the year to reach a goal of 2,121 minutes (our address). We had a total of 26 staff participate in the Summer/Fall/Winter challenge and received positive feedback from this virtual challenge. We wanted to encourage ALL employees to take advantage of the 30 minutes of paid wellness time that you get every workday. This was a self-care approach to help with the physical, mental, spiritual, and emotional health which is especially important during this time. Consistently taking care of yourself in all these areas can help build your immune system, promote clear thinking to make decisions and overall physical wellbeing.

A few of our member Tribes also held their own virtual challenges and invited health board staff and family to participate. A few of the health tracking apps, include inKin, Strava, MapMyRun and the Nike Plus app. If you have a Garmin or Apple watch, there are certain apps that can track your workouts, heart rate and other health information. For our virtual challenges, we used a Google doc and staff would log their weekly activities and minutes. At the end of each month, we sent out monthly updates on the minutes and activities we participated in along with encouraging words and slogans to get folks going on their health and wellness. During our check-in meetings, staff would share their activities with one another, allowing for other staff to engage with one another by sharing HOW they were using their wellness time during the week.



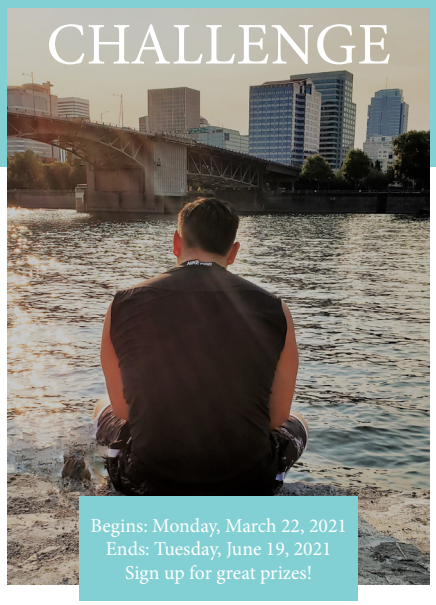
During the summer, we also held our 2020 Virtual Picnic and all staff were gifted a wellness bag from Native Preserve filled with Sweet Grass from Sakari Farm (Tumalo, Oregon), a Sweet Grass candle, sunscreen, chap stick, hand sanitizer and thermometer. Staff and family were invited to meet at the 12 o'clock hour and enjoy lunch together.

Going outside each day for 15 minutes of fresh air and sunshine helps the body make vitamin D. Vitamin D deficiency can create vulnerability to the common cold (Source: John's Hopkins Medicine). It's also important to keep in touch with friends, especially the ones who uplift you, and give people the benefit of the doubt during this challenging time. Practicing mindfulness and gratitude promotes your well-being. Spending time each day to say positive affirmations for yourself can improve your mental health and mood (Source: John's Hopkins Medicine).

61 Top Self Care Tips During the Coronavirus Pandemic updated 3.23.21

- Prioritize Sleep – Your Mood and Immune System Are Counting On It
- Work. It. Out – Test Ride A Workout You've Never Done Before
- Skip, Jump, Hop and Get Silly
- Play A Game
- Avoid Mindless Snacking, Eat Intuitively Instead
- Enjoy the Healing Power of Baking
- Practice Kindness and Gratitude
- Practice Positive Self Talk
- Practice Diaphragm Breathing
- Stand Up and Stretch
- Reap the Health Benefits of Laughter by Watching YouTube Videos

SPRING FITNESS CHALLENGE



Spring begins March 20th! Time to get out and about.

Safety Note: Check with your medical provider before starting any exercise plan.

NPAIHB has been Challenged!

The Burns Wellness Center has asked us to join their Spring Fitness Challenge.

Simply keep track of your physical activity minutes by using the link provided. Wellness committee will compile and send to Burns.

https://docs.google.com/spreadsheets/d/1B0V27VVDare4D8_Lmaun0dit-wr9aRXXPCwbiLWdPKI/edit?usp=sharing

Most health organizations recommend at least 150 minutes of any kind of physical activity. (30 minutes a day, 5x a week)

NW Portland Area Indian Health Board
2121 SW Broadway, Ste. 300
Portland, Oregon 97201
www.npaihb.org

Currently NPAIHB staff are participating in a Spring Wellness Challenge with the Burns-Paiute Tribe (3.22-6.19) and we have a total of 20-24 staff participating each week.

Have a Healthy Mother's Day!

Tyanne Conner, MS

Native Boost
Project Coordinator

Mother's Day is coming up soon! In honor, we want to share with you what we know about pregnancy, breastfeeding, and vaccines in the era of COVID-19. We wish for all* people to be safe and healthy in these uncertain times. To that end, we want to provide useful vaccine-related information so that each person may make the best and most informed decision for themselves and their families.

American Indians and Alaska Natives have been negatively affected by COVID-19 at **disproportionate rates** compared to non-Natives, and while Tribes have done great work to reduce the spread and to distribute vaccines, there is still work to be done to safeguard our communities. To protect the most vulnerable including mothers, babies, elders, and others with serious health conditions, we must make sure we reach **community immunity.** The safest and best way to do that is by making sure that all people eligible to receive vaccines, including those who are pregnant and breastfeeding have the opportunity to do so.

Vaccines are one of the **most studied,** regulated, and safest medical interventions ever created. Increased **safety monitoring** has been put into place for all COVID-19 vaccines including monitoring for those who are pregnant. The **FDA** has stated that for the three currently available COVID-19 vaccines, there are no contraindications for those who are pregnant or breastfeeding. In fact, antibodies generated from the vaccine have been found in both breast milk and umbilical cord blood. This means that immunity from the vaccine is **passed** from mother to baby, giving baby the best possible chance at good health.

Pregnant people are more prone to severe illness if they get COVID-19 and though it is rare, it is possible for babies to get COVID-19 through the placenta, during birth, or after via what is called vertical transmission. For this reason, it is especially important to provide accurate vaccine information so that those experiencing pregnancy can make informed decisions.

Understanding how vaccines work arms us with the information we and our communities need. Messenger RNA or mRNA vaccines DO NOT contain the live virus so CANNOT give someone COVID-19. Viral vector vaccines like the Johnson & Johnson (J&J) vaccine also DO NOT contain the COVID-19 virus and thus cannot make us sick with COVID-19. In response to questions whether Moderna vaccine was safe for those who are pregnant, the World Health Organization (WHO) has updated its stance: "Based on what we know about this kind of vaccine [mRna], we don't have any specific reason to believe there will be specific risks that would outweigh the benefits of vaccination for pregnant women." Pfizer is currently in clinical trials with healthy pregnant people over 18 years and once those results are available, we will provide updates.

V-safe, a smartphone-based tool that prompts an online health check-in by answering simple questions after vaccination helps us gather more information on safety of vaccines. Pregnant people who have been vaccinated are highly encouraged to participate. Vaccinated pregnant people also may choose to enroll in a registry that gathers more information about their experiences. Currently more than 69,000 people have enrolled in the registry and the more who register, the more safety information can be gathered. MotherToBaby, a trusted source of information about medications and other exposures during pregnancy and breastfeeding, includes information regarding COVID-19 exposure, and vaccine safety during pregnancy. More information from the FDA on vaccines currently available can be found here.

New Faces

Dawn Bankson,
PHN, MSN, ARNP/CPNP

Oregon Tribal and Urban
Testing Liaison

My name is Dawn Rae Bankson. It is an honor to be a part of the Northwest Portland Area Indian Health Board and Northwest Tribal Epidemiology Center. I received a Bachelor of Science degree in Nursing at Loma Linda University and a Master of Science/Pediatric Nurse Practitioner Certification at California State University Fresno in 1997. My love for science/medicine may have been influenced by my father's work as a medical research engineer. His involvement in science and medicine started before I was born and included his work in developing the first positive pressure mechanical ventilator, called the Puritan-Bennett Ventilator, which replaced the iron lung.

In my early years, I had the opportunity to work in public health with the Riverside-San Bernardino Tribes in California. After moving to Washington, I was privileged to work for the Quinault Indian Nation as their Pediatric provider and cherished my years working with the Tribe. I feel very fortunate to now have this opportunity to put on a new hat by serving the many Northwest Tribes. I am humbled and excited to be a part of this wonderful NPAIHB team!

Asia Brown
(Choctaw)

Sexual Health
Communications Specialist

Halito! My name is Asia Brown (pronouns: she/her/hers) and I am a member of the Choctaw Nation of Oklahoma. I was born in Tulsa, OK but consider Skiatook my hometown. At a young age my parents and I moved to Florida where I spent most of my childhood, then made our way out here to Oregon where I completed high school and college. I graduated from OSU in spring 2020 with a B.S. in Public Health, minor in Ethnic Studies, and emphasis on Microbiology. Shortly after, I joined the board in October 2020 as the Communications Intern for the Native Dental Therapy Initiative (NDTI), then switched gears to coming on full time as the Sexual Health Communications Specialist on the Washington Youth Sexual Health (WYSH) project. I am so grateful to be a part of this work and to continue being in community with you all.

Tammy Cranmore

Finance Director

I've been a CFO for the last 15 years, with 25 years working in Finance & Accounting. I graduated from PSU with a degree in Finance. I live in Battle Ground, WA and have 2 kids, 17 & 20. I am a people person that loves to mentor my team and embrace new ideas. I have extensive experience specializing in Finance and Accounting and serving as an expert on senior executive teams. I have experience with leadership of multi-million-dollar entities and I deliver quantifiable profitability through cost management, analytical reasoning, training, and technology. I have a track record of raising profitability, uncovering high-impact issues, and rolling out new technologies. I am very excited for this new opportunity and I look forward to working with all of you in my new position at the Board.

New Faces (continued)

Jane Manthei

Healthy Native Youth
Outreach Specialist

My name is Jane Manthei and I'm from Winslow, Arizona. My family largely resides in the Midwest and in Russell County, Alabama. I am the new outreach specialist for Healthy Native Youth and I am excited to help educators deliver culturally relevant curricula for AI/AN youth. I have a BS in Biology from the University of New Mexico with a focus on immunology. After college, I taught high school science in McLaughlin, SD in a small public school in Standing Rock. Prior to accepting this role, I was working as a policy journalist in Northeast Arizona for a small radio station with an emphasis on Navajo Nation, Hopi tribal, and city/county government.

I like science fiction and hockey, I read a lot, and I've never turned down a fried egg sandwich. I'm thrilled to be in the Pacific Northwest and I am delighted to sign on with the Project Red Talon team!

Holly Thompson Duffy, MPH

Environmental Health
Science Manager

Holly Thompson Duffy spent the past year as an Environmental Health Consultant working to assist the NPAIHB Environmental Public Health staff carry out immediate activities in response to the COVID-19 public health emergency. Prior to this she served for nine years as an Environmental Protection Specialist with the Portland Area Indian Health Service, Division of Environmental Health Services, managing an interagency agreement with the EPA to reduce the environmental health risks of pests and pesticides by educating and empowering communities to adopt Integrated Pest Management (IPM). While there she also served as the technical lead on a project with the EPA to collect valuable data on children's exposures to lead, allergens, pesticides, and PCBs in Tribal childcare facilities, utilizing a comprehensive data collection strategy which included environmental sampling. Holly came to IHS from Chicago where she spent four years as an Environmental Health Programs Manager at a small nonprofit working with schools, childcare facilities, residents, property managers and municipalities to reduce toxic exposures in the built environment and improve environmental health outcomes. She initiated programs targeting refugee and Spanish speaking populations, as well as a series of pollinator protection projects. She received her undergraduate degree from Trinity College in Hartford, Connecticut. She will be graduating this spring from the University of Alabama at Birmingham with an MPH in Environmental Health and Toxicology.

988 and the National Suicide Prevention Lifeline

30 Percent

The percent the suicide rate has climbed since 1999

1 in 5

people above the age of 12 has a mental health condition

280

For every one person that dies by suicide, 280 people seriously consider suicide but go on to live

Why Do We Need 988?

America is experiencing a mental health crisis. But the crisis is not irreversible.

- The suicide rate has climbed nearly 30% since 1999 – and the rate has increased in 49 out of 50 states over the last decade.
- From 2016-2017 alone, there was a 10% increase in suicides of young people between 15-24 years old in the US.
- Approximately one in five people above the age of 12 has a mental health condition in the US.
- Suicide is the second leading cause of death among young people, and the tenth leading cause of death in the US.
- **More Americans died from mental health crises and substance abuse in 2018 alone than have died in combat in every war combined since World War II.**
- However, suicide is most often preventable. For every person who dies by suicide, there are 280 people who seriously consider suicide but do not kill themselves.
- Over 90% of people who attempt suicide go on to live out their lives.

For too long, our system for mental health crisis services has been underfunded and undervalued. We will now meet this challenge with the evidence-based crisis intervention that the 988 crisis line will provide.

What Is 988?

A direct three-digit line to trained National Suicide Prevention Lifeline counselors will open the door for millions of Americans to seek the help they need, while sending the message to the country that healing, hope, and help are happening every day.

In 2020, the Lifeline received over 2.6 million calls, chats, and texts. **With an easy to remember and dial number like 988, the Lifeline hopes to reach many more people in emotional crisis.**

A 988 crisis line that is **effectively resourced and promoted** will be able to:

- Connect a person in a mental health crisis to a trained counselor who can address their immediate needs and help connect them to ongoing care.
- Reduce healthcare spending with more cost-effective early intervention.
- Reduce use of law enforcement, public health, and other safety resources.
- Meet the growing need for crisis intervention at scale.
- Help end stigma toward those seeking or accessing mental healthcare.

When you've got a police, fire or rescue emergency, you call 911.
When you have an urgent mental health need, you'll call 988.

Lifeline Crisis Centers are Effective

The National Suicide Prevention Lifeline provides 24/7, free and confidential emotional support to people in suicidal crisis or emotional distress across the United States. The Lifeline is administered by the nonprofit Vibrant Emotional Health and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). **The Lifeline is effective in reducing suicidal and emotional distress.**

- Evaluations and caller feedback show that Lifeline counselors are effective in reducing caller distress and suicidality, and help tens of thousands of people get through crises every day.
- Since launching in 2005, the Lifeline call volume has increased approximately 14% annually.
- In 2005, the first year of the Lifeline, it answered over 46,000 calls. In 2020, the Lifeline received over 2.6 million calls, chats, and texts.

The Lifeline is a network of over 180 accredited crisis call centers.

- Crisis centers are local and connected to their community resources, community mental health, hospitals, social service and first responders.
- All Lifeline centers are accredited, provide extensive training in crisis intervention and suicide prevention, and must apply Lifeline's best practices on calls.
- These same crisis centers continue to answer more than 12.1 million additional non-Lifeline crisis calls on their local, city, county and state crisis lines.

The current Lifeline grant is not designed to fund the centers answering local Lifeline calls. The Lifeline and Vibrant Emotional Health currently provide the following support to the national network for local crisis call centers:

- Routes calls through the network to a local crisis center or national backup center and pays for incoming call charges.
- Sets clinical standards and sector-wide best practices, and provides constant quality assurance, training, assessments, and guidelines to ensure quality, effective help for people in crisis.
- Runs state-of-the-art technology to ensure responsiveness, including online 24/7 chat platform technologies.
- Provides specialty national services for the network, such as: national backup centers; Lifeline's crisis chat centers; and Lifeline's Spanish-speaking subnetwork, translation services and accessibility options for individuals who are deaf or hard of hearing.
- Provides grants to temporarily support some states to answer more Lifeline calls until they can sustain their own funding, and one-time planning grants to help state agencies and centers plan and prepare for 988.
- Lifeline and its partner, the National Association of State Mental Health Program Directors, work closely with state officials to promote awareness and approaches for successfully funding local Lifeline crisis centers.

How Does 988 Improve Health Care and Public Safety Costs?

When 988 is fully implemented, Lifeline call centers could potentially divert many calls from 911, resulting in substantial cost-savings for health and safety crisis and emergency systems nationally.

- Reducing the dispatch of law enforcement to persons in non-emergency mental health crises frees more resources to respond to public safety needs, and reduces the hesitation associated with reporting mental health crises.

Call centers in the Lifeline divert hundreds of thousands of calls from 911 every year.

- The Lifeline dispatches emergency services for only 2% of calls.
- People in crisis who call the Lifeline have better health outcomes than people in crisis who are triaged with emergency services personnel.

What Is Next?

Vibrant Emotional Health, the administrator of the Lifeline, has identified three key themes to guide 988 implementation:

1. **Universal and Convenient Access**, including omnipresent public awareness and varying modalities for individuals to access 988 through their preferred method of communication.
2. **High Quality and Personalized Experience** that is tailored to the unique needs of the individual while also in line with identified best practices.
3. **Connection to Resources and Follow Up** to ensure all persons contacting 988 receive additional local community resources as needed.

In keeping with these themes, Vibrant has several key recommendations:

It is critical that **appropriate funding** for the network, individual crisis centers, and the crisis continuum be allocated to serve more people in crisis. States should exercise their authority to implement a 988 fee, similar to the current 911 fee, that would be restricted to crisis center and service provider expenses, to ensure a robust infrastructure. In 2018, fees for 911 generated $2.6 billion to support that service; similar investment is needed for mental and behavioral health crises. The fee revenue should supplement, not supplant, funding from diverse sources, including federal, state and local governments.

Increased **collaboration between 911 and 988** can provide more options for those in crisis, such as dispatching mobile crisis teams to individuals in mental health or suicidal crisis rather than police or EMS, and greater coordination of care options like crisis stabilization units. Such collaborations can reduce the burden on the costly use of hospital emergency departments.

We must also seek to optimize and support services that ensure **access and inclusion** within 988 to meet the unique needs of at-risk groups, including youth, rural populations, BIPOC communities, and LGBTQ+ individuals.

We encourage stakeholders, crisis centers, telecommunications agencies, mental health providers, and people with lived experience to work together to help build this public health safety net for all.

For source materials for any part of this document, please contact communications@vibrant.org.

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

2121 SW Broadway • Suite 300 • Portland, OR 97201

Return Service Requested

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD OCTOBER 2020 RESOLUTIONS

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

21-02-02 Environmental Protection Agency Region 10 General Assistance Program (GAP) Proposal

21-02-03 TI- 21-007 Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Opioid Response (TOR) Grant

21-02-04 Behavioral Health Aid Training and Support Project

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