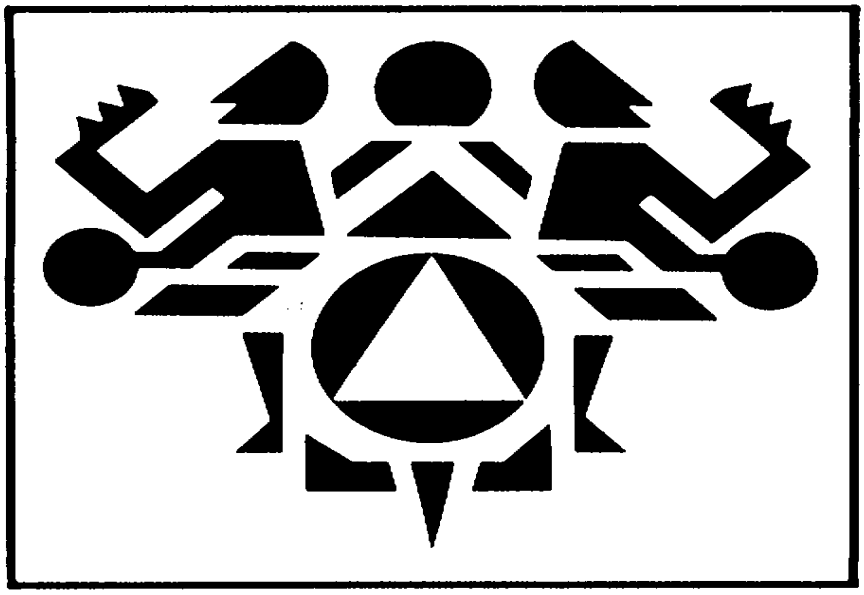
MINUTES

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD



QUARTERLY BOARD MEETING

JANUARY 22-24, 2019

SUQUAMISH CLEARWATER CASINO RESORT

SUQUAMISH, WA

QUARTERLY BOARD MEETING

Suquamish Clearwater Casino Resort
15347 NE Suquamish Way
Suquamish, WA 98392

January 22 - 24, 2019

Summary of Minutes

Issue	Summary	Action	Follow-Up
TUESDAY JANUARY 22, 2019			
EXECUTIVE DIRECTOR UPDATE, JOE FINKBONNER:	**PERSONNEL** **NEW HIRES:** • **Ashley Thomas**, NARCH Cancer Project Coordinator • **Megan Woodbury**, Opioid Project Coordinator • **Paige Smith**, THRIVE & RC Coordinator • **Rosa Frutos**, Cancer Project Coordinator • **Heidi Lovejoy**, Substance Use Epidemiologist • **Michelle Singer**, Health Native Youth Project Manager **PROMOTIONS/TRANSFER:** • **Christina Peters**, TCHP Project Director • **Nicole Smith,** Senior Biostatistician 1 • **Candice Jimenez**, Research Manager • **Danica Brown**, Behavioral Health Program Manager **TEMPS & INTERNS:** • Morgan Thomas • Zoe Watson **RECOGNITION:** • **Clarice Charging**		

Summary of Minutes

- 15 Years of Service Recognition
- **Nora Frank-Buckner**
  - 2018 Employee of the Year

Meetings

NOVEMBER

- Public Health Leader Panel & Speed Mentoring, UW, Seattle, WA (11/6)
- 2018 American Indian Health Commission for Washington State's Tribal and State Leaders Health Summit, Suquamish, WA (11/8)
- EHS Presentation Shoshone-Bannock, Fort Hall, ID (11/13)
- 2021 PA Budget Formulation Meeting, Portland, OR (11/15)
- PHAB Board of Director's Meeting ~ Washington, DC (11/28-11/29)

DECEMBER

- NPAIHB Holiday Party ~ Friday December 7th, Grand Central Bowl (12/7)
- WA State Medicaid DHAT Spa Hearing, Seattle, WA (12/17)

UPCOMING MEETINGS

JANUARY

- ANTI – Portland, OR (1/28-1/31)

FEBRUARY

- NCAI – Washington, DC (2/11-2/14)
- IHCIF
- DSTAC
- 2021 Budget Formulation
- Hill Visits (tentatively), Washington, DC (2/25-2/28)

Summary of Minutes

MARCH

- Arcora Foundation Board Meeting, Seattle, WA (3/8)
- PHAB Board Meeting, Washington, DC (3/19 - /3/20)

APRIL

- IHS Tribal Self-Governance Annual Consultation Conference, Traverse City, MI (4/1-4/4)

Youth Delegates

The Tribal Youth Delegates will be joining the Legislative Committee at lunch to present a resolution for formal recognition by the Board

- They will also be working with a film crew to develop some recruitment videos for the Youth Delegate Program.
- If there are any Delegates who are interested in being a part of this video project, they can learn more at the Youth Committee meeting.

Youth Delegates attending will be:

- **Sadie Olsen** (Lummi)
- **William Lucero** (Lummi)
- **Jedah DeZurney** (Siletz)
- **Adilia Hart** (Umatilla)
- **Lindsey Pasena Little Sky** (Umatilla Rep - Pueblo of San Felipe)
- **Cheydon Herkshan** (Warm Springs)
- **Josiah Spino** (Warm Springs)
- **Lark Moses** (Umatilla)

Northwest Tribal Epidemiology Center Survey

Summary of Minutes

	• The EpiCenter and it's WEAVE NW project are requesting Tribal delegate assistance in completing a The EpiCenter Priorities survey which also includes questions about chronic disease policies in your Tribal community. This survey was last administered in 2015/2016. • We ask that this survey is completed by March 1st. All those that do complete their survey by that date will be entered into a drawing for a Tribal blanket. **Survey is on your IPad**		
REVIEW NATIONAL COMMITTEE LIST	***National and Regional Committees*** • U.S. Department of Health and Human Services (HHS) • Indian Health Service (IHS) • Substance Abuse Mental Health Services Administration (SAMHSA) • Centers for Disease Control and Prevention (CDC) • Centers for Medicare and Medicaid Services (CMS) • National Institutes of Health (NIH) **HHS Secretary's Tribal Advisory Committee (STAC)** • The last STAC meeting was an informal HHS update meeting in DC December 11-12. Klamath Vice Chairwoman Gail Hatcher attended the informal STAC updates meeting as the Portland Area representative as well as Laura. • The next STAC meeting will be held February 7-8 in DC. • The next STAC meeting will include discussion topics like Drug Pricing Reform, Addressing the Opioid Epidemic, Quality Care, Tribal Emergency Preparedness needs, and age related health concerns in Indian Country. Are there any specific issues or benefits that you would like Chairman Ron Allen to address? • Portland Area Representatives:		

Summary of Minutes

- Ron Allen, Jamestown S'Klallam (Primary)
- Gail Hatcher, Klamath (Alternate)

- Meetings:
  - Last meeting: HHS Updates December 11-12 in Washington, D.C
  - **Next meeting: February 7-8 in Washington, D.C.**

HHS STAC Discussion Items

- HHS Workgroup on Workforce Development
- National Advisory Committee on Rural Health and Human Services Overview and Update
- HHS Reimagine "Re-Invent Grants Management" Overview
- HHS Tribal Advisory Committee Discussion
- President's Council on Physical Fitness

The STAC had a discussion on the **HHS Workgroup on Workforce Development** with the AI/AN Policy Lead at the Office of Minority Health on improving workforce development in Indian Country. Tribal leaders expressed that tribal communities continue to lead the way in oral health workforce by the employment of DHATs. The need to approve the WA DHAT SPA was emphasized.

HHS released a report on "Reforming America's Healthcare System Through Choice and Competition", which notes that the federal government and states should accompany legislative and administrative proposals to allow non-physician and non-dentist provider to be paid for their services.

Ben Smith, Deputy Director for Intergovernmental Affairs at IHS provided and overview of the **National Advisory Committee on Rural Health and Human Services Committee (NACRHHS).** The Committee advises the Secretary on healthcare challenges in rural America. The STAC highlighted that tribal and rural communities should not be differentiated, most tribal

Summary of Minutes

communities are rural themselves.
STAC was provided an overview of the HHS **Reimagine "Re-Invent Grants Management"** initiative is an effort to reduce administrative burden, while increasing transparency, resource optimization, and efficiency across HHS grants management.
Each **HHS Tribal Advisory Committee** provided updates on the priorities and work of each Committee.
STAC engaged in a discussion on engagement from **the President's Council on Physical Fitness** with tribal communities.

IHS Tribal Leader Diabetes Committee (TLDC)

Last TLDC meeting occurred December 12-13 in Tucson.
The next TLDC meeting is proposed for March 19-20 in Washington DC, it still needs final approval by IHS.
Cassie and Sharon attended and presented on SDPI at the 2018 Healing Our Spirit Conference in Sydney, Australia November 26-29
A Conference on Diabetes in Indian Country 2019 has been scheduled for August 6-9, 2019 in Oklahoma City, OK.
Sharon and Cassie can you share more information about the previous TLDC meeting and conference calls?

- Portland Area Representatives:
  - Cassandra Sellards-Reck, Cowlitz (Primary)
  - Sharon Stanphill, Cow Creek (Alternate)
    - Conference calls-Third Wednesday of every month 1-2pm PST.
    - Last meeting: December 12-13 in Tucson, AZ
    - **Next meeting: March 19-20, 2019 in Washington, D.C. (proposed)**

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IHS Budget Formulation Workgroup

The Portland Area Budget Formulation Process was on November 15, 2018.
The National Budget Formulation Meeting is scheduled for February 14-15, 2019 in Crystal City.
Opportunity for IHS NTBFW to present recommendations at HHS Annual Tribal Consultation scheduled for April 3-4, 2019 in DC.

- Portland Area Representatives:
  - Workgroup Co-Chair, Andy Joseph, Jr., Colville
  - Steve Kutz, Cowlitz Tribe
- FY 2021 National Budget Formulation Meeting:
  - **Next meeting: February 14-15 in Crystal City, VA**

IHS PRC Workgroup

The charge of the IHS Director's Workgroup is to provide recommendations to the Director on strategies to improve the agency's PRC programs. Reviews input received to improve PRC program, evaluates the existing formula for distributing PRC funds, and recommends improvements in the way PRC operations are conducted within the IHS and Indian Health System.

- Portland Area Representatives:
  - Andy Joseph, Jr., Colville (Primary)
  - John Stephens, Swinomish (Alternate)
- Meetings:
  - Last meeting: October 16-17, 2018 in Portland, OR
  - Next meeting: **TBD**

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IHS CSC Workgroup

The CSC Workgroup meets to further the federal government's administration of CSC within the IHS. The agency is in active participation with Tribes, has developed a comprehensive CSC policy to implement the statutory provisions of ISDA.

- Portland Area Representative:
  - Tribal Co-Chair, Andy Joseph, Jr., Colville
- Meetings:
  - Last meeting: April 23, 2018 12:00pm-1:30pm in Albuquerque, NM
  - Next meeting: **TBD**

IHS 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 Representatives:
  - Janice Clements, Warm Springs (Primary)
  - Greg Abrahamson, Spokane (Alternate)
- Meetings:
  - Last meeting: October 1-3, 2018 in Washington D.C.
  - **Next meeting: Postponed**

IHS 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

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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 Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Tyson Johnston, Quinault (Alternate)
- Meetings:
  - Last quarterly meeting: October 1-4, 2018 in Washington D.C.
  - **Next quarterly meeting: Rescheduled for April 24-25, 2019 in Washington D.C.**
  - 2019 TSGAC Annual Conference: March 31-April 4, 2018 in Traverse City, MI.

IHS IHCIF Workgroup

- Just a reminder that the FY 2018 IHCIF allocations went to only 3 tribes in the Portland Area.
- The last meeting was held August 30. The next meeting was scheduled for February 12-13, but due to the partial government shutdown has been postponed.
- Portland Area Representatives:
  - Gail Hatcher, Klamath (Primary)
  - Steve Kutz, Cowlitz (Alternate)
- Meetings:
  - Last meeting: December 12-13, 2018 in Rockville, MD.
  - **Next meeting: Postponed**

IHS IHCIF Sub-Workgroup Decisions

<u>Benchmark Workgroup:</u>

- Finished their work and transferred the facility factor, to the access to care workgroup.

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User Population Workgroup:

- Fractionalization analysis still outstanding

Alternate Resources Workgroup:

- waiting for evaluation on NDW data and whether this can be used. Preference of workgroup is to use this data but without analysis of the data, the workgroup can't make a decision.

Access to Care Workgroup:

Unable to pinpoint a solid factor to move forward for access to care. This resulted in discussion and decision to look at another budget that could include access issues.

IHS CHAP TAG

- A key discussion topic of the CHAP TAG is the Interim Policy, which was originally created by ANTHC and the Board.
- The next CHAP TAG meeting has not been scheduled yet.
- Portland Area Representatives:
  - John Stephens, Swinomish (Primary)
  - Andy Joseph, Jr., Colville (Alternate)
- Meetings:
  - Last meeting: October 10, 2018 in Rockville, MD.
  - Next meeting: **TBD**

IHS CHAP TAG Updates

November 5:

- CHAP TAG requested that IHS provide an updated policy for discussion.

December 20:

Summary of Minutes

- Version VI of the draft policy was sent out to CHAP TAG with letter that it would be announced January 3, 2019 on the IHS Tribal Leaders and Urban Conferees monthly call, but it wasn't.

January 1:

- CHAP TAG submitted a letter to IHS expressing concern that the most current draft policy was not approved by the TAG prior to being finalized for tribal consultation

In Process:

- NPAIHB is preparing a separate letter to IHS

IHS NTAC

- The last NTAC meeting was held December 12-13. The Committee has been reviewing the formula and data to provide proposals on the Domestic Violence Prevention, Substance Abuse and Suicide Prevention, and Zero Suicide Initiative funding to RADM Weahkee in response to the DTLL on putting funds into compacts and contracts. Cassie, Sharon, and Laura were in attendance of the meeting.
- The next NTAC meeting will likely occur with SAMHSA TTAC week of March 11 in California.
- Portland Area Representatives:
  - Cassandra Sellards Reck, Cowlitz (Primary)
  - Cheryl Sanders, Lummi (Alternate)
- Last meeting: December 12-13 in Tucson, AZ
- **Next meeting: Week of March 11, 2019 in California (proposed)**

IHS NTAC Updates

- For past two meetings, NTAC has been discussing proposed changes to the IHS behavioral health program initiatives funding mechanisms.

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- NTAC spent much of the 2-day meeting in Tribal Caucus to formulate their recommendation to Admiral Weahkee, calling IHS staff in as needed for information.
- NTAC tribal representatives worked on a letter to Admiral Weahkee with recommendations on funding for SASPP, DVPP, and ZSI.

IHS FAAB

- The last FAAB meeting was scheduled for January
- Due to the lack of fiscal appropriations for the IHS, the FAAB that was scheduled for January 14-16, was postponed. They requested availability for February 5-6, 2019 or February 20-21, 2019.
- Portland Area Representatives:
  - Tim Ballew, Lummi (Primary)
  - Andy Joseph, Jr., Colville (Alternate)
- Meetings:
  - **Next meeting: February 5-6, 2019 or February 20-21, 2019 in Washington, D.C.**

CDC TAC

- The last meeting was scheduled in March, but was cancelled and replaced with a Tribal Public Health Workgroup.
- The next meeting is scheduled for February 4-5 in Atlanta.
- Does anyone have any updates for the CDC TAC?
- Portland Area Representatives:
  - Vacant (Primary)
  - Steve Kutz, Cowlitz (Alternate) and Cassandra Sellard-Recks, Cowlitz (Alternate)
- Meetings:

Summary of Minutes

- Last meeting: March 13-14, 2018 TAC cancelled; instead, Tribal Public Health Workgroup had a collaborative work session with CDC.
- Next meeting: **February 4-5, 2019 in Atlanta, GA.**

SAMHSA TTAC

- **Last meeting was a virtual meeting on December 18.** The following SAMHSA TTAC Tribal Priorities were discussed:
- ***Access to grants*** -- Many tribes have been able to keep grants. There has been greater collaboration across SAMHSA to support tribes.
- ***Improve data*** -- Need national data to understand the priorities globally and local data for tribes for programming.
- **Improve communications** to tribes on behavioral health resources; information for behavioral health administrators; and substance abuse information for the community. SAMHSA is updating their website.

The next in-person meeting will be March 13-14, 2019: The March meeting will be in California and take place over two full days (1.5 days for TTAC's business and policy discussions and .5 day for a TTAC site visit to a local tribal behavioral health program). IHS requested a joint meeting between TTAC and its National Tribal Advisory Committee on Behavioral Health (NTAC). Should NTAC agree to the March meeting dates, the recommendation is that the meeting be expanded to 2.5 days to facilitate the joint advisory meeting discussion, allow for a separate TTAC discussion, and for a site visit. A discussion topic for TTAC will be its policy and program priorities given the new SAMHSA Strategic Plan FY 2019 – FY 2023.

- Portland Area Representative:

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- Jeremiah Julius, Lummi (primary)
- Nickolaus Lewis, Lummi (alternate)

- At-Large Member:
  - Andy Joseph, Jr., Colville
- Meetings:
  - Last meeting (virtual): December 18, 2018
  - Next meeting: **March 13-14, 2019 in California**

CMS TTAG

- John Stephens was in attendance as the Portland Area representative with Sarah Sullivan from our staff during the last meeting November 15-16 in DC.
- During the last meeting in DC, the TTAG met with Mary Mayhew (CMCS Director) for the first time. However, Mary Mayhew has left CMCS this month. The new Acting Director for CMCS is Chris Traylor. The TTAG met Chris at November TTAG when he presented on the Rural Initiative Strategies.
- The next meeting will be held in DC, February 20-21.
- Portland Area Representatives:
  - John Stephens, Swinomish (Primary)
  - Nickolaus Lewis, Lummi (Alternate)
- Meetings:
  - Last meeting: November 15-16, 2018 in Washington D.C.
  - Last conference call: January 9, 2019
  - **Next meeting: February 20-21, 2019 in Washington D.C.**

CMS TTAG Updates

- Tribal Consultation

Summary of Minutes

- Medicaid work requirements
- Care for Kids (InCK) and Maternal Opioid Misuse (MOM) Models Grant Opportunity
- Rural Health Strategy Initiative
- Managed Care issues in tribal communities
- Medicare Rule to Require Hospitals to Post Standard Charges Online (January 1)

MMPC

- Last MMPC meeting was held in November/ John and Sarah were in attendance. The was discussion was focused on preparation for the TTAG meeting and was focused on work and community engagement strategy, managed care issues
- Membership in MMPC is open to individuals authorized to represent a tribe, tribal organization, urban Indian program, or IHS.
- Meetings:
    - Last meeting: November 14, 2018 in Washington D.C.
    - Last conference call: January 8, 2019
    - **Next meeting: February 19, 2019 in Washington D.C.**

NIH TAC

NIH is working on creating a tribal consultation policy

- Portland Area Representatives:
    - Robyn Sigo, Suquamish (Primary)
    - Jeromy Sylvan, Port Gamble S'Klallam (Alternate)
- Meetings
    - Last meeting: October 3-4, 2018 in Oklahoma City, OK
    - Next meeting: **Week of March 21-22, 2019 in Bethesda, MD**

Summary of Minutes

	Other Meetings • IHS Information Systems Advisory Committee (ISAC) • ISAC will be meeting November 14-15 in Albuquerque, NM. • IHS Strategic Plan Workgroup • The IHS Strategic Plan is being finalized by IHS and should be released soon. • IHS Catastrophic Health Emergency Fund (CHEF) Workgroup • IHS Health Promotion/Disease Prevention Policy Advisory Committee (HP/DP) • IHS Health Research Advisory Council (HRAC) • Portland Area Fund Distribution Workgroup (FDWG) • Portland Area Facilities Advisory Committee (PAFAC)		
LEGISLATIVE & POLICY UPDATE, LAURA PLATERO, GOVERNMENT AFFAIRS/POLICY DIRECTOR	**Report Overview** 1. 2018 Mid Term Elections 2. Legislation 3. GAO Reports 4. IHS Budget Formulation Process 5. Current & Pending Federal Policies 6. Litigation 7. Upcoming National/Regional Meetings **2018 Midterm Elections** • 116th Congress – Senate: Republican Majority o 53 Republicans, 47 Democrats – House: Democratic Majority o 235 Democrats, 199 Republicans		

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- Governor Races: 23 Democratic Governors, 27 Republican Governors.
- Medicaid Expansion: Idaho (61%)- will expand coverage for 2,500 AI/ANs

Legislation

IHS Appropriations FY 2019

- In Partial Government Shutdown
  - Continuing resolution expired 12/21/18
- H.R. 266 -- Department of Interior, Environment, and Related Agencies Appropriations Act, 2019
  - Introduced by Rep. Betty McCollum (D-MN-4) on 1/8/19.
  - Passed House on 1/11/19 (240-179)
  - Status: Senate Legislative Calendar
- H.R. 21 – Consolidated Appropriations Act
  - Passed House on 1/3/19 (241-190)

Pay Our Doctors Act of 2019 (H.R. 195)

- Introduced by Rep. Markwayne Mullin (R-OK-2) on 1/3/19; 13 co-sponsors.
- Provides funding at the FY 2018 level for IHS in the absence of a continuing resolution from Congress.
- Would end the lapse in funding for IHS, tribal and urban Indian facilities and allow continued operations.
- Referred to House Committee on Appropriations on 1/3/19.

***To Be Introduced* - Equal Access To Medicaid for All AI/AN**

- Tribal Self-Governance Advisory Committee initiative
- The aim is to *fix gaps in access to high-quality health care services* under Medicaid for low-

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and moderate-income American Indians and Alaska Natives (AI/ANs) across all states.

- Approach:
  - Do no harm.
  - Build on existing administrative infrastructure.
    - Indian health care providers (IHCPs) are defined in federal regulations.
    - Most services to AI/ANs by IHCPs are currently supported with 100% federal funding.
  - Establish new authorities as either "requirements" or "options" based on assessment of: (a) ability to achieve policy goal and (b) ability to enact legislation.
- Would authorize Indian Health Care Providers (IHCPs) in all states to receive Medicaid reimbursement for a federally-defined set of health care services—referred to as Qualified Indian Provider Services (QIPS)—when delivered to AI/ANs.
- Would create the option for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level (FPL).
- Would extend full federal funding (through 100% FMAP) and the IHS encounter rate to Medicaid services furnished by *urban* Indian health programs to AI/ANs.
- Would clarify federal law and regulations related to AI/AN specific policy.
- Would Address the "four walls" limitations on IHCP "clinic" services.

House E&C Indian Health Task Force

- House Energy & Commerce Committee established the IHS Task Force in 2017.
- Tribes and tribal organizations across Indian country, including NPAIHB, provided input to the Task Force on ways to reform IHS so that it can better serve AI/AN.
- Task Force conducted a survey to tribes in the fall.
- Task Force has not disseminated results of their findings.

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GAO Reports

GAO Report for IHS Advance Appropriations

- On 9/13/18, GAO issued a report titled, "Indian Health Service: Considerations Related to Providing Advance Appropriation Authority" – GAO-18-652.
- GAO makes recommendations for policy makers to consider
- *Next steps*: In-person testimony, letters, Hill and IHS meetings, tribal conference gatherings - that the FY 2020 Interior and Related Agencies appropriations bill include FY 2021 advance appropriations for the IHS.
- Report available at www.gao.gov

GAO Report on the Affordable Care Act - Pending

- Government Accountability Office (GAO) conducting a study on the effects of the Affordable Care Act on Indian health facilities and on health insurance coverage for AI/AN.
- Visited Portland Area on December 4, 2018
- Collecting information on Portland Area impacts to facility operations (including patient coverage, collections and use of collections, PRC, etc).

IHS Budget Formulation Process

FY 2020 IHS Budget

- National Tribal Budget Formulation Workgroup co-chairs presented the recommendations for FY 2020 at the HHS Annual Tribal Consultation in D.C. on March 1 and to HHS Budget Council for the Tribal Budget Formulation in D.C. on April 11.
- Recommends over $7 billion for FY 2020 (36% increase over FY 2017 enacted level).
- Recommends $36.83 billion for tribal needs based budget to be implemented over 12 year

period.
- Available at: https://www.nihb.org/legislative/budget_formulation.php
- Portland Area Budget Formulation Process was on November 15, 2018.
- National Budget Formulation Meeting is scheduled for February 14-15, 2019 in Crystal City.
- Following February meeting, NIHB writes up the recommendation for IHS National Tribal Budget Formulation Workgroup (NTBFW)
- Opportunity for IHS NTBFW to present recommendations at HHS Annual Tribal Consultation scheduled for April 3-4, 2019 in DC.

Current & Pending Federal Policies
HHS Report: Reforming America's Healthcare System Through Choice and Competition
- Issued: 12/3/18
- Issues Identified:
  - Health Care Workforce and Labor Markets;
  - Health Care Provider Markets;
  - Health Care Insurance Markets; and
  - Consumer-Driven Health Care.
- Examples of Recommendations:
  - Broaden Scope of Practice
  - Improve Workforce Mobility
  - Facilitate Telehealth to Improve Patient Access
  - Positively Realign Incentives through Payment Reform
  - Using Choice to bring a Longer-Term View to Health Care
  - Quality Improvement and the Measurement and Reporting of Quality
  - Facilitate Price Transparency

Summary of Minutes

- Improve Health IT

HHS Draft Strategy to Reduce Regulatory and Administrative Burden of Health IT and EHRs

- Comments Due: 1/28/2019
- Purpose: With the passage of the 21st Century Cures Act, Congress directed HHS to establish a goal, develop a strategy, and provide recommendations to reduce EHR-related burdens that affect care delivery.
- Burden Reduction Goals:
  - Reduce the effort and time required to record health information in EHRs for clinicians;
  - Reduce the effort and time required to meet regulatory reporting requirements for clinicians, hospitals, and healthcare organizations; and
  - Improve the functionality and ease of use of EHRs.

HHS Draft Report Pain Management Best Practices

- Comments Due: 4/1/19
- Issued by: Office of the Assistant Secretary for Health, HHS (12/31/18)
- Request for Public Comments on the Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations
- The Draft Report highlights the progress made towards identifying, reviewing, and determining whether there are gaps in or inconsistencies between best practices for pain management (including chronic and acute pain) developed or adopted by Federal agencies. It includes the Task Force's proposed updates to best practices and recommendations on addressing gaps or inconsistencies.

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OCR/HHS Modification of HIPAA Rules to Improve Coordinated Care

- Comments Due: 2/12/19
- Issued by: Office for Civil Rights (OCR); HHS (12/14/18).
- Request for Information on Modifying HIPAA Rules to Improve Coordinated Care
- Additionally, the RFI is soliciting comments within the HIPAA Privacy Rule in relation to the following items:
  - Encouraging information-sharing for treatment and care coordination.
  - Facilitating parental involvement in care.
  - Addressing the opioid crisis and serious mental illness.
  - Accounting for disclosures of Protected Health Information (PHI) for treatment, payment, and health care operations as required by the Health Information Technology for Economic and Clinical Health (HITECH) Act.
  - Changing the current requirement for network providers to make a good faith effort to obtain an acknowledgement of receipt of the Notice of Privacy Practices.

CDC Tobacco Control Practice

- Comments Due: February 11, 2019
- Agency: CDC
- CDC is seeking input to inform future activities to advance tobacco control practices to prevent initiation of tobacco use among youth and young adults; eliminate exposure to secondhand smoke; and identify and eliminate tobacco-related disparities.
- The information gathered will be used to inform activities that encompass technical assistance and guidance to state tobacco control programs and collaborative work with national governmental and nongovernmental partners, who share CDC's goals to prevent

initiation of tobacco use among youth and young adults; eliminate exposure to secondhand smoke; and identify and eliminate tobacco-related disparities.

CMS SMD Letter #18-011 New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services

- Outlines existing and new opportunities for states to design innovative service delivery systems for adults with SMI and children with SED.
- New authority for states to pay for short-term residential treatment services in an IMD for these patients.
- Emphasis that inpatient treatment is just one part of the continuum of care, participating states will be expected to improve community-based mental health care.

CMS Medicaid and CHIP Managed Care Proposed Rule

- Comments Closed: 1/14/2018 (issued 11/18/2018)
- CMS is proposing significant regulatory revisions to streamline the 2016 managed care regulatory framework.
- Reflects a strategy to relieve regulatory burdens, support state flexibility and local leadership, and promotes transparency and innovation.
- Removes barriers that made it difficult to transition new services and populations into managed care.
- No proposed changes to the Indian managed care provisions.
- Our comment letter focused on some of managed care issues raised in our area (access and payments).

CMS Work Requirements Issue

Summary of Minutes

- On 1/17/18, CMS issued a DTLL stating that CMS could not provide an exemption to the work requirements for AI/AN because of civil rights concerns.
- On 5/7/18, CMS updated its position, stating that they would actively consider state proposed accommodations for AI/AN from work requirements on a state by state basis.
- On 9/24/18, at STAC meeting, HHS Deputy Secretary Eric Hargan requested a legal opinion on the AI/AN exemption from work requirements. *Still Pending*
- As of 1/9/19, states with approved work requirement and community engagement waivers include: IN, AR, NH, NC, WI, ME and MI.
- Pending waivers: AZ, MS, OH, OK, SD, UT and VA.

CMS 4 Walls Limitation

- CMS determined that If a Tribal facility is enrolled in the state Medicaid program as a provider of clinical services under 42 CFR 440.90, the Tribal facility may not bill for services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility.
- Per CMS, under FQHC designation there is no requirement that the services be provided within the 4 walls.
- Section 1905 of the SSA recognizes outpatient Tribal clinics as FQHCs.
- CMS FAQ released January 18, 2017.
- Effective Date: January 30, 2021.
- CMS Guidance pending-currently under interval review (over a year).

IHS Indian Health Care Improvement Fund (IHCIF)

- DTLL 6/8/18 Indian Health Care Improvement Fund (IHCIF) Workgroup Recommendations on IHCIF formula changes.

Summary of Minutes

- Comments were due 7/13/18.
- DTLL 8/13/18 with final decisions:
  - Benchmark: National Health Expenditure (was Federal Employee Health Benefits Program)
  - User count: National unduplicated users (was regional)
  - Alternate resources: Statewide averages (was flat 25%)
- Only 3 Portland Area tribes received funding.
- IHCIF Workgroup reconvened to continue phase 2 work for FY 2019
- Last meeting was December 12-13, 2018
- February 11-12 meeting in DC area POSTPONED

Recent IHS DTLLs

- **DTLL on 12/20/18:** IHS notice about IHS Headquarters Reorganization
- **DTLL on 12/11/18:** Update on the Mechanism to Distribute Behavioral Health Initiative Funding
- **DTLL on 11/20/18:** IHS Initiation of Consultation on the PRC program to perform a detailed analysis of PRC implications for the entire State of Arizona to be identified as a PRCDA/CHSDA (Comments were due 1/15/19)
- **DTLL on 11/19/18:** IHS Progress on Certification of Suite of Applications for IHS RPMS to meet Certification Standards in the 2015 Edition Health IT published by the Office of the National Coordinator.
- **IHS Blog 11/1**: RADM Michael Toedt, Chief Medical Officer, IHS, announced that IHS has released a new "Internet Eligible Controlled Substance Provider Designation" policy (IHM, Ch. 38, part 3) to increase access to the treatment of opioid use disorder for AI/AN living in rural or remote areas.

Summary of Minutes

- **DTLL on 10/29/18**: Developments related to IHS and Department initiatives to modernize health information technology (consultation is open).

Pending IHS Responses

- **IHS Draft Strategic Plan FY 2018-2022;** DTLL on 7/24/18; comment period closed.
- **Special Diabetes Program for Indians** funding distribution for FY 2019; DTLL issued 7/12/18
  - *Follow-up*: Stated that RADM Weahkee to ask Area Directors to meet with tribal leaders to discuss the Area's proposed budget for its share of the SDPI FY 2019 data infrastructure fund.
- **IHS Sanitation Deficiency System (SDS)**; DTLL on 7/2/18; comment period closed.
- **IHS Manual, PRC Chapter Revisions;** DTLL on 5/18/18; comment period closed.
- **Contract Support Costs – Indian Health Manual, Chapter 3 CSC**, rescission of 97/3 split language; DTLL 4/13/18; comment period closed.
- **CHEF Regulation** / *Redding Rancheria* Case

VA Updates

- Suicide Prevention Initiatives
  - Focus on using prevention approaches that cut across all sectors that Veterans may interact, including states.
- Appeals Modernization
  - Simplification of the appeals process. Veterans will have 3 options for claims and appeals beginning February.
- Mission Act Implementation
- VA Care Coordination Committee

Summary of Minutes

- Focus on barriers and challenges of care coordination with VA.
- VA TAC bill (S.3269)
  - Will be reintroduced and be pushed forward in 116th Congress.

Litigation

Brakeen v. Zinke

Challenge to ICWA

- On October 5, 2018, Judge Reed O'Conner (USDC ND Texas) ruled that ICWA is unconstitutional.
- Found that *Morton v. Mancari* rule does not apply because ICWA extends to Indians who are not members of tribes.
- ICWA struck down in violation of equal protection.
- **Current Status**: Decision appealed to the U.S. Court of Appeals for the Fifth Circuit.

Texas v. United States

Challenge to Affordable Care Act

- On December 14, 2018, Judge Reed O'Conner (USDC ND Texas) found that Congress' 2017 elimination of the ACA individual tax penalty for non-compliance with not having health insurance resulted in the mandate being invalid.
- Reasoning:
  - In the absence of a tax, Congress has no authority to issue a mandate.
  - Individual mandate essential to the rest of the ACA, not "severable"
- If ACA struck down, then ICHIA could also be struck down.
- **Current Status:**
  - Decision appealed to U.S. Court of Appeals for the Fifth Circuit.

Summary of Minutes

	– No impact to IHCIA during appeal **Opioid Litigation** • All federal court lawsuits have been combined in multi-district litigation under Federal District Judge Dan A. Polster (USDC-ND Ohio) • More than 1,100 cases were filed against pharmaceutical manufacturers, distributors, and retailors of prescription opiate drugs. • Nearly 100 tribes and tribal organizations have filed complaints to join the litigation • Tribal Amicus Brief: 448 tribes and tribal organizations signed on and provided statements of interest (NPAIHB, ATNI, NCAI, and NIHB). • For each test case, defendants have filed motions to dismiss. • Judge issued ruling in Track One Cases. • Judge found that nearly all the claims alleged are sufficient to survive Defendants' motions to dismiss. • Gives an indication of potential ruling in Tribal Track cases. **Upcoming National/Regional Meetings** **January--February 2019** • IHS Tribal Self Governance Advisory Committee, January 22-23, Washington DC (RESCHEDULED to April 24-25) • ATNI Winter Convention, January 28-31, Portland • CDC Meeting, February 5-6, Atlanta, GA. • HHS STAC Meeting, February 7-8, Washington, D.C. • NCAI Executive Council Winter Session, February 10-14, Washington, D.C. • DSTAC meeting, February 12-13, Washington, D.C. (POSTPONED)		

Summary of Minutes

	• IHCIF meeting, February 12-13, Rockville, MD (POSTPONED) **February-March 2019** • National Tribal Budget Formulation Meeting, February 14-15, 2018, Crystal City, VA • MMPC/TTAC Meetings, February 19-21, Washington, DC • NIHB Board Meeting, February 24 • SAMHSA TTAC/NTAC, March 11-14, (TBD), California • TLDC, March 19-20, Washington, DC • MMPC Strategy Session, March 19-20, Bemidji • NIH TAC Meeting, March 21-22, Bethesda, MD • TSGAC Annual Conference, March 31-April 4, Traverse City, MI		
REVIEW OF LEGISLATIVE AND POLICY ISSUES IN 2018, LAURA PLATERO, GOVERNMENT AFFAIRS/POLICY DIRECTOR AND SARAH SULLIVAN, HEALTH POLICY ANALYST	*See Meeting Minutes*		
ELECTIONS OF OFFICERS:	**Vice Chairman:** Motion to nomination of Cheryle Kennedy, Grand Ronde, by Cassie Sellards-Reck, Cowlitz; 2nd by Shawna Gavin, Umatilla; Motion to close by Shawna Gavin, Umatilla; 2nd by Dan		

Summary of Minutes

	Gleason, Chehalis; **Voted in by acclamation** **Treasure:** Motion to nomination of Shawna Gavin, Umatilla, by Cassie Sellards-Reck, Cowlitz, 2nd by ---motion to close Cassie Sellards-Reck, Cowlitz, 2nd by Dan Gleason, Chehalis. **Voted in by acclamation** **Sergeant-At-Arms**: Nomination of Kim Thompson, Shoalwater Bay; by Shawna Gavin, Umatilla: 2nd by Cassie Sellards-Reck, Cowlitz; Motion to close by Cassie Sellards-Reck, Cowlitz; 2nd by Dan Gleason, Chehalis; **Voted in by acclamation**	**MOTION** **MOTION** **MOTION**	**PASSED** **PASSED** **PASSED**
NW NATIVE AMERICAN RESEARCH CENTER FOR HEALTH (NW NARCH) & PREVENTION RESEARCH, DR. TOM BECKER, NW NARCH PROJECT DIRECTOR	*Please see PowerPoint Presentation*		
MATTIE PALMANTEER, ASTHMA PROJECT COORDINATOR, AND GRAHAM HARKER	*Please see PowerPoint Presentation*		

Summary of Minutes

SENIOR RESEARCH ASSISTANT			
OPIOID UPDATE, COLBIE CAUGHLIN, MPH, THRIVE & RESPONSE CIRCLES, PROJECT DIRECTOR & JESSICA LESTON, MPH, HIV/STI/HCV CLINICAL PROGRAMS DIRECTOR	*Please see PowerPoint Presentation*		
A PRACTICAL APPLICATION OF CHAS AND BHAS FOR SUD TREATMENT, SUE STEWARD, CHAP DIRECTOR	*Please see PowerPoint Presentation*		
HUMAN TRAFFICKING: THE PIVOTAL ROLE OF HEALTHCARE, JERI MOOMAW, EXECUTIVE	*Please see PowerPoint Presentation*		

Summary of Minutes

DIRECTOR OF INNOVATIONS HUMAN TRAFFICKING COLLABORATIVE			
Recess @ 4:40pm			
WEDNESDAY JANUARY 23, 2019			
I-LEAD –YOUTH AMBASSADOR	*Please see PowerPoint Presentation*		
HRSA SHORTAGE DESIGNATION MODERNIZATION PROJECT, DR. JANELLE MCCUTCHEN, CHIEF OF BHWS SHORTAGE DESIGNATION BRANCH – HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)	*Please see PowerPoint Presentation*		

Summary of Minutes

CLINICAL TRAINING, ERIC VINSON PROJECT MANAGER, TRIBAL ECHO PROJECT	*Please see PowerPoint Presentation*		
CHAP BOARD ADVISORY WORK GROUP, SUE STEWARD, CHAP PROJECT DIRECTOR	*Please see PowerPoint Presentation*		
2019 POLICY AND LEGISLATIVE PRIORITIES, LAURA PLATERO, DIRECTOR OF GOVERNMENT AFFAIRS, AND SARAH SULLIVAN, HEALTH POLICY ANALYST	*Please see Meeting Minutes*		
PUBLIC HEALTH EMERGENCY PREPAREDNESS WORK, LOU SCHMITZ, AMERICAN	*Please see PowerPoint Presentation*		

Summary of Minutes

INDIAN HEALTH COMMISSION (AIHC) CONSULTANT			
PUBLIC HEALTH IMPROVEMENT AND PROGRAM PLANNING, BRIDGET CANNIFF, PUBLIC HEALTH IMPROVEMENT & TRAINING PROJECT DIRECTOR	*Please see PowerPoint Presentation*		
CHAIRMAN'S REPORT, ANDY JOSEPH, JR.	*Please see PowerPoint Presentation*		
CROSSWALK COMPARISON OF COMMUNITY & BEHAVIORAL HEALTH AIDES AND EXISTING PROVIDERS IN WASHINGTON	*Please see PowerPoint Presentation*		

Summary of Minutes

STATE, TESS ABRAHAMSON-RICHARDS, MPH RESEARCH ASSOCIATE			
NW JUVENILE JUSTICE ALLIANCE, DANICA BROWN, BEHAVIORAL HEALTH MANAGER	*Please see PowerPoint Presentation*		
5:10 p.m. Recess			
THURSDAY JANUARY 24, 2019			
COMMITTEE REPORTS	**Elders Committee – Theresa Lehman, Jamestown S'Klallam** (A copy of the report is attached) **Veterans – Jim Steinruck, Tulalip** (A copy of the report is attached) **Public Health – Andrew Showgren, Squamish** (A copy of the report is attached) **Behavioral Health – None** (A copy of the report is attached)		

Summary of Minutes

	Personnel – Cassie Sellards-Reck, Cowlitzs (A copy of the report is attached) **Youth** – **Tana Atchley-Culbertson, NPAIHB** (A copy of the report is attached)		
FINANCE REPORT	Eugene Mostofi motion to approve: **by Andrew Shogren (Suquamish) 2nd Debra Jones (Samish Nation); MOTION PASSES**	**MOTION**	**PASSED**
MINUTES:	Motion to approve: **by Greg Abrahamson (Spokane) 2nd by Shawna Gavin (Umatilla); MOTION PASSES**	**MOTION**	**PASSED**
	Legislative/Resolution Committee – Laura Platero (A copy of the report is attached)		
RESOLUTIONS:	***We R Native: "How Can Technology Support AI/AN Adolescent Mental Wellness?"*** Needs to be ratified: Motion by Cheryle Kennedy, Grand Ronde, 2nd by Shawna Gavin, Umatilla**: MOTION PASSES** ***Advance Appropriations for Indian Health Service*** Motion by Shawna Gavin, Umatilla, 2nd by Cassie Sellards-Reck, Cowlitz; **MOTION PASSES** ***Formal Recognition of Tribal Youth Delegate Program*** Motion by Shawna Gavin, Umatilla, 2nd Kim Thompson, Shoalwater Bay; **MOTION PASSES**	**MOTION** **MOTION** **MOTION**	**PASSED** **PASSED** **PASSED**
ADJOURN	**9:22 am Motion to adjourn Shawna Gavin, Umatilla, 2nd by Kim Thompson, Shoalwater Bay**	**MOTION**	**PASSED**

QUARTERLY BOARD MEETING

Suquamish Clearwater Casino Resort
15347 NE Suquamish Way
Suquamish, WA 98392

January 22 - 24, 2019
MINUTES

TUESDAY JANUARY 22, 2019

Call to Order: Andy Joseph, Chairman,

Invocation:

Posting of Flags: Suquamish Veterans Color Guard posted the flags.

Welcome: Leonard Foresman, Suquamish Chairman

Roll Call: Shawna Gavin, Secretary, called roll:

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

There were 26 delegates present, a quorum is established.

January 22 - 24, 2019
MINUTES

EXECUTIVE DIRECTOR REPORT, JOE FINKBONNER

PERSONNEL
NEW HIRES:

- **Ashley Thomas**, NARCH Cancer Project Coordinator
- **Megan Woodbury**, Opioid Project Coordinator
- **Paige Smith**, THRIVE & RC Coordinator
- **Rosa Frutos**, Cancer Project Coordinator
- **Heidi Lovejoy**, Substance Use Epidemiologist
- **Michelle Singer**, Health Native Youth Project Manager

PROMOTIONS/TRANSFER:

- **Christina Peters**, TCHP Project Director
- **Nicole Smith,** Senior Biostatistician 1
- **Candice Jimenez**, Research Manager
- **Danica Brown**, Behavioral Health Program Manager

TEMPS & INTERNS:

- Morgan Thomas
- Zoe Watson

RECOGNITION:

- **Clarice Charging**
  - 15 Years of Service Recognition
- **Nora Frank-Buckner**
  - 2018 Employee of the Year

Meetings
NOVEMBER

- Public Health Leader Panel & Speed Mentoring, UW, Seattle, WA (11/6)
- 2018 American Indian Health Commission for Washington State's Tribal and State Leaders Health Summit, Suquamish, WA (11/8)
- EHS Presentation Shoshone-Bannock, Fort Hall, ID (11/13)
- 2021 PA Budget Formulation Meeting, Portland, OR (11/15)
- PHAB Board of Director's Meeting ~ Washington, DC (11/28-11/29)

DECEMBER

- NPAIHB Holiday Party ~ Friday December 7th, Grand Central Bowl (12/7)
- WA State Medicaid DHAT Spa Hearing, Seattle, WA (12/17)

January 22 - 24, 2019
MINUTES

UPCOMING MEETINGS

JANUARY

- ANTI – Portland, OR (1/28-1/31)

FEBRUARY

- NCAI – Washington, DC (2/11-2/14)
- IHCIF
- DSTAC
- 2021 Budget Formulation
- Hill Visits (tentatively), Washington, DC (2/25-2/28)

MARCH

- Arcora Foundation Board Meeting, Seattle, WA (3/8)
- PHAB Board Meeting, Washington, DC (3/19 - /3/20)

APRIL

- IHS Tribal Self-Governance Annual Consultation Conference, Traverse City, MI (4/1-4/4)

Youth Delegates

The Tribal Youth Delegates will be joining the Legislative Committee at lunch to present a resolution for formal recognition by the Board

- They will also be working with a film crew to develop some recruitment videos for the Youth Delegate Program.
- If there are any Delegates who are interested in being a part of this video project, they can learn more at the Youth Committee meeting.

Youth Delegates attending will be:

- **Sadie Olsen** (Lummi)
- **William Lucero** (Lummi)
- **Jedah DeZurney** (Siletz)
- **Adilia Hart** (Umatilla)
- **Lindsey Pasena Little Sky** (Umatilla Rep - Pueblo of San Felipe)
- **Cheydon Herkshan** (Warm Springs)
- **Josiah Spino** (Warm Springs)
- **Lark Moses** (Umatilla)

Northwest Tribal Epidemiology Center Survey

- The EpiCenter and it's WEAVE NW project are requesting Tribal delegate assistance in completing a The EpiCenter Priorities survey which also includes questions about chronic disease policies in your Tribal community. This survey was last administered in 2015/2016.

- We ask that this survey is completed by March 1st. All those that do complete their survey by that date will be entered into a drawing for a Tribal blanket.
  Survey is on your IPad

NATIONAL AND REGIONAL COMMITTEE UPDATES

National and Regional Committees

- U.S. Department of Health and Human Services (HHS)
- Indian Health Service (IHS)
- Substance Abuse Mental Health Services Administration (SAMHSA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- National Institutes of Health (NIH)

HHS Secretary's Tribal Advisory Committee (STAC)

- The last STAC meeting was an informal HHS update meeting in DC December 11-12. Klamath Vice Chairwoman Gail Hatcher attended the informal STAC updates meeting as the Portland Area representative as well as Laura.
- The next STAC meeting will be held February 7-8 in DC.
- The next STAC meeting will include discussion topics like Drug Pricing Reform, Addressing the Opioid Epidemic, Quality Care, Tribal Emergency Preparedness needs, and age related health concerns in Indian Country. Are there any specific issues or benefits that you would like Chairman Ron Allen to address?
- Portland Area Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Gail Hatcher, Klamath (Alternate)
- Meetings:
  - Last meeting: HHS Updates December 11-12 in Washington, D.C
  - **Next meeting: February 7-8 in Washington, D.C.**

HHS STAC Discussion Items

- HHS Workgroup on Workforce Development
- National Advisory Committee on Rural Health and Human Services Overview and Update
- HHS Reimagine "Re-Invent Grants Management" Overview
- HHS Tribal Advisory Committee Discussion
- President's Council on Physical Fitness

The STAC had a discussion on the **HHS Workgroup on Workforce Development** with the AI/AN Policy Lead at the Office of Minority Health on improving workforce development in

Indian Country. Tribal leaders expressed that tribal communities continue to lead the way in oral health workforce by the employment of DHATs. The need to approve the WA DHAT SPA was emphasized.

HHS released a report on "Reforming America's Healthcare System Through Choice and Competition", which notes that the federal government and states should accompany legislative and administrative proposals to allow non-physician and non-dentist provider to be paid for their services.

Ben Smith, Deputy Director for Intergovernmental Affairs at IHS provided and overview of the **National Advisory Committee on Rural Health and Human Services Committee (NACRHHS).** The Committee advises the Secretary on healthcare challenges in rural America. The STAC highlighted that tribal and rural communities should not be differentiated, most tribal communities are rural themselves.

STAC was provided an overview of the HHS **Reimagine "Re-Invent Grants Management"** initiative is an effort to reduce administrative burden, while increasing transparency, resource optimization, and efficiency across HHS grants management.

Each **HHS Tribal Advisory Committee** provided updates on the priorities and work of each Committee.

STAC engaged in a discussion on engagement from **the President's Council on Physical Fitness** with tribal communities.

IHS Tribal Leader Diabetes Committee (TLDC)

Last TLDC meeting occurred December 12-13 in Tucson.

The next TLDC meeting is proposed for March 19-20 in Washington DC, it still needs final approval by IHS.

Cassie and Sharon attended and presented on SDPI at the 2018 Healing Our Spirit Conference in Sydney, Australia November 26-29

A Conference on Diabetes in Indian Country 2019 has been scheduled for August 6-9, 2019 in Oklahoma City, OK.

Sharon and Cassie can you share more information about the previous TLDC meeting and conference calls?

- Portland Area Representatives:
  - Cassandra Sellards-Reck, Cowlitz (Primary)
  - Sharon Stanphill, Cow Creek (Alternate)
    - Conference calls-Third Wednesday of every month 1-2pm PST.
    - Last meeting: December 12-13 in Tucson, AZ
    - **Next meeting: March 19-20, 2019 in Washington, D.C. (proposed)**

IHS Budget Formulation Workgroup

The Portland Area Budget Formulation Process was on November 15, 2018.

The National Budget Formulation Meeting is scheduled for February 14-15, 2019 in Crystal City.
Opportunity for IHS NTBFW to present recommendations at HHS Annual Tribal Consultation scheduled for April 3-4, 2019 in DC.

- Portland Area Representatives:
  - Workgroup Co-Chair, Andy Joseph, Jr., Colville
  - Steve Kutz, Cowlitz Tribe
- FY 2021 National Budget Formulation Meeting:
  - **Next meeting: February 14-15 in Crystal City, VA**

IHS PRC Workgroup

The charge of the IHS Director's Workgroup is to provide recommendations to the Director on strategies to improve the agency's PRC programs. Reviews input received to improve PRC program, evaluates the existing formula for distributing PRC funds, and recommends improvements in the way PRC operations are conducted within the IHS and Indian Health System.

- Portland Area Representatives:
  - Andy Joseph, Jr., Colville (Primary)
  - John Stephens, Swinomish (Alternate)
- Meetings:
  - Last meeting: October 16-17, 2018 in Portland, OR
  - Next meeting: **TBD**

IHS CSC Workgroup

The CSC Workgroup meets to further the federal government's administration of CSC within the IHS. The agency is in active participation with Tribes, has developed a comprehensive CSC policy to implement the statutory provisions of ISDA.

- Portland Area Representative:
  - Tribal Co-Chair, Andy Joseph, Jr., Colville
- Meetings:
  - Last meeting: April 23, 2018 12:00pm-1:30pm in Albuquerque, NM
  - Next meeting: **TBD**

IHS 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 Representatives:
  - Janice Clements, Warm Springs (Primary)

  - Greg Abrahamson, Spokane (Alternate)
- Meetings:
  - Last meeting: October 1-3, 2018 in Washington D.C.
  - **Next meeting: Postponed**

IHS 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 Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Tyson Johnston, Quinault (Alternate)
- Meetings:
  - Last quarterly meeting: October 1-4, 2018 in Washington D.C.
  - **Next quarterly meeting: Rescheduled for April 24-25, 2019 in Washington D.C.**
  - 2019 TSGAC Annual Conference: March 31-April 4, 2018 in Traverse City, MI.

IHS IHCIF Workgroup

- Just a reminder that the FY 2018 IHCIF allocations went to only 3 tribes in the Portland Area.
- The last meeting was held August 30. The next meeting was scheduled for February 12-13, but due to the partial government shutdown has been postponed.
- Portland Area Representatives:
  - Gail Hatcher, Klamath (Primary)
  - Steve Kutz, Cowlitz (Alternate)
- Meetings:
  - Last meeting: December 12-13, 2018 in Rockville, MD.
  - **Next meeting: Postponed**

IHS IHCIF Sub-Workgroup Decisions

Benchmark Workgroup:

- Finished their work and transferred the facility factor, to the access to care workgroup.

User Population Workgroup:

- Fractionalization analysis still outstanding

Alternate Resources Workgroup:

- waiting for evaluation on NDW data and whether this can be used. Preference of workgroup is to use this data but without analysis of the data, the workgroup can't make a decision.

Access to Care Workgroup:
Unable to pinpoint a solid factor to move forward for access to care. This resulted in discussion and decision to look at another budget that could include access issues.

IHS CHAP TAG
- A key discussion topic of the CHAP TAG is the Interim Policy, which was originally created by ANTHC and the Board.
- The next CHAP TAG meeting has not been scheduled yet.
- Portland Area Representatives:
    - John Stephens, Swinomish (Primary)
    - Andy Joseph, Jr., Colville (Alternate)
- Meetings:
    - Last meeting: October 10, 2018 in Rockville, MD.
    - Next meeting: **TBD**

IHS CHAP TAG Updates
November 5:
- CHAP TAG requested that IHS provide an updated policy for discussion.

December 20:
- Version VI of the draft policy was sent out to CHAP TAG with letter that it would be announced January 3, 2019 on the IHS Tribal Leaders and Urban Conferees monthly call, but it wasn't.

January 1:
- CHAP TAG submitted a letter to IHS expressing concern that the most current draft policy was not approved by the TAG prior to being finalized for tribal consultation

In Process:
- NPAIHB is preparing a separate letter to IHS

IHS NTAC
- The last NTAC meeting was held December 12-13. The Committee has been reviewing the formula and data to provide proposals on the Domestic Violence Prevention, Substance Abuse and Suicide Prevention, and Zero Suicide Initiative funding to RADM Weahkee in response to the DTLL on putting funds into compacts and contracts. Cassie, Sharon, and Laura were in attendance of the meeting.
- The next NTAC meeting will likely occur with SAMHSA TTAC week of March 11 in California.
- Portland Area Representatives:
    - Cassandra Sellards Reck, Cowlitz (Primary)
    - Cheryl Sanders, Lummi (Alternate)
- Last meeting: December 12-13 in Tucson, AZ

- **Next meeting: Week of March 11, 2019 in California (proposed)**

IHS NTAC Updates

- For past two meetings, NTAC has been discussing proposed changes to the IHS behavioral health program initiatives funding mechanisms.
- NTAC spent much of the 2-day meeting in Tribal Caucus to formulate their recommendation to Admiral Weahkee, calling IHS staff in as needed for information.
- NTAC tribal representatives worked on a letter to Admiral Weahkee with recommendations on funding for SASPP, DVPP, and ZSI.

IHS FAAB

- The last FAAB meeting was scheduled for January
- Due to the lack of fiscal appropriations for the IHS, the FAAB that was scheduled for January 14-16, was postponed. They requested availability for February 5-6, 2019 or February 20-21, 2019.
- Portland Area Representatives:
    - Tim Ballew, Lummi (Primary)
    - Andy Joseph, Jr., Colville (Alternate)
- Meetings:
    - **Next meeting: February 5-6, 2019 or February 20-21, 2019 in Washington, D.C.**

CDC TAC

- The last meeting was scheduled in March, but was cancelled and replaced with a Tribal Public Health Workgroup.
- The next meeting is scheduled for February 4-5 in Atlanta.
- Does anyone have any updates for the CDC TAC?
- Portland Area Representatives:
    - Vacant (Primary)
    - Steve Kutz, Cowlitz (Alternate) and Cassandra Sellard-Recks, Cowlitz (Alternate)
- Meetings:
    - Last meeting: March 13-14, 2018 TAC cancelled; instead, Tribal Public Health Workgroup had a collaborative work session with CDC.
    - Next meeting: **February 4-5, 2019 in Atlanta, GA.**

SAMHSA TTAC

- **Last meeting was a virtual meeting on December 18.** The following SAMHSA TTAC Tribal Priorities were discussed:
- ***Access to grants*** -- Many tribes have been able to keep grants. There has been greater collaboration across SAMHSA to support tribes.

- ***Improve data*** -- Need national data to understand the priorities globally and local data for tribes for programming.
- **Improve communications** to tribes on behavioral health resources; information for behavioral health administrators; and substance abuse information for the community. SAMHSA is updating their website.

The next in-person meeting will be March 13-14, 2019: The March meeting will be in California and take place over two full days (1.5 days for TTAC's business and policy discussions and .5 day for a TTAC site visit to a local tribal behavioral health program). IHS requested a joint meeting between TTAC and its National Tribal Advisory Committee on Behavioral Health (NTAC). Should NTAC agree to the March meeting dates, the recommendation is that the meeting be expanded to 2.5 days to facilitate the joint advisory meeting discussion, allow for a separate TTAC discussion, and for a site visit. A discussion topic for TTAC will be its policy and program priorities given the new SAMHSA Strategic Plan FY 2019 – FY 2023.

- Portland Area Representative:
  - Jeremiah Julius, Lummi (primary)
  - Nickolaus Lewis, Lummi (alternate)
- At-Large Member:
  - Andy Joseph, Jr., Colville
- Meetings:
  - Last meeting (virtual): December 18, 2018
  - Next meeting: **March 13-14, 2019 in California**

CMS TTAG

- John Stephens was in attendance as the Portland Area representative with Sarah Sullivan from our staff during the last meeting November 15-16 in DC.
- During the last meeting in DC, the TTAG met with Mary Mayhew (CMCS Director) for the first time. However, Mary Mayhew has left CMCS this month. The new Acting Director for CMCS is Chris Traylor. The TTAG met Chris at November TTAG when he presented on the Rural Initiative Strategies.
- The next meeting will be held in DC, February 20-21.
- Portland Area Representatives:
  - John Stephens, Swinomish (Primary)
  - Nickolaus Lewis, Lummi (Alternate)
- Meetings:
  - Last meeting: November 15-16, 2018 in Washington D.C.
  - Last conference call: January 9, 2019
  - **Next meeting: February 20-21, 2019 in Washington D.C.**

CMS TTAG Updates

- Tribal Consultation
- Medicaid work requirements
- Care for Kids (InCK) and Maternal Opioid Misuse (MOM) Models Grant Opportunity
- Rural Health Strategy Initiative
- Managed Care issues in tribal communities
- Medicare Rule to Require Hospitals to Post Standard Charges Online (January 1)

MMPC

- Last MMPC meeting was held in November/ John and Sarah were in attendance. The was discussion was focused on preparation for the TTAG meeting and was focused on work and community engagement strategy, managed care issues
- Membership in MMPC is open to individuals authorized to represent a tribe, tribal organization, urban Indian program, or IHS.
- Meetings:
    - Last meeting: November 14, 2018 in Washington D.C.
    - Last conference call: January 8, 2019
    - **Next meeting: February 19, 2019 in Washington D.C.**

NIH TAC

NIH is working on creating a tribal consultation policy

- Portland Area Representatives:
    - Robyn Sigo, Suquamish (Primary)
    - Jeromy Sylvan, Port Gamble S'Klallam (Alternate)
- Meetings
    - Last meeting: October 3-4, 2018 in Oklahoma City, OK
    - Next meeting: **Week of March 21-22, 2019 in Bethesda, MD**

Other Meetings

- IHS Information Systems Advisory Committee (ISAC)
- ISAC will be meeting November 14-15 in Albuquerque, NM.
- IHS Strategic Plan Workgroup
- The IHS Strategic Plan is being finalized by IHS and should be released soon.
- IHS Catastrophic Health Emergency Fund (CHEF) Workgroup
- IHS Health Promotion/Disease Prevention Policy Advisory Committee (HP/DP)
- IHS Health Research Advisory Council (HRAC)
- Portland Area Fund Distribution Workgroup (FDWG)
- Portland Area Facilities Advisory Committee (PAFAC)

January 22 - 24, 2019
MINUTES

POLICY AND LEGISLATIVE UPDATE & REVIEW OF 2018 POLICY AND LEGISLATIVE PRIORITIES, LAURA PLATERO, GOVERNMENT AFFAIRS/POLICY DIRECTOR AND SARAH SULLIVAN, HEALTH POLICY ANALYST

Report Overview

1. 2018 Mid Term Elections
2. Legislation
3. GAO Reports
4. IHS Budget Formulation Process
5. Current & Pending Federal Policies
6. Litigation
7. Upcoming National/Regional Meetings

2018 Midterm Elections

- 116th Congress
  - Senate: Republican Majority
    - 53 Republicans, 47 Democrats
  - House: Democratic Majority
    - 235 Democrats, 199 Republicans
- Governor Races: 23 Democratic Governors, 27 Republican Governors.
- Medicaid Expansion: Idaho (61%)- will expand coverage for 2,500 AI/ANs

Legislation

IHS Appropriations FY 2019

- In Partial Government Shutdown
  - Continuing resolution expired 12/21/18
- H.R. 266 -- Department of Interior, Environment, and Related Agencies Appropriations Act, 2019
  - Introduced by Rep. Betty McCollum (D-MN-4) on 1/8/19.
  - Passed House on 1/11/19 (240-179)
  - Status: Senate Legislative Calendar
- H.R. 21 – Consolidated Appropriations Act
  - Passed House on 1/3/19 (241-190)

Pay Our Doctors Act of 2019 (H.R. 195)

- Introduced by Rep. Markwayne Mullin (R-OK-2) on 1/3/19; 13 co-sponsors.
- Provides funding at the FY 2018 level for IHS in the absence of a continuing resolution from Congress.

- Would end the lapse in funding for IHS, tribal and urban Indian facilities and allow continued operations.
- Referred to House Committee on Appropriations on 1/3/19.

***To Be Introduced* - Equal Access To Medicaid for All AI/AN**

- Tribal Self-Governance Advisory Committee initiative
- The aim is to *fix gaps in access to high-quality health care services* under Medicaid for low- and moderate-income American Indians and Alaska Natives (AI/ANs) across all states.
- Approach:
  - Do no harm.
  - Build on existing administrative infrastructure.
    - Indian health care providers (IHCPs) are defined in federal regulations.
    - Most services to AI/ANs by IHCPs are currently supported with 100% federal funding.
  - Establish new authorities as either "requirements" or "options" based on assessment of: (a) ability to achieve policy goal and (b) ability to enact legislation.
- Would authorize Indian Health Care Providers (IHCPs) in all states to receive Medicaid reimbursement for a federally-defined set of health care services—referred to as Qualified Indian Provider Services (QIPS)—when delivered to AI/ANs.
- Would create the option for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level (FPL).
- Would extend full federal funding (through 100% FMAP) and the IHS encounter rate to Medicaid services furnished by *urban* Indian health programs to AI/ANs.
- Would clarify federal law and regulations related to AI/AN specific policy.
- Would Address the "four walls" limitations on IHCP "clinic" services.

House E&C Indian Health Task Force

- House Energy & Commerce Committee established the IHS Task Force in 2017.
- Tribes and tribal organizations across Indian country, including NPAIHB, provided input to the Task Force on ways to reform IHS so that it can better serve AI/AN.
- Task Force conducted a survey to tribes in the fall.
- Task Force has not disseminated results of their findings.

GAO Reports

GAO Report for IHS Advance Appropriations

- On 9/13/18, GAO issued a report titled, "Indian Health Service: Considerations Related to Providing Advance Appropriation Authority" – GAO-18-652.

- GAO makes recommendations for policy makers to consider
- *Next steps*: In-person testimony, letters, Hill and IHS meetings, tribal conference gatherings - that the FY 2020 Interior and Related Agencies appropriations bill include FY 2021 advance appropriations for the IHS.
- Report available at www.gao.gov

GAO Report on the Affordable Care Act - Pending

- Government Accountability Office (GAO) conducting a study on the effects of the Affordable Care Act on Indian health facilities and on health insurance coverage for AI/AN.
- Visited Portland Area on December 4, 2018
- Collecting information on Portland Area impacts to facility operations (including patient coverage, collections and use of collections, PRC, etc).

IHS Budget Formulation Process
FY 2020 IHS Budget

- National Tribal Budget Formulation Workgroup co-chairs presented the recommendations for FY 2020 at the HHS Annual Tribal Consultation in D.C. on March 1 and to HHS Budget Council for the Tribal Budget Formulation in D.C. on April 11.
- Recommends over $7 billion for FY 2020 (36% increase over FY 2017 enacted level).
- Recommends $36.83 billion for tribal needs based budget to be implemented over 12 year period.
- Available at: https://www.nihb.org/legislative/budget_formulation.php
- Portland Area Budget Formulation Process was on November 15, 2018.
- National Budget Formulation Meeting is scheduled for February 14-15, 2019 in Crystal City.
- Following February meeting, NIHB writes up the recommendation for IHS National Tribal Budget Formulation Workgroup (NTBFW)
- Opportunity for IHS NTBFW to present recommendations at HHS Annual Tribal Consultation scheduled for April 3-4, 2019 in DC.

Current & Pending Federal Policies
HHS Report: Reforming America's Healthcare System Through Choice and Competition

- Issued: 12/3/18
- Issues Identified:
  - Health Care Workforce and Labor Markets;
  - Health Care Provider Markets;
  - Health Care Insurance Markets; and
  - Consumer-Driven Health Care.

- Examples of Recommendations:
  - Broaden Scope of Practice
  - Improve Workforce Mobility
  - Facilitate Telehealth to Improve Patient Access
  - Positively Realign Incentives through Payment Reform
  - Using Choice to bring a Longer-Term View to Health Care
  - Quality Improvement and the Measurement and Reporting of Quality
  - Facilitate Price Transparency
  - Improve Health IT

HHS Draft Strategy to Reduce Regulatory and Administrative Burden of Health IT and EHRs

- Comments Due: 1/28/2019
- Purpose: With the passage of the 21st Century Cures Act, Congress directed HHS to establish a goal, develop a strategy, and provide recommendations to reduce EHR-related burdens that affect care delivery.
- Burden Reduction Goals:
  - Reduce the effort and time required to record health information in EHRs for clinicians;
  - Reduce the effort and time required to meet regulatory reporting requirements for clinicians, hospitals, and healthcare organizations; and
  - Improve the functionality and ease of use of EHRs.

HHS Draft Report Pain Management Best Practices

- Comments Due: 4/1/19
- Issued by: Office of the Assistant Secretary for Health, HHS (12/31/18)
- Request for Public Comments on the Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations
- The Draft Report highlights the progress made towards identifying, reviewing, and determining whether there are gaps in or inconsistencies between best practices for pain management (including chronic and acute pain) developed or adopted by Federal agencies. It includes the Task Force's proposed updates to best practices and recommendations on addressing gaps or inconsistencies.

OCR/HHS Modification of HIPAA Rules to Improve Coordinated Care

- Comments Due: 2/12/19
- Issued by: Office for Civil Rights (OCR); HHS (12/14/18).
- Request for Information on Modifying HIPAA Rules to Improve Coordinated Care

- Additionally, the RFI is soliciting comments within the HIPAA Privacy Rule in relation to the following items:
  - Encouraging information-sharing for treatment and care coordination.
  - Facilitating parental involvement in care.
  - Addressing the opioid crisis and serious mental illness.
  - Accounting for disclosures of Protected Health Information (PHI) for treatment, payment, and health care operations as required by the Health Information Technology for Economic and Clinical Health (HITECH) Act.
  - Changing the current requirement for network providers to make a good faith effort to obtain an acknowledgement of receipt of the Notice of Privacy Practices.

CDC Tobacco Control Practice

- Comments Due: February 11, 2019
- Agency: CDC
- CDC is seeking input to inform future activities to advance tobacco control practices to prevent initiation of tobacco use among youth and young adults; eliminate exposure to secondhand smoke; and identify and eliminate tobacco-related disparities.
- The information gathered will be used to inform activities that encompass technical assistance and guidance to state tobacco control programs and collaborative work with national governmental and nongovernmental partners, who share CDC's goals to prevent initiation of tobacco use among youth and young adults; eliminate exposure to secondhand smoke; and identify and eliminate tobacco-related disparities.

CMS SMD Letter #18-011 New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services

- Outlines existing and new opportunities for states to design innovative service delivery systems for adults with SMI and children with SED.
- New authority for states to pay for short-term residential treatment services in an IMD for these patients.
- Emphasis that inpatient treatment is just one part of the continuum of care, participating states will be expected to improve community-based mental health care.

CMS Medicaid and CHIP Managed Care Proposed Rule

- Comments Closed: 1/14/2018 (issued 11/18/2018)
- CMS is proposing significant regulatory revisions to streamline the 2016 managed care regulatory framework.
- Reflects a strategy to relieve regulatory burdens, support state flexibility and local leadership, and promotes transparency and innovation.

- Removes barriers that made it difficult to transition new services and populations into managed care.
- No proposed changes to the Indian managed care provisions.
- Our comment letter focused on some of managed care issues raised in our area (access and payments).

CMS Work Requirements Issue

- On 1/17/18, CMS issued a DTLL stating that CMS could not provide an exemption to the work requirements for AI/AN because of civil rights concerns.
- On 5/7/18, CMS updated its position, stating that they would actively consider state proposed accommodations for AI/AN from work requirements on a state by state basis.
- On 9/24/18, at STAC meeting, HHS Deputy Secretary Eric Hargan requested a legal opinion on the AI/AN exemption from work requirements. *Still Pending*
- As of 1/9/19, states with approved work requirement and community engagement waivers include: IN, AR, NH, NC, WI, ME and MI.
- Pending waivers: AZ, MS, OH, OK, SD, UT and VA.

CMS 4 Walls Limitation

- CMS determined that If a Tribal facility is enrolled in the state Medicaid program as a provider of clinical services under 42 CFR 440.90, the Tribal facility may not bill for services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility.
- Per CMS, under FQHC designation there is no requirement that the services be provided within the 4 walls.
- Section 1905 of the SSA recognizes outpatient Tribal clinics as FQHCs.
- CMS FAQ released January 18, 2017.
- Effective Date: January 30, 2021.
- CMS Guidance pending-currently under interval review (over a year).

IHS Indian Health Care Improvement Fund (IHCIF)

- DTLL 6/8/18 Indian Health Care Improvement Fund (IHCIF) Workgroup Recommendations on IHCIF formula changes.
- Comments were due 7/13/18.
- DTLL 8/13/18 with final decisions:
  - Benchmark: National Health Expenditure (was Federal Employee Health Benefits Program)
  - User count: National unduplicated users (was regional)
  - Alternate resources: Statewide averages (was flat 25%)
- Only 3 Portland Area tribes received funding.

- IHCIF Workgroup reconvened to continue phase 2 work for FY 2019
- Last meeting was December 12-13, 2018
- February 11-12 meeting in DC area POSTPONED

Recent IHS DTLLs

- **DTLL on 12/20/18:** IHS notice about IHS Headquarters Reorganization
- **DTLL on 12/11/18:** Update on the Mechanism to Distribute Behavioral Health Initiative Funding
- **DTLL on 11/20/18:** IHS Initiation of Consultation on the PRC program to perform a detailed analysis of PRC implications for the entire State of Arizona to be identified as a PRCDA/CHSDA (Comments were due 1/15/19)
- **DTLL on 11/19/18:** IHS Progress on Certification of Suite of Applications for IHS RPMS to meet Certification Standards in the 2015 Edition Health IT published by the Office of the National Coordinator.
- **IHS Blog 11/1**: RADM Michael Toedt, Chief Medical Officer, IHS, announced that IHS has released a new "Internet Eligible Controlled Substance Provider Designation" policy (IHM, Ch. 38, part 3) to increase access to the treatment of opioid use disorder for AI/AN living in rural or remote areas.
- **DTLL on 10/29/18**: Developments related to IHS and Department initiatives to modernize health information technology (consultation is open).

Pending IHS Responses

- **IHS Draft Strategic Plan FY 2018-2022;** DTLL on 7/24/18; comment period closed.
- **Special Diabetes Program for Indians** funding distribution for FY 2019; DTLL issued 7/12/18
  - *Follow-up*: Stated that RADM Weahkee to ask Area Directors to meet with tribal leaders to discuss the Area's proposed budget for its share of the SDPI FY 2019 data infrastructure fund.
- **IHS Sanitation Deficiency System (SDS)**; DTLL on 7/2/18; comment period closed.
- **IHS Manual, PRC Chapter Revisions;** DTLL on 5/18/18; comment period closed.
- **Contract Support Costs – Indian Health Manual, Chapter 3 CSC**, rescission of 97/3 split language; DTLL 4/13/18; comment period closed.
- **CHEF Regulation** / *Redding Rancheria* Case

VA Updates

- Suicide Prevention Initiatives
  - Focus on using prevention approaches that cut across all sectors that Veterans may interact, including states.
- Appeals Modernization

  - Simplification of the appeals process. Veterans will have 3 options for claims and appeals beginning February.
- Mission Act Implementation
- VA Care Coordination Committee
  - Focus on barriers and challenges of care coordination with VA.
- VA TAC bill (S.3269)
  - Will be reintroduced and be pushed forward in 116th Congress.

Litigation

Brakeen v. Zinke

Challenge to ICWA

- On October 5, 2018, Judge Reed O'Conner (USDC ND Texas) ruled that ICWA is unconstitutional.
- Found that *Morton v. Mancari* rule does not apply because ICWA extends to Indians who are not members of tribes.
- ICWA struck down in violation of equal protection.
- **Current Status**: Decision appealed to the U.S. Court of Appeals for the Fifth Circuit.

Texas v. United States

Challenge to Affordable Care Act

- On December 14, 2018, Judge Reed O'Conner (USDC ND Texas) found that Congress' 2017 elimination of the ACA individual tax penalty for non-compliance with not having health insurance resulted in the mandate being invalid.
- Reasoning:
  - In the absence of a tax, Congress has no authority to issue a mandate.
  - Individual mandate essential to the rest of the ACA, not "severable"
- If ACA struck down, then ICHIA could also be struck down.
- **Current Status:**
  - Decision appealed to U.S. Court of Appeals for the Fifth Circuit.
  - No impact to IHCIA during appeal

Opioid Litigation

- All federal court lawsuits have been combined in multi-district litigation under Federal District Judge Dan A. Polster (USDC-ND Ohio)
- More than 1,100 cases were filed against pharmaceutical manufacturers, distributors, and retailors of prescription opiate drugs.
- Nearly 100 tribes and tribal organizations have filed complaints to join the litigation
- Tribal Amicus Brief: 448 tribes and tribal organizations signed on and provided statements of interest (NPAIHB, ATNI, NCAI, and NIHB).

- For each test case, defendants have filed motions to dismiss.
- Judge issued ruling in Track One Cases.
- Judge found that nearly all the claims alleged are sufficient to survive Defendants' motions to dismiss.
- Gives an indication of potential ruling in Tribal Track cases.

Upcoming National/Regional Meetings
January--February 2019

- IHS Tribal Self Governance Advisory Committee, January 22-23, Washington DC (RESCHEDULED to April 24-25)
- ATNI Winter Convention, January 28-31, Portland
- CDC Meeting, February 5-6, Atlanta, GA.
- HHS STAC Meeting, February 7-8, Washington, D.C.
- NCAI Executive Council Winter Session, February 10-14, Washington, D.C.
- DSTAC meeting, February 12-13, Washington, D.C. (POSTPONED)
- IHCIF meeting, February 12-13, Rockville, MD (POSTPONED)

February-March 2019

- National Tribal Budget Formulation Meeting, February 14-15, 2018, Crystal City, VA
- MMPC/TTAC Meetings, February 19-21, Washington, DC
- NIHB Board Meeting, February 24
- SAMHSA TTAC/NTAC, March 11-14, (TBD), California
- TLDC, March 19-20, Washington, DC
- MMPC Strategy Session, March 19-20, Bemidji
- NIH TAC Meeting, March 21-22, Bethesda, MD
- TSGAC Annual Conference, March 31-April 4, Traverse City, MI

REVIEW OF LEGISLATIVE AND POLICY ISSUES IN 2018, LAURA PLATERO, GOVERNMENT AFFAIRS/POLICY DIRECTOR AND SARAH SULLIVAN, HEALTH POLICY ANALYST

2018 Legislative Requests

- Indian Health Service
  - Exempt IHS from Sequestration (p. 1)
  - Require IHS to provide detailed breakdown of IHS funding nationally and to areas (p. 1, RES)
  - Mandatory funding for IHS (p. 1)
  - Advance Appropriations for IHS (p. 1-2)
  - Equity in Health Care Facility Funding (p 2, RES)

  - Permanently Reauthorize the Special Diabetes Program for Indians (p. 2, RES)
  - Support transfer of IHS Appropriations from jurisdiction of Interior, Environment & Related Appropriations to Labor, Health and Human Services, Education and Related Appropriations (p. 5)
- ACA/IHCIA and Medicaid
  - Preserve the Indian Health Care Improvement Act and Indian-Specific Protections in the ACA (p. 6, RES)
  - Preserve Medicaid/CHIP & 100% FMAP (p. 8)
  - Equal Access for AI/AN under Medicaid (RES only)
- Veterans
  - Preserve VA reimbursement agreements, reimbursements at OMB encounter rate, allow an exemption for tribes from value-based structure and ensure tribal consultation
  - Support for Veteran's Tribal Advisory Committee (TAC) (RES only)

2018 DOI/IHS Appropriations Requests

- Fully Fund the Indian Health Service at $32 billion (p. 1, RES)
- Fund Small Ambulatory Care Facilities (p. 3)
- Fund Regional Referral Specialty Care Center for planning and design at $3.4 million (p. 3, BF)
- Fund Dental Health Aide Therapy/Community Health Aide Nationalization (p. 4, BF, RES)
- Market pay Increases for providers (p. 4, BF)
- Fully Fund the Indian Health Care Improvement Act (p. 6, BF)
  - Provider Recruitment and Training Programs (p. 4)
  - Long Term Care (p. 6)
  - Behavioral Health and Substance Abuse (p. 6)
- Fund HCV Treatment (p. 10, BF, RES)
- Increase funding for Sanitation Facilities & M&I programs (p. 11, BF)
- Increase funding for IHS Scholarship Program (RES only)

2018 HHS Appropriations Requests

- Fund HCV Prevention and Treatment (HHS)
  - Fund Secretary's Minority AIDS Initiative Fund (p. 10)
- Public Health & Environment (CDC)
  - Fund tribes directly for tribal public health infrastructure (p. 10)
  - Authorize and fund a public health emergency fund through Secretary of HHS (p. 10)
  - Increase funding for asthma treatment programs (p. 11)
  - Fund training and remediation for housing contamination (p. 11)

- Fund Native American Center of Excellence (HRSA) (RES only)
- Behavioral Health and Substance Abuse (SAMHSA)
  - Increase funding to implement the National Tribal Behavioral Health Agenda (p. 6, BF)
  - Ensure that all tribes have access to State Targeted Response Funding and other SAMHSA funding to address opioid crisis with consideration of reduced administrative burden to ensure there are no barriers for tribes and tribal organizations to access these funds (RES only)
  - Provide support for prevention (BF)
  - Expand telebehaviorial health platform (BF)

2018 Policy Requests-IHS

Indian Health Service – IT/EHR System Replacement (pp. 4-5)

- Provide tribal consultation in each IHS Area throughout process
- Provide training, and technical assistance
- Focus on the benefits to patient care
- Consider the various EHR systems that tribes are using
- Provide additional training and technical support, especially for smaller tribal health clinics.
- Provide a more user-friendly format for health care providers to highlight certain patient information and reporting for data collection.
- Make operability more of a focus

Indian Health Service – DHAT/CHAP Nationalization (pp. 4-5)

- Amend IHCIA to remove state authorization requirement
- Support the Training and Utilization of DHATs in Tribal communities. (RES)
- Expand CHAP in the Portland and California IHS Areas (RES)
- Support the development of regional certification boards with federal baseline standards (RES)
- Increase funding for CHAPs in order to expand and implement the program nationally (appropriations)
- Provide more resources for behavioral health and dental aides
- Allow tribes to authorize/license/certify CHAP providers that at a minimum meet Alaska CHAP Standards.

2018 Policy Requests-CMS

Centers for Medicare and Medicaid Services (CMS)-Medicaid Initiatives (pp. 7-8)

  - Monitor and Enforce Tribal Consultation
  - Include IHS in discussions with tribes, HHS/CMS, and state when waivers are being considered that will impact the Indian health system.

- Provide more information to IHS/tribes on Value Based Payment (VBP) models
- Allow tribes an exemption from VBP models and preserve fee-for-service payment structure within states.

CMS-Medicaid HCV Treatment (p. 10)

- State Medicaid Agencies must make HCV treatment a clinical priority and ensure access to medications to all (p. 10, RES)

Policy Requests-Veterans 2018

Veteran's Administration (pp. 8-9)

- Conduct Area tribal roundtables on the VA reimbursement agreements prior to the end of the existing renewal agreements.
- Improve care coordination for AI/AN Veterans.
- Reimburse tribal PRC dollars for specialist care to AI/AN veterans.
- improve eligibility and service eligibility determinations.
- Expand direct care services for care provided to all veterans regardless if they are eligible for IHS funding or not.

ELECTIONS OF OFFICERS:

Vice Chairman: Motion to nomination of Cheryle Kennedy, Grand Ronde, by Cassie Sellards-Reck, Cowlitz; 2nd by Shawna Gavin, Umatilla; Motion to close by Shawna Gavin, Umatilla; 2nd by Dan Gleason, Chehalis; **Voted in by acclamation**

Treasure: Motion to nomination of Shawna Gavin, Umatilla, by Cassie Sellards-Reck, Cowlitz, 2nd by ---motion to close Cassie Sellards-Reck, Cowlitz, 2nd by Dan Gleason, Chehalis. **Voted in by acclamation**

Sergeant-At-Arms: Nomination of Kim Thompson, Shoalwater Bay; by Shawna Gavin, Umatilla: 2nd by Cassie Sellards-Reck, Cowlitz; Motion to close by Cassie Sellards-Reck, Cowlitz; 2nd by Dan Gleason, Chehalis; **Voted in by acclamation**

Committee Meetings

1:30 BACK IN SESSION

NW NATIVE AMERICAN RESEARCH CENTER FOR HEALTH (NW NARCH) & PREVENTION RESEARCH, DR. TOM BECKER, NW NARCH PROJECT DIRECTOR AND

MATTIE PALMANTEER, ASTHMA PROJECT COORDINATOR, AND GRAHAM HARKER SENIOR RESEARCH ASSISTANT

Game Plan

- Provide a short update on the history of our NW NARCH (Native American Research Centers for Health)
- Relate summary information from various projects, past and present
- Provide update on the Prevention Research Center (PRC), a collaboration among the Board, several member tribes, and OHSU

Short NARCH History

- Relatively new federal program that required collaborations among tribes and academic programs
- Initial planning for the NIH and Indian HS-funded program began 16 years ago
- The Board was awarded funding in the first round, and has received funding for every round for which we have applied ($15 million)

NARCH First Round

- Toddler obesity and tooth decay prevention
- Child safety seat use
- Scholarship program
- Use of internet for diabetes self-management
- Other components of that application were not funded (7 submitted)

Subsequent Components of NARCH

- NARCH 3 Scholarship program
- NARCH 4 Summer Research Training Institute
- NARCH 5 Monitoring Abuse of Drugs
- NARCH 5 Supplement: HIV prevention
- NARCH 6, 7 Continued scholarships and Summer Institute
- NARCH 8 Dental follow up study of 'tweens'
- NARCH 9 includes: Improving asthma management in tribal children, and Cancer Prevention and Control fellowship program for tribal trainees
- NARCH 10 includes: Graduate fellowship program for tribal students in biomedical or social science research (Summer Institute was not renewed)

2018 Accomplishments

- Continued support of prior fellows—many new graduates

- Identified several new fellows
- Added Board-based scholars
- Hosted summer institute with 84 participants
- Implemented NARCH 9 and 10 grants
- Hired Asthma Project Director (Celeste) and Coordinator (Mattie)

Coming up in 2019

- Continue fellow/scholar support (Grazia Cunningham)
- Conduct follow up of summer institute trainees and graduate trainees (Grazia Cunningham)
- Continue asthma (Mattie Tomeo-Palmanteer and Celeste Davis) and Cancer (Ashley Thomas) projects
- Prepare new NARCH grant for round 11 when funding announcement comes out
- Attend and present at conferences on Indian health and on public health

Current NARCH staff and valued helpers

- Mattie Tomeo-Palmanteer
- Celeste Davis
- Ashley Thomas
- Grazia Ori Cunningham
- Tam Lutz
- Nicole Smith
- Candice Jimenez
- Kerri Lopez
- Jacqueline Left Hand Bull
- Victoria Warren-Mears
- Eugene Mostofi
- Tara Fox
- Tom Weiser
- Teshia Solomon
- Linda Burhansstipanov
- Nancy Scott
- Board of advisors

Prevention Research Center (PRC)

- Funding from CDC to OHSU, to partner with the Board and member tribes in health projects
- Main topics: preservation of sight and hearing via community-based research projects, avoidance of risky decisions by tribal youth
- Additional activities: regular seminar series on Indian health, classes in epidemiology of health conditions in tribal people, assisting with Board projects, provided funding for expansion of HPV vaccine

Future of the PRC

- In our last year of funding in current cycle
- We were not eligible to apply for renewal
- We will seek the Delegates' support for exploring additional funding sources (like NIH)

- We have a viable research idea that has met with enthusiastic response from local tribal people –related to fall prevention in older American Indians

Key Participants in PRC

- Caitlin Donald
- Michelle Singer
- Bill Lambert
- Brittany Morgan
- Jodi Lapidus
- Stephanie Craig-Rushing
- Jackie Shannon
- Raina Croff

- Thanks much...please contact me if questions at tbecker@npaihb.org
- Mattie Tomeo-Palmanteer will update you on the Asthma (NARCH 9) Project and seek volunteer tribal sites
- Graham Harker is also here to answer questions about falls and new balance-related technology

"Enhancing Control of Childhood Asthma in AI/AN Communities"

- The Asthma project is funded by the U.S. Department of Health and Human Services, National Institutes of Health and is sponsored by the Northwest Portland Area Indian Health Board in partnership with the Indian Health Service. Watch the video: https://www.youtube.com/watch?v=PzfLDi-sL3w

Purpose

- We want to learn how to help AI/AN children and their caregivers be successful in managing asthma triggers, medications, and decreasing hospitalization visits

Project Aims

- Provide clinic-based education by pharmacy emphasizing self-management and coordinated with home environment management
- Provide training materials and recommended practices for dissemination and implementation of childhood asthma control programs in additional Pacific NW Tribes and/or Urban Indian Health Clinics
- Support Tribal and Urban Indian Health Clinic's ability to sustain their pediatric asthma control program through organizational and institutional resources

Benefits

- Benefits: the goal of this research is to improve asthma management for AI/AN children and their quality of life
- Tribes and participants will help create better asthma education for AI/AN children
- Participants and their parent and/or caregiver will receive asthma education
- Patients and their parent and/or caregiver will receive in-home visits in order to conduct an environmental health assessment
- Participants will receive vacuum cleaners with High Efficiency Particulate Air (HEPA) filters, mattress & pillow covers, and green cleaning supplies

Risks

- Risks are minimal. However, we will be collecting personal information and asthma related data from children and adolescent participants IHS electronic health record
- Participants who choose to enroll will be assigned with a random participant identification number to de-identify data obtained from three questionnaires

Progress

- December 17, 2019 The Portland Area Institutional Review Board granted approval
- The Yakama Indian Health Service Clinic is enrolling patients to participate in the project.
- Supplies to complete environmental home visits are now in the process of being ordered after receiving recommendations from the Indian Health Service, Environmental Protection Agency and Housing and Urban Development
- We are seeking additional volunteer NW tribes and/or Urban Indian Health Centers that serve AI/AN to join our research project expansion efforts.

Please contact Mattie if you are interested in obtaining more information in person during QBM or via email asthma@npaihb.org

Additional Resources

- https://www.healthandenvironment.org/our-work/publications/a-story-of-health
- https://www.thecommunityguide.org/topic/asthma
- https://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma/living-with-asthma/creating-asthma-friendly-environments/asthma-at-home.html

OPIOID UPDATE, COLBIE CAUGHLIN, MPH, THRIVE & RESPONSE CIRCLES, PROJECT DIRECTOR & JESSICA LESTON, MPH, HIV/STI/HCV CLINICAL PROGRAMS DIRECTOR

Overview

What is Tribal Opioid Response?
What is the community telling us?

How are we responding?

What is a Tribal Opioid Response?

- *"Honestly, at this time, we are not certain."*
- *"Housing is a problem in our community especially for people with substance use issues and poor rental and legal history. A good plan moving forward would be to implement a pathway to affordable/subsidized/transitional housing for those in treatment."*
- *"Low rate of new opiate prescriptions for pain to reduce risks related to unintentionally starting new addictions, CD support through the tribe…"*
- *"Successful participation in our MAT program and the community embracing a Harm Reduction way!"*
- *"Our plan would include lots of education/prevention to the tribal community in terms they could understand. We desperately need follow up services/housing for clients to return to. We need community buy in to provide a healthier drug free atmosphere."*
- *"An outline of strategies to be implemented in pursuit of the tribe's ultimate goals to: 1) Prevent opioid misuse and abuse 2) Identify and treat opioid use disorder 3) reduce morbidity and mortality from opioids."*
- *"Having access to treatment services up to and including OTP (Opiate Treatment Program) and MAT (Medication Assisted Treatment)"*
- *"The whole community receives quality services"*
- *"Community Awareness-Harm Reduction Primary Care support -Medical Assistance SUD-BH counseling Community Support -Peer Counselors Overdose prevention – Narcan"*
- *"Prevention! And, perhaps, a Chemical Dependency Professional."*
- *"Treatment of the whole person, mind, body, spirit. Understanding this is a disease, that a person should not be shamed about it but supported to heal."*

See PowerPoint for additional graphics

The Right to Health

- Health is a Human Right
- Access to essential medications is a Human Right
- Access to Rights is a Human Right
- People who use drugs are People first, and foremost
- Universal, People-friendly systems are the most equitable ones
- Cost is reality, Price is choice
- No elimination without decriminalization
- *Advocacy is repeating the same truth, over and over again.*

Harm Reduction Conference – Roundtable

- What are your ideas for policies that can support harm reduction at the national and Tribal levels?
- What are your suggestions for improving ham reduction skills and capacity?
- What are two things you would like to see done to advance harm reduction nationally and in Indian Country?

National Policy Suggestions - Involving our people in policy change

Funding

- Mandatory HCV treatment funding to Tribes
- **Reconciliation – restorative justice**
- Funding for trainings for behavioral health providers
- Mandatory HCV education funding to Tribes
- **Improve resources/policies for telemedicine and mobile services**

Legal

- **Decriminalizing maternal substance use laws**
- **Support sovereignty**
- **Decriminalization**
- National legalization of safe injection facilities

Allocation of existing resources

- **Federal support to buy syringes**
- Use of federal funds to purchase needles
- Change reimbursement policies for medication-assisted treatments (MAT) and remove limits to prescribe them

Indigenizing Programs

- **Programs run by Tribes – not federal government**
- Decolonize funding access – federal government needs to take more chances on programs that don't fit narrow requirements
- **Prioritizing indigenous-driven and culturally focused projects**
- **Tribes make their own policies as sovereign nations**
- End genocide – systems that intersect through colonization, capitalism, criminalization of drug users, destruction of environment

Tribal Policy Suggestions - Nothing about us without us approach

Programming

- **Development and distribution of indigenous-focused harm reduction**
- HIV/HCV education and materials
- **Tribal level data**

Legal

- Fewer requirements to start harm reduction programs
- **Decriminalize use of substance on reservations**
- Decriminalize maternal substance use
- **Syringe exchange could be made easier**
- Change laws for syringe programs

Leadership considerations

- **Getting Tribal leaders engaged in grassroots issues**
- **Mandate harm reduction policies**
- **Move away from abstinence only**
- **Issues are not just opioids**
- **Move away from abstinence**

Suggestions for Skills/Capacities Development - Understand what harm reduction truly is

Clinical education

- Healthcare providers working in native communities need training in harm reduction and substance use treatment
- **Practitioner and all health care workers training in harm reduction**

Collaboration

- **Buy-in from the community**
- **Respect for those with lived experiences**
- Navigating and creatively utilizing funding streams

Systems education

- **Policies and practices to destigmatize substance use**
- Rid of shame-based for people less successful – move away from abstinence only
- **Accept something different – people are living lives with harm reduction**
- **Trauma-informed care**
- **Advocacy, education, culturally sensitive harm reduction**

Things we would like to see changed -

Education

- **Space beyond abstinence conversation** – teaching regarding impacts of colonization and substance use
- Train the trainers by and for indigenous harm reduction champions as well as other folks working in communities
- **More education/knowledge sharing**
- **Education about harm reduction**

Legal

- Reform drug laws with attention to rural realities
- Drug-related banishment must end (perpetuates isolation)

- **Discuss decriminalization**

Stigma change

- **Non-judgmental care and holistic approaches –** acknowledging that folks live full lives while using substances
- Acceptance for harm reduction
- Reduce stigma

Culture

- **An indigenous harm reduction network – to share, support, and organize**
- Bringing ceremony to folks who are excluded due to substance use – low barrier cultural activities
- Developing culturally responsive trainings for all providers

Access

- **Opiate options for our people – suboxone access**
- **Narcan availability and behavioral health services**
- Universal access to buprenorphine and IHS and Tribal run facilities beyond borders
- Connections among physicians working with indigenous communities to network and share
- **24-hour access to drop-in services (safe consumption, safer injection supplies, naloxone, etc.)**
- **Syringe service programs (SSPs) and universal screening everywhere**
- **Connect with existing services to share knowledge and get services to isolated communities**

How are we responding?

"We choose to go to the Moon! We choose to go to the Moon in this decade and do the other things, not because they are easy, but because they are hard; because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one we intend to win, and the others, too."

NPAIHB Opioid Projects

- Tribal Opioid Response (TOR) – SAMHSA
    - Consortium of 22 Tribes (35 Total)
    - *Capacity Building*
- Strategic Planning (CDC)
    - Regional and National Work
    - Comprehensive
- Opioid Overdose Data and Surveillance (CDC)

    - Improve accuracy and access to data on drug and opioid overdoses for Northwest Tribes
- Indian Country Substance Use Disorder ECHO clinic (SAMHSA + OMH)
    - Integrating Medications for Addictions Treatment in Primary Care
    - *Clinical Focus*

NPAIHB Tribal Opioid Response Consortium
The overarching goal of the NPAIHB TOR Consortium is to develop a comprehensive and strategic approach to assist Tribes in developing capacity to address the complex factors associated with a comprehensive opioid response. This includes:

- Developing a framework for a NW Opioid Response strategic plan,
- Increasing awareness of opioid use disorder,
- Preventing opioid use disorder,
- Increasing access to treatment and recovery services and overdose reversal capacity
- Reducing the health consequences of opioid use disorder in tribal communities.

Indian Country Strategy Process
The overarching aim of this project will address *regional* and *national* level strategy planning for addressing opioid overdose by using the SOAR (Strengths, Opportunities, Aspirations and Results) framework. Goals include:

- Increased awareness about regional and national opioid response in AI/AN communities.
- Developed understanding of the strengths and opportunities related to the Opioid Response in Indian Country.
- Increased tribal capacity to deliver Opioid Response services in Indian Country.
- Innovated and disseminated Regional and National Strategy to address Opioid Use in Indian Country

Opioid Overdose Data and Surveillance
The overarching goal of the project is to improve drug & opioid surveillance among Northwest tribes and improve tribal access to drug/opioid data.
Goals include:

- Create advisory group to assess tribal opioid data needs
- Address AI/AN racial misclassification in state data systems
- Use corrected data to create accurate opioid reports for Northwest AI/AN
- Provide a substance use/opioid epidemiology workshop and other opioid data technical assistance for tribes
- Work with states to improve collection of race, tribal affiliation, and overdose cause of death information

- Explore gaining access to additional opioid/overdose data systems

Opioid Overdose Data and Surveillance
Opioid and overdose data challenges:

- Racial misclassification
  - Many AI/AN are not classified as AI/AN in state data systems = **underrepresentation** of burden on AI/AN
- Limited access to behavioral health/treatment data
  - Takes time to develop data-sharing agreements
- Difficulty obtaining tribe-level data
  - Can only provide regional data
- Inconsistency in overdose cause of death reporting
  - What drug(s) actually involved?

Among American Indian/Alaska Natives in Washington

- Overdose death rates increased 20% in the last 5 years
- AI/AN had 3 times the death rate of whites in 2014-2016
- 40-54 year olds have the most overdose deaths
- 70% of drug overdoses involved opioids

Indian Country Substance Use Disorder ECHO
The overarching aim of the Indian Country SUD ECHO is to prevent opioid use disorder, increase access to treatment and recovery services and overdose reversal capacity (focusing on MAT services for persons with an opioid use disorder), and reduce the health consequences of opioid use disorder in tribal communities using evidence-based interventions.

- In-person trainings with DATA Waiver
- Telehealth sessions
- Options for telemedicine options

Limited Uptake of Buprenorphine

- Only one third of addiction treatment programs offer medications for treatment of OUD[1]
- 43% of U.S. counties have no waivered buprenorphine prescriber[2] - Many waivered providers don't prescribe
- Barriers to adoption include:[3] - Lack of belief in agonist treatment, Lack of time for new patients, Belief that reimbursement rates insufficient

Indian Country Opioid Project ECHO Curriculum Design and Learning Objectives

Each teleECHO clinic will offer learners the opportunity to benefit from didactics presented by experts in the field supported by references and will contain at least three main learning objectives. The didactic curriculum will be inter-professional in scope and will provide:

- Current practice guidelines pertaining to opioid use disorders, addiction and MAT management
- Foundations of opioid use disorders to provide a baseline understanding of the topic, and will include epidemiology, diagnosis, and treatment/management approaches
- Topics based on organizational, local and national trends in Indian Country, new findings in peer-reviewed medical literature, as well as participant feedback of interest

Upcoming Trainings:

- Grand Ronde, OR – Feb 28th
- Pendleton, OR – March 5-6th
- Green Bay, WI – May 1-2nd

Possible Trainings:

- Tulsa, OK – May 10th or 17th
- MT – June?
- Rapid City, SD – Fall 2019?

A PRACTICAL APPLICATION OF CHAS AND BHAS FOR SUD TREATMENT, SUE STEWARD, CHAP DIRECTOR

Goals:

- Comparison of Community Health Worker types
- CHAs and BHAs role in SUD treatment

Community Health Worker

- Community health worker are members of a community who are chosen by tribes to provide basic health and medical care to their community capable of providing preventive, promotional and rehabilitation care to these communities. Other names for this type of health care provider include village health worker, community health representative, community health promoter, health coach and lay health advisor.

Statistics

- **Median salary:** $45,360 USD (2017)
- **Median hourly rate:** $21.81 USD (2017)
- **Work experience in related occupation:** None
- **Openings:** 118,500 (2016)

CHR v. CHA

- **Legislative Authority**- CHAP is authorized under 25 USC § 1616 a-d while the CHR Program is authorized under IHCIA PL. 100-713.
- **Funding Sources**- The Alaska CHAP is funded through the hospital and health clinics (H&HC) line item in the IHS budget and CHRs are funded through a specific CHR line item.
- **Scopes of Work**- While the "community health" portion of the names are similar, the scope of work for a Community Health Aide and Community Health Representative are vastly different. CHAs are mid-level primary medical providers who can provide basic medical attention and can connect a patient to clinical care. CHRs provide health promotion, prevention, and outreach to community members.

CHAP Compensation Average

- CHA/T $29,250 to $37,050
- CHA I certified $33,150 to $40,950
- CHA II certified $37,050 to $44,850
- CHA III certified $40,950 to $48,750
- CHA IV certified $44,850 to $52,650
- CHP Certified $48,750 to $68,250

BHA Average Salary Range

- BHA $29,250 to $37,050
- BHA I/II certified $33,150 to $40,950
- BHA III/IV/P certified $37,050 to $48,750

SUD Treatment BHAs Role

- BHA/P's
    - Provide traditional healing/spiritual healing holistic care
    - Provide health education
    - Provide Patient Support and Advocacy
    - Arrange Transportation
    - Make Home Visits

CHA/Ps

- Provide health education
- Provide patient support and advocacy
- Make home visits
- Provide history, vitals, exam, labs, treatment and care coordination.

CHAs and BHAs Role

CHA/P Role
- Check in
- Vitals
- History
- Labs
- Exam
- Treatment
- Follow up/Care Coordination
- Order medication

BHA/P Role
- Set up VTC
- Observe labs
- Village based counselor
- Patient advocate
- Patient liaison

Sustainability
Three critical issues are linked to the sustainability of community health aide programs (CHAP):
- Evaluation
- Financing
- Credentialing/Certification

BREAK

HUMAN TRAFFICKING: THE PIVOTAL ROLE OF HEALTHCARE, JERI MOOMAW, EXECUTIVE DIRECTOR OF INNOVATIONS HUMAN TRAFFICKING COLLABORATIVE

Approach to Trafficking
- Criminal Justice
- Public health

In the past, human trafficking was typically viewed through a criminal justice point of view, which influenced our response to it. A criminal justice response to trafficking provides identified victims with services that are often of short duration and focused on services victims need to be able to become witnesses against their traffickers. While this perspective is important, we now realize that human trafficking is also a public health issue that affects individuals, families, and communities across generations.

Public Health Approach to Violence Prevention

Identify the Problem Trafficking	**Risk/Protective Factors** What's causing trafficking?	What are the risk and protective factors? **Prevention Strategies**	How can trafficking be prevented by considering social and economic

determinants involved?	How can we implement identified	interventions and determine their effectiveness?
Implementation		

One of the primary benefits of looking at human trafficking as a public health issue is the emphasis on prevention: that is, looking at the systemic issues that cause people to be vulnerable to human trafficking in the first place. A public health approach begins by identifying the problem. In this case, the problem is human trafficking. The second step of a public health approach is to ask what's causing human trafficking and to identify risk factors that make certain populations more vulnerable to it.
There are many social and economic determinants of health that lead to human trafficking. Awareness of these determinants allows us to create interventions aimed at preventing and reducing trafficking. The final step in a public health approach is to determine how to implement these interventions and determine their effectiveness. This training is intended to focus more specifically on how together we can apply a public health approach to Native communities that are impacted by human trafficking, not just to respond but to help prevent it from occurring.

What do we mean by human trafficking?
So, what is human trafficking? According to the Trafficking Victims Protection Act of 2000, or TVPA, human trafficking is a crime involving the exploitation of someone for the purpose of compelled labor or a commercial sex act through the use of force, fraud, or coercion. According to federal law, "a commercial sex act means any sex act on account of which anything of value is given to or received by any person. Where a person younger than 18 is induced to perform a commercial sex act, it is a crime regardless of whether there is any force, fraud, or coercion.

Trafficking Victims Protection Act of 2000 (TVPA)
The TVPA identifies three elements of human trafficking: Action, Means, and Purpose. In order to successfully prosecute an incident of human trafficking, each of these elements must be proven in a court of law.

Action

- Recruiting
- Harboring (or housing)
- Transporting
- Providing
- Obtaining

In the case of sex trafficking

- Patronizing
- Soliciting
- Advertising

Action includes recruiting, harboring, transporting, providing, and/or obtaining. For sex trafficking, it also includes patronizing, soliciting, and advertising. The action focuses on what the trafficker does, which is considered a crime.
Housing is tight in many Native communities and minors are often housed by their adult traffickers. This brings home the reality that family members traffic family members in Native communities, including intimate partner relationships. This level of control, loss of trust, is very important in understanding trafficking in Native Communities

Means
Force—Physical assault, sexual assault, physical confinement, or isolation
Fraud—False promises about work and living conditions, false pretenses for interpersonal relationships, use of fraudulent travel documents, fraudulent employment offers, withholding wages
Coercion—Threats of serious harm or psychological manipulation such as holding someone at gunpoint, threating the life and safety of a person or their family and friends, withholding legal documents, debt bondage
Means is how a trafficker accomplishes the eventual exploitation. He or she may use force, fraud, or coercion.

- **Force** can involve the use of physical restraint or serious physical harm. Physical violence, including rape, beatings, and physical confinement, is often employed as a means to control victims, especially during the early stages of victimization, when the trafficker breaks down the victim's resistance.
- **Fraud** involves luring individuals with false promises regarding employment, wages, working conditions, or other matters. Once away from home and support, they are forced into labor or sex trafficking. This happens frequently to Native Americans who leave or are lured away from the reservation with promises of a better life. They may wind up in a vulnerable situation because things are so different from where they came from.
- **Coercion** can involve threats of serious harm to or physical restraint against any person, threatening harm to family members and/or loved ones, mental health or substance use coercion, confiscating personal identification such as driver's license. It often involves manipulating victims through fear. We'll talk more about the historical context of human trafficking in Tribal communities shortly, but for now you should know that Native people and other indigenous populations may be particularly susceptible to coercion in part because of historical trauma.

Sex Trafficking of Minors
Minors induced into commercial sex are trafficking victims regardless of whether force, fraud, or coercion have been used.

There is an exception to the rule that Action, Means and Purpose must be proven to successfully prosecute human trafficking, and that is that when a minor (anyone under 18 years of age) is involved in commercial sex. In this case, it is considered human trafficking regardless of the means, and means does not need to be proven.

Purpose
Purpose: This is either forced labor or commercial sexual exploitation.
Many individuals who are trafficked, particularly women and children, are exploited for purposes of prostitution and pornography.
Trafficking also takes place in diverse labor contexts, such as domestic servitude, small businesses, factories, and agricultural work.

Labor traffickers often make false promises of a high-paying job, exciting education or travel opportunities to lure people into horrendous working conditions. Yet, victims find that the reality of their jobs proves to be far different than promised and must frequently work long hours for little to no pay.
https://polarisproject.org/labor-trafficking

Labor Trafficking - *Hidden in Plain Sight*

- Domestic labor
- Agriculture
- Landscaping
- Day labor sites
- Panhandling/Beggi ng
- Garment factories
- Meat-packing plants
- Door-to-door sales
- Nail salons
- Massage parlors
- Chain and fast-food restaurants
- Bars
- Fishing Industry

Sex and Labor Trafficking **May Co-Occur** Although state and federal law divides human trafficking into the **categories of sex trafficking or labor trafficking, in many cases a survivor has experienced both forms of exploitation**. When working with victims, it is important to ask about potential sex and labor exploitation to identify the full range of services they may need.

- Prostitution
- Pornography
- Strip clubs
- Commercial/Residential Brothels
- Illicit massage parlors
- Escort services
- Truck stops

Relationships Between Trafficker and Trafficked Individual
See PowerPoint for additional graphics
The relationship between the trafficker and the person being trafficked may also make it difficult to identify a trafficker. A 2013 study by Covenant House New York revealed that was that **36% of the children being trafficked were being trafficked by their parents or immediate family members**. It's also important to note that while the term boyfriend can mean a romantic partner, it's also a euphemism used for the trafficker. Don't discount someone as being a potential victim just because they appear to be presenting with a "relative" or a romantic partner. This study also helped to debunk the myth that traffickers are most often strangers to their victims.

Traditional View of Women and Children
- No words for rape or prostitution
- Violence against women was a capital offense
- Women were viewed as sacred
- Children were seen as a gift from the Creator

In traditional Native culture, there were no words for rape or prostitution.
Women were viewed as sacred and violence against them was a capital offence.
Children were valued as gifts from the Creator.
Unfortunately, with the arrival of Europeans came genocide, violence against women and children, forced removal, boarding schools, separation of children, sterilization, reservations, and the loss of traditional laws and ways of dealing with such offences. All of these contributed to historical trauma.

American Indian / Alaska Native Statistics
Native American women experience domestic violence at a rate that is 50% higher than the national average.

- U.S. Department of Justice. Violence Against American Indian and Alaska Native Women and the Criminal Justice Response: What is known. 2008:7

Native Americans are the most raped, assaulted, stalked, and murdered of all ethnicities.

- U.S. Department of Justice. Violence Against American Indian and Alaska Native Women and the Criminal Justice Response: What is known. 2008:7

"Perfect Population"
"If you're a trafficker looking for the perfect population of people to violate, Native [American] women would be a prime target. You have poverty. You have a people who have been traumatized. And you have a legal system that doesn't step in to stop it."

Historical Trauma

Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants.
Brave Heart, M.Y.H. (2003)

Results of Historical Trauma

- Defense mechanisms
- Developmental malfunctions
- Behavioral issues
- Depression
- Anger
- Isolation
- Violence
- Suicide
- Shame
- Substance use
- Anxiety

Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants. When working with and among Tribal communities, its vital that we understand and recognize the legacy of colonization, forced relocation away from their historic land, separation of parents and families and placement of children in boarding schools and other historic trauma continues to impact Tribal people today. It results in defense mechanisms, developmental malfunctions, and behavioral issues as well as depression, anger, isolation, violence and suicide, shame, substance use, and anxiety.

- Mohatt, Thompson, Thai, Kraemer Tebes. (2014). Social Science and Medicine. 106: 128-136. Retrieved: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4001826/#

Adverse Childhood Experiences (ACEs)
Adverse childhood experiences, or ACEs, are stressful or traumatic events that occur during a child's formative years. ACEs **include** a wide variety of issues, including abuse and neglect, and household dysfunction, and are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including human trafficking.
When looking to prevent human trafficking, understanding these risk factors is a critical step to be able to assess individual risk for your patients or clients, and ACEs gives us one invaluable tool to do so.

Signs of Trauma

Physical

- Frequent sexually transmitted infections
- Multiple pregnancies /abortions
- Dental issues
- Bruising and burns
- Signs of self-harm
- Weight loss or malnourishment
- Respiratory issues
- Suicide attempts
- Physical and sexual abuse

Behavioral

- Confusing or contradicting stories
- Inability to focus
- Unaware of current date, location, or time
- Minimizes abuse
- Extreme timidity
- Aggressive or defensive
- Heightened stress response
- Withdrawn or depressed

Social/Environmental

- Frequent school absences/failing grades
- Increase in substance use
- Change in dress
- Age-inappropriate romantic partner
- Change in friends
- Repeat runaway
- Doesn't share information
- Evidence of being controlled
- Crowded living conditions
- No address

There are a variety of "red flags" that may indicate either sex or labor trafficking. These red flags may be physical, behavioral, or social/environmental. The list here provides some examples, but it is not definitive and not every individual will present the same red flags. Also, individuals at risk, and those who have been trafficked, typically do not experience their first victimization when they are exploited as victims of trafficking. Many of them experience multiple traumas, at various phases of their lives, including traumatic events that began during their formative childhood years and continue into adulthood. The issues they present when you work with them may be related to trauma they experienced prior to being trafficked.

Barriers That Prevent Identification
Patient/Client-Related **Provider-Related**
The reality is that individuals who are at risk, or who have been trafficked, are not being recognized. This is often due to various barriers that hinder identification. These barriers fall into two categories, patient or client-related and provider-related barriers. What I would like to do now.

Reasons Why Individuals May Not Self-Identify
Individuals who are at risk, or who have been trafficked, are often not recognized due to various barriers that hinder identification.
A person being trafficked may not self-identify or admit to it either because they don't realize that they are being trafficked or for many other reasons.

- Lack of awareness of victimization
- Lack of understanding of victim and legal rights
- Fear of law enforcement or social services
- Fear that reporting could lead to being returned to an abusive home, jail, or foster care placement
- Distrust of provider or those in authority
- Feels hopeless and helpless
- Feels isolation, shame, or guilt
- Feels complicit in an illegal act
- Fear that traffickers will cause harm to self, family, or loved ones
- Trauma bonding with trafficker or other victims
- Dependence on trafficker for drugs or emotional support

Reasons Why Professionals May Not Identify

- Its vital when responding to human trafficking that professionals understand their own limitations, preconceptions and other barriers that can prevent us from identifying individuals at risk as well as those being trafficked.

- Lacks knowledge about human trafficking
- Inadequate understanding of federal, state, local and tribal human trafficking laws
- Fears violating Health Insurance Portability and Accountability Act (HIPAA rules)
- Lacks trauma-informed care training
- Has preconceived notions of how an individual who has been trafficked will present
- Doesn't believe it is his or her role to get involved
- Mistrust of law enforcement
- Lacks access to neutral, professional interpreters
- "Checks off boxes" without seeing the full patient or client situation

- Thinks that asking will be time consuming or too complex
- Feels the patient/client is unresponsive or hostile to questioning or tells a rehearsed story
- Lacks information on good referral options
- Attributes behavior(s) to harmful cultural stereotypes
- Misidentifies the case

Mandated Reporting

- Human Trafficking
- Child Abuse or Neglect
- Domestic Violence
- Health Insurance Portability and Accountability Act (HIPAA)

When to Report?

During the screening process for any of these crimes, if you are a mandated reporter, you are required to report suspected abuse. Many federal laws have expanded mandatory reporting requirements related to human trafficking.

Mandatory reporting requirements vary from state to state, and within states, and where tribal law has jurisdiction, so it is important to know the requirements in your area and continue to work within HIPAA guidelines.

If your screening of a patient leads to the disclosure of traumatization, such as child abuse or domestic violence, state and federal laws may require that you disclose that information to the proper authorities. Many federal laws, such as the Trafficking Victims Protection Act (TVAP) and the Preventing Sex Trafficking and Strengthening Families Act may also require you to report certain information to varying entities in order to further protect those who have experienced trafficking or are at risk of being trafficked.

Mandatory reporting requirements vary from state to state, and within states, or where Tribal Law has jurisdiction, so it is important to know the requirements in your area and continue to work within the HIPAA guidelines. Mandatory laws might include informing law enforcement or child protection agencies of suspected child abuse, domestic violence, and laws requiring reports of knife or gunshot wounds. State laws on suspected child abuse, domestic violence, and vulnerable populations' abuse may apply even if you are not sure this is a trafficking case. As part of your protocol, include specific guidance on the mandatory reporting requirements related to human trafficking. Remember that you are not likely to have a patient seeking treatment for human trafficking. They'll be seeking care for other health concerns that may need to be reported.

Reporting can be a tricky topic for several reasons:

- The traumatic physical and psychological impacts for victims are extensive; necessitating that health care providers and social workers must be able to respond to these needs.
- Persons being trafficked may interface with health care providers on several occasions before human trafficking is suspected.

Whenever possible, keep visits positive to encourage a relationship and extend an invitation to return as needed. *The goal for any provider during interactions should not be disclosure.* Our role is to assist our patients and clients and that should be the focus.
Select each button to learn more.
Programming Notes:
Human Trafficking
Trafficking Victims Protection Act (https://www.congress.gov/bill/114th-congress/senate-bill/178)

Requires Federal, State, or local officials to notify HHS within 24 hours of discovering a child who may be a foreign victim of trafficking. If you are a federal, state, or local official, notify an HHS Child Protection Specialist at ChildTrafficking@acf.hhs.gov or call 202.205.4582.

- *Polaris Policy & Legislation*

Child Abuse or Neglect
Justice for Victims of Trafficking Act of 2015(https://www.congress.gov/bill/114th-congress/senate-bill/178)
Mandated reporters should report suspected trafficking of a minor as they would abuse and neglect in accordance with the protocols in their state.
Preventing Sex Trafficking and Strengthening Families Act(https://www.congress.gov/bill/113th-congress/house-bill/4980)

This federal law requires public child welfare agencies to identify and serve minors who have been, or are at risk of being victims of sex trafficking. Additionally, state child welfare agencies must report any missing children to law enforcement and the National Center for Missing & Exploited Children (NCMEC) within 24 hours. If you work for a state child welfare agency, you can report a missing child to NCMEC by calling 1-800-843-5678.

- *Mandatory Reporters of Child Abuse and Neglect*

Domestic Violence

- *Compendium of State Statutes and Policies on Domestic Violence and Health Care*

Health Insurance Portability and Accountability Act

- *Department of Health and Human Services: HIPAA for Professionals*

HHS Screening Tools
The National Human Trafficking Training and Technical Assistance Center, or NHTTAC, has developed a human trafficking screening tool to be used to screen potential adult victims of human trafficking to complement the screening tool created by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to identify minor victims of trafficking. Through use of the NHTTAC and ASPE human trafficking screening tools, professionals in social services, behavioral health, public health, and health care will apply trauma-informed principles to identify individuals who have been trafficked and provide appropriate referrals to supportive and culturally competent services.

Creating a Safe Environment

- Creating a safe environment and building rapport with individuals who have been trafficked are foundational elements of trauma informed care. There are several practical ways to enhance feelings of safety and security when screening a client. Select the button to learn more.
- **Programming Notes:**
- Practical ways to enhance feelings of safety and security when screening a client:
    - Ask for permission to speak to a survivor before screening them
    - Ensure that meeting space is private, neutral and comfortable
    - Begin with a warm welcome. For example, it can be helpful to meet new referrals outside of the building or in the lobby to avoid confusion about where they are going and to send the message that the meeting is important.
    - Provide a brief tour of the building, particularly is this is the first time the victim has been there. This will help familiarize them with a new environment. Note what services are offered on site and offer coffee, tea, or water (if possible).
    - Explain your role and that of other service providers who may be involved
    - If needed, secure a safe and appropriate interpreter in the language the survivor identified as preferred.
    - Review the concept of confidentiality and the specific policy where you work, outlining the commitment to not share any information with any outsider (including law enforcement or other providers associated with the case) without specific, written permission
    - Be sure to have all documents outlining available services, confidentiality, and victims' rights on hand; have them printed in the victim's preferred language.
    - Avoid discussions about clients in public spaces
    - Be aware of nonverbal cues and body language that you're displaying. Maintain openness in your posture, avoid crossing your arms, sit at the same level as the person you are screening, and avoid displaying emotional reactions or judgments

to things that are said in the course of the discussion, including your judgments of the trafficker

Survivor-Centered Screening Techniques

- When screening a client who may have been trafficked, it's important to first create a setting that supports a victim-centered, trauma-informed screening.
- Get informed consent prior to screening a person who has been trafficked.
- Be sure to let them know the purpose of the screening, and provide information about the screening process, including potential uses of the information they provide.
- Individuals being screened should also be informed about confidentiality and any limitations in the context of your screening, particularly any mandated reporting obligations you may have.

Trauma-Informed Screening

- When screening a person who has been trafficked, remember the goal is not to obtain a disclosure about trafficking, but rather to obtain enough information that helps you best respond to the needs of your client.
- When applying a trauma-informed lens to screening, it is highly invasive and triggering to ask individuals who may have been trafficked to share a detailed history of their exploitation to secure access to support services.
- Many individuals who have been trafficked are distrusting of service providers and may be hesitant to respond. Such in-depth questioning may lead them to become unresponsive, defensive, and distrusting of the screener.

What Do We Mean by "Trauma"?

Let's take a moment to be sure you understand what we mean by a trauma-informed, culturally and linguistically appropriate approach to trafficking.

The Substance Abuse and Mental Health Services Administration, or SAMHSA, defines trauma as the results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being. In short, trauma is any experience, such as child abuse or domestic violence, that overwhelms one's ability to cope. Individuals who have been trafficked may have experienced trauma not only from their actual trafficking exploitation, but also from some of the upstream determinants that made them at risk to trafficking.

Trauma-Informed Services

- Incorporate knowledge about trauma in all aspects of service delivery
- Minimize traumatization or re-traumatization

- Facilitate healing, connection, and empowerment

Trauma-informed services

- Recognize that we are spiritual beings on a human journey, not human beings on a spiritual journey.
- When victimized by violence, often a westernized approach does not acknowledge the spiritual wound of our whole being. A holistic approach is necessary to help heal individuals who have been trafficked.

Trauma Informed Care

- You have the opportunity to help support individuals at risk, and those who have been trafficked, in a variety of ways. While your role may vary, depending on where you work, the types of services your organization provides, and the populations you serve, it's important to use a trauma-informed, culturally and linguistically appropriate response with everyone you work with. Select each button to learn more.

Programming Notes:

Safety

- Throughout the organization, staff and the people they serve feel physically and psychologically safe.
- Recognize what it means when someone leaves their tribal community, especially when someone is traditionally a tribal person. Suggesting they leave the community for safety or shelter may be traumatizing.
- In rural communities, it may take a long time to reach services. Safety planning will look different in rural vs urban vs reservations vs island communities.
- Provide a welcoming environment.
- Be sensitive to potential triggers that might remind a patient of past trauma.
- Be kind. Individuals who have been trafficked may be belligerent or hostile. Try to remember that their life experiences and past traumatization's make it difficult to trust care providers or people in authority.
- Incorporate regular safety planning within your organization, including how to strategize safety concerns with your patient
- Conduct screenings in a confidential setting

Trustworthiness and Transparency

- Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, patients, and family members of those receiving services.
- Explain your role and that of other medical or service providers who may work with the patient

- Involve the patient in decision making, when possible, and respect their decisions even when you disagree with them.
- Provide qualified interpreters and translated materials as needed

Peer Support

- Peer support provides a way for survivors of human trafficking to meet together and share their strengths and weaknesses as they recover from the trauma of trafficking. Seek out opportunities for peer support.
- Identify and work with survivor leaders. Know elders in the community who have an understanding of trafficking.
- Coordinate peer-to-peer counseling and mentoring from survivors who are now serving in a **direct** services or life coach capacity

Collaboration and Mutuality

- There should be true partnering and leveling of power differences between staff and patients and among organizational staff from direct care staff to administrators. The organization recognizes that everyone has a role to play in a trauma-informed approach.
- Advocate for trauma-informed training for all staff to ensure the whole organization is aware of trauma and its impact both on patients and on staff
- Collaborate with other medical professionals and network across different departments
- Create a resource and referral protocol for use with outside service providers

Empowerment, Voice, and Choice

- Throughout the organization and among the patients served, individuals' strengths and experiences are recognized and built upon.
- Be transparent in explaining patient options and your role in working with them
- Respect the decisions patients make, even if you disagree
- Provide interpreters and translated materials, as needed, to insure that all patients feel equally empowered and have a voice in the services they receive

Cultural, Historical, and Gender Considerations

- The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.
- Avoid letting stereotypes and biases prevent you from identifying a person who has been trafficked
- Respect a patient's decision to follow traditional practices and treatment. Consider learning more about these approaches
- Seek training and collaboration opportunities from community-based organizations who represent diverse cultural, religious, and ethnic communities

Spiritual Healing

- We are emotional, mental, physical, and spiritual.

- We are spiritual beings on a human journey, not human beings on a spiritual journey.
- When victimized by violence, often a westernized approach does not acknowledge the spiritual wound of our whole being.
- A holistic approach is necessary to help heal individuals who have been trafficked.
- Both traditional and Western approaches can be utilized at the same time.

Honoring Culture and Tradition

- Modeling of traditional behavior
- Offering sage, sweet grass, or something to drink in a warm, caring environment
- Traditional healing, sacred medicines, ceremonies
- Welcome home ceremonies
- Wiping Away the Tears (Lakota)
- Naming ceremony
- Making relatives
- Connect to Elders

Building a Response to Trafficking in Native Communities
Collaborating Across the Public Health Sectors

Every person who has been trafficked is unique, and will require a different mix of services. A vital component of responding to human trafficking is collaborating across the public health sectors with experts who can provide services such as legal aid, housing, medical care, and behavioral health services. Select each button to learn more.

Programming Notes:

Partner with organizations in the community:

- Many urban and reservation sites have Boys & Girls Clubs – they should be linked and staff should have training. All JDCs (juvenile detention centers) have routine visit with healthcare for a variety of reasons including sexual exploitation. My only experience for this is reservation based and we are linked to our JDC.
- Build a relationship with Residential Recovery Programs. There is a connection between human trafficking and substance use. These programs are highly likely to be serving people who may have been or are being trafficked. It's a great place to screen for potential trafficking as well as raise awareness.

Health Care Providers

- For help in finding health care providers who have worked with individuals who were trafficked, contact HEAL Trafficking, an independent, interdisciplinary network of health professionals across the country. IHS/Tribal/Urban Indian healthcare centers could be encouraged to develop foster care clinics to touch base with all Native children in the foster care system as this is a high risk group.
- Client health care needs will vary, but may include:
  - Dental care

- Broken bones
- Sexual assault forensic examination
- Substance use treatment
- Malnutrition and/or dehydration
- Short- and long-term medical treatment, depending on the seriousness of the injury or infection
- Long-term physical impact of trauma

Legal Aid

- As with health care, behavioral health, and social service needs, your client's legal needs will vary. Legal aid professionals can provide services such as:

- Applying for "T" visas, for victims and their families
- Helping with orders of protection
- Representing victims who testify against their traffickers
- Assisting with eviction and housing issues
- Obtaining proper legal documentation, including proof of age and name at birth
- Vacatur and expungement relief for victims with a criminal history as a result of their trafficking

Public Health Professionals

- As a field, public health professionals provide a variety of services in many different settings. Depending on the role they play, they may contribute to preventing and identifying human trafficking in a variety of ways, some more obvious than others, including:

- Health safety inspectors identifying potential indicators of trafficking in businesses or homes
- Community health workers noticing the spread of disease and infection amongst vulnerable populations
- Researchers identifying methods for preventing trafficking that have worked in other communities

Law Enforcement

- Human trafficking is a crime in all 50 states and 16 territories. To learn more about the laws in your state or territory, visit the Polaris's State Ratings web page. As a mandatory reporter, you likely already have members of law enforcement in your referral network. In addition to services within the criminal justice system, law enforcement can also:
  - Refer you to victim service providers in the area
  - Provide a network of resources through a human trafficking task force, where available
  - Provide certification to help patients apply for immigration relief

Behavioral Health Providers

- Many individuals who have been trafficked have experienced multiple traumas over the course of their lives. They develop unique responses to these events, as well as coping mechanisms. Develop an internal protocol for referring your patients to behavioral health specialists within your organization, as well as one for outside referrals.
- Behavioral health providers can help survivors address their trauma through:
  - Counseling services
  - Treatment for addiction
  - Sexual assault trauma services
  - Short and long-term therapy
  - Referrals for more specialized care
  - School based counselors

Engaging Survivor Leaders
"A survivor-informed practice acknowledges the unique perspectives of survivors with relevant expertise based on knowledge of their trafficking experiences and challenges they have faced in their efforts to regain and rebuild their lives. A survivor-informed practice includes meaningful input from a diverse community of survivors at all stages of a program or project, including development, implementation, and evaluation." *Human Trafficking Leadership Academy, 2017*

Survivor engagement allows organizations to better serve clients, craft programs, identify challenges and opportunities, and achieve agency missions and mandates. As a primary stakeholder in the anti-trafficking field, survivor leaders offer invaluable insight and expertise. Anti-trafficking efforts can only be successful with comprehensive inclusion of diverse professionals, including survivor leaders. It offers insight into the anti-trafficking field that, through application, adaptation and validation, will contribute to the development of evidence-based practices. Consider ways that your organization can collaborate with professionals who have a history of human trafficking to further inform your response.
Understanding the degree to which your organization is survivor-informed is a critical first step. You can assess your organization by eliciting feedback from staff, consultants, and clients through surveys, focus groups, or exit interviews. Regularly assess across the entire organization, including mission, vision, and culture; approach to program development, implementation, and evaluation; referral networks and partnerships; outreach and awareness-raising activities; fundraising strategies; and human resource and staffing development.

- Programming: pop up text box
- Solicit survivor expertise throughout program development, implementation, and evaluation. Include diverse human trafficking survivor perspectives (i.e., sex and labor trafficking survivors, adult and minor survivors, LGBTQ survivors, and foreign-national and domestic survivors).

- Integrate promising practices from other related fields (i.e., intimate partner violence, sexual assault, and labor exploitation), when appropriate.
- Leverage survivor strengths and expertise to determine the most appropriate activities and level of engagement.
- Be mindful of survivor's length of time out of their trafficking situation and support survivors in managing their triggers.
- Train everyone within the organization on trauma-informed and person-centered practices.
- For guiding principles, assessments tools, resources, and practical tips for implementing survivor-informed policies and procedures as well as information on how to support survivor leaders as staff, volunteers, and consultants, download this toolkit: **Survivor Toolkit for Building Survivor-Informed Organizations (https://www.acf.hhs.gov/otip/resource/nhttacorgtoolkit) .**

Involving Elders/Leaders
Wherever possible, solutions should involve Elders and leaders.
[Facilitator share example of MOU partnership with a Native direct service organization in Washington State. Through this partnership, she works with Elders from different tribes to provide insight and oversight – they are part of the mobile response team to help survivors regain their culture.]

Protocol Components
To be able to apply SOAR within your workplace, you'll need a protocol for working with individuals who have been trafficked. Protocols are guidelines created for an organization to help guide care providers in the appropriate response to trafficking. The components of a human trafficking protocol within the public health system should include many of the things we have discussed in this module, such as identification, screening, and separation procedures. At a minimum, protocol components should also include guidance for multidisciplinary treatment, mandatory reporting, a referral process, and follow-up or follow-through procedures. Select each component to learn more.
Programing Notes:

1. Staff Training: In order to identify patients or clients who have been trafficked, all staff in an organization, including administrative and support staff, should be trained in the basic indicators of human trafficking and red flags based on local trends in trafficking.
2. As you learned in the Ask lesson, screening tools for people who may have been trafficked should focus on collecting information about the individual's emergency, medium, and long-term needs. In addition to the screening tool, organizations also need to have a plan in place that considers screening procedures and how to plan for safety

3. As we just discussed, a person who has been trafficked will require the services of a multidisciplinary team of experts. Each individual will have a unique set of needs, which you can prepare to meet by creating a referral network that includes providers from law enforcement, health care, tribal elders, behavioral health, social services, legal aid and peer support, just to name a few.
4. As we discussed in the Ask section, understanding and knowing how and when mandatory reporting applies is vital.
5. After you have properly identified a person who is being trafficked, it's important you use trauma-informed care to gain their trust. For example, include them in decisions that are made about their future, both with creating a safety plan and when identifying the services they will receive. Once your trust has been established, use a warm handoff when it's time for the individual to meet their next provider. As you introduce them, explain what will happen next, and answer any questions they have. Maintain a high level of confidentiality while continuing to develop their after-care plan. Enabling individuals who have been trafficked to take back control of their life will help them to feel empowered by the process and avoid abandonment or re-exploitive situations or feelings.

Suspicion or Disclosure: Now what?
See PowerPoint for additional graphics

Prevention

1. Engage schools
    - Educate youth about healthy relationships
    - Strengthen cultural identity through traditional dance clubs, drum groups and craft classes
2. Address poverty
    - Establish programs that provide employment opportunities, especially for youth and women
    - Work toward economic equality
    - Provide access to higher education
3. Prevent and reduce ACEs
    - ACEs includes abuse, neglect, and household dysfunction; reducing the number of ACEs will reduce negative health outcomes, including trafficking

4. Awareness
    - Hold talking circles and support groups to raise awareness and provide safety and support

National Human Trafficking Hotline

- Comprehensive service referrals for potential victims of human trafficking
- Tip reporting to trained law enforcement
- Data and trends on human trafficking in the United States
- **Text HELP to 233733 (BEFREE)** to get help for potential victims of human trafficking or to connect with local services.

CONTACT US
www.innovationshtc.com
info@innovationshtc.org
360-705-8575

Recess at 4:40 p.m.

January 22 - 24, 2019
MINUTES

WEDNESDAY JANUARY 23, 2019

Call to Order: by Cheryle Kennedy, Vice Chairwoman

Invocation:

I-LEAD –YOUTH AMBASSADOR

2018-2019 Youth Delegates
Tribal Nations Represented:
Chehalis, Lummi, Quinault, Siletz, Spokane, Umatilla, and Warm Springs
The NPAIHB Tribal Youth Delegate program is a yearlong initiative for young Native American leaders working toward health equity in their communities. The program connects emerging tribal leaders from Idaho, Oregon and Washington to people, institutions, and other resources that can amplify Youth Delegate's voices within broader movements.

Virtual Meetings
- Bylaw brainstorming
- Resolution creation
- Johns Hopkins University – Suicide Prevention Roundtable

Conference Attendance
- Washington State Tribal Youth Suicide Prevention Summit

Winter Quarterly Board Meeting
- Formalizing Bylaws
- Presenting Resolution for formal recognition
- Brainstorming future projects
- Suquamish Tribal Youth Center tour
- Creation of promotional video

Applicant Criteria:
- Member or Descendant of a NPAIHB Member Tribe in Idaho, Oregon or Washington.
- Between the ages of 14-24
- Interested in learning more about health or wellness careers
- Able to participate in and attend delegate trainings, projects and activities
- Prepared to represent themselves, their Tribe, NPAIHB, and the cohort of delegates with honor and respect at a regional and national level
- Have access to phone, email and social media to stay in regular communication with NPAIHB staff
- **For more information, check out our website at:**

- **http://www.npaihb.org/youth-delegate/**
- **Questions?**
- **Contact Tana Atchley-Culbertson at: tatchley@npaihb.org**

HRSA SHORTAGE DESIGNATION MODERNIZATION PROJECT, DR. JANELLE MCCUTCHEN, CHIEF OF BHWS SHORTAGE DESIGNATION BRANCH – HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Health Resources and Services Administration (HRSA)

- Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically challenged
- HRSA does this through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities
- Every year, HRSA programs serve tens of millions of people, including people living with HIV/AIDS, pregnant women, mothers and their families,
- and those otherwise unable to access quality health care

Please see presentation for additional graphics

The National Health Service Corps (NHSC)
THE NATIONAL HEALTH SERVICE CORPS (NHSC) builds healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care.

The NHSC is part of HRSA's Bureau of Health Workforce (BHW).
BHW improves the health of underserved populations by strengthening the health workforce and connecting skilled professionals to communities in need.

28% of **BHW** funding supports the **NHSC** and other programs that improve the distribution of health professionals to underserved areas.

ITU approved sites in Idaho, Oregon and Washington as of 01/23/2019
• Total of 83 approved NHSC sites
• Total of 61 NHSC participants at 33 of these sites
• Health Workforce Connector (43 of 83 sites have profiles)
    • Idaho: 6 sites, 1 opportunity

- Oregon 15 sites, 2 opportunities
- Washington: 22 sites, 3 opportunities

Ratio of Population to Providers

Which Providers Count?

Primary Care

Includes Doctors of Medicine (MD) and Doctors of Osteopathy (DO) who provide services in the following specialties:

- Family Practice
- Internal Medicine
- Obstetrics and Gynecology
- Pediatrics

Mental Health

Includes:

Psychiatrists, and may include other Core Mental Health (CMH) providers, such as:

- Clinical Psychologists
- Clinical Social Workers
- Psychiatric Nurse Specialists
- Marriage & Family Therapists

Dental Health

Includes:

- Dentists, and takes into account
- Dental Auxiliaries

Dental auxiliaries are defined as any non-dentist staff employed by the dentist to assist in the operation of the practice.

Note: Providers solely engaged in administration, research or training are excluded.

Automatically Designated Facility HPSAs

Using the statute and regulations, HRSA has deemed the following facility types as eligible for automatic HPSA designation:

- **Tribally-Run Clinics**
- **Urban Indian Organizations**
- **Dual-Funded Tribal Health Centers**
- **Federally-Run Indian Health Service Clinics**
- **Health Centers (funded under Sec. 330)**
- **Health Center Look-Alikes**
- **CMS-Certified Rural Health Clinics meeting NHSC site requirements**

Auto-HPSAs compared to other HPSAs
Similar but not the same

Other HPSAs
- Designation & scoring done online
- Criteria used to first designate as HPSA
- Criteria used to determine HPSA score
- Scores range from 0-25 (26 for dental)
- Designations are required to be reviewed and updated as necessary annually
- Score of "0" is rare

Automatic Facility (Auto-HPSAs)
Designation & scoring currently done ***manually***
- ***No application*** process necessary
- Same criteria used to determine HPSA score as other HPSAs
- Same scoring range used
- HRSA has not historically required Auto-HPSA scores to be reviewed regularly; updates are requested by facility
- Score of "0" ***more frequent*** and means low shortage or no data was available for scoring

Purpose of Auto-HPSA Update Previews
Planning and Information Tool + Transparency = Auto-HPSA Update Preview

- Scores are subject to change; PCO provider data changes will likely result in score changes.
- Update preview scores are for information only. They are not published in the HRSA Data Warehouse.
- Update preview scores will not be used for NHSC LRP 2019 application cycle.
- No scores will change until the national update is implemented. *(Update is tentatively planned for spring/summer 2019. No earlier than April 2019.)*

Determining the Default Service Area
1. Site is geocoded
2. 30 or 40 min travel polygon is drawn around the site
3. Census tracts (CT) that overlap the travel polygon are identified and saved as the service area
4. All usable providers located in the CT service area are identified

NOTE: A provider used in the population to provider ratio can be more than 30 or 40 minutes away from the site.
*Default Service Area is used for RHCs, ITUs and FQHCs/LALs that have not reported UDS data.

What You Can Do Now

- Focus on supplemental data collection
    - Particularly zip codes in which patients reside
    - The percent of population of patients served with known income at or below 100% FPL
- Connect with your State Primary Care Office
- Continue to review Auto-HPSA Update Previews upon receipt
- Make sure contact information is correct in the EHBs or BHW Portal/BMISS system
- Participate in upcoming technical assistance webinars to learn more about HPSA scoring and the supplemental data submission

To Whom to Direct Questions

• Project itself (purpose, timeline, etc.):	SDMP@HRSA.gov
• Data shown on Update Preview Report:	State PCO
• Provider data:	State PCO
• Update preview scores:	State PCO
• Supplemental data:	State PCO
• Score or rescore* before the national update:	SDB@HRSA.gov

CLINICAL TRAINING, ERIC VINSON PROJECT MANAGER, TRIBAL ECHO PROJECT

Clinical Training and capacity building

- Are there any specific workforce shortages/capacity building that you/your tribes would like to see?

Types of trainings

- In-person or online
    - Lecture (didactic) w/o Q&A
        - Seminar, Conference, workshop
    - Group discussions
    - Case Presentations
    - Skills building (hands on)
    - One on one mentoring

CE Professions

- See a profession missing from what we currently offer? Let us know! What other types of CE would you like to see offered by NPAIHB?

Continuing Education professions

- **Medical (CME):** Accreditation Council for Continuing Medical Education
- **Nursing (CNE):** Accreditation Commission for Education in Nursing
- **Social Work**: Association of Social Work Boards
- **Chemical Dependency**: NAADAC, the Association for Addiction Professionals
- **Health Education**: National Commission for Health Education Credentialing
- **Others:** Depending on specialty (ex. Child Safety Seat)

Trainings offered by NPAIHB

Training Title: Health Data Literacy and Applications for Tribal Health

- **Topic:** Epidemiology 101, Sources of AI/AN Health Data, Introduction to GIS Mapping, Data Visualization, Finding and Using Data for Strategic Planning/Policy Development
- **Format:** Lecture w/ Q&A, Hands On Skill Building
- **Frequency:** At least once a year
- **Audience:** Tribal health staff (clinical and non-clinical), planners, grant writers, anyone who needs an introduction/refresher course for tribal epidemiology
- **Accreditation:** none
- **Funding:** CDC
- **Upcoming Dates:** TBD
- **Contact:** Sujata Joshi, MSPH sjoshi@npaihb.org

Training Title: EHR/RPMS

- **Topics:** Basic CAC, Advanced CAC, Advanced TIU, Reminders, Integrated Behavioral Health, Data Management, Advanced Reminders
- **Format:** Didactic lectures, hands-on, Q&A
  - Most courses available in computer training room at NPAIHB, also available remotely (log in from your home site).
- **Frequency:** Typically one class per month
  - (monitor https://www.ihs.gov/rpms/training/ and http://www.npaihb.org/events/ for schedule)
- **Audience:** CACs (Informaticists)
- **Accreditation:** N/A
- **Funding:** IHS
- **Upcoming Dates:** February for Basic CAC
- **Contact:** Katie Johnson, Pharm D kjohnson@npaihb.org
-

RPMS Recordings Repository

- Including iCare, Behavioral Health, Radiology, Pharmacy, Lab, CAC, etc
- Nearly every RPMS package is covered

Training Title: Recorded EHR/RPMS Trainings

- NPAIHB YouTube Channel
  - Playlist of recordings aimed at providers new to using RPMS EHR

- https://www.youtube.com/watch?v=v6ZecSIm2nY&list=PLzTTmEbo5e5FHNrDsqZM6JJ_5qz08-sNk
- IHS Recorded Training Repository
  - Large variety of topics on RPMS
  - Requires registration, but ANYONE can register https://ihscqpub.cosocloud.com/content/connect/c1/7/en/events/event/shared/181203210 2/event_landing.html?sco-id=1812096787&_charset_=utf-8

Training Title: Diabetes ECHO series

- **Topic:** Diabetes
- **Format:** In-person and subsequent 1 hour virtual telehealth sessions include didactics, case presentations, and treatment recommendations for patients
- **Frequency:** Monthly
- **Audience:** All staff who work with patients with diabetes
- **Accreditation:** CME
- **Funding:** CDC
- **Upcoming Dates:** April – Sept 2019
- **Contact:** Kerri Lopez klopez@npaihb.org

Training Title: Western Tribal Diabetes Project DMS training

- **Topic:** Diabetes Management System – RPMS
- **Format:** Hands On training – Presentations
- **Frequency:** Quarterly
- **Audience:** CAC-RN-MA-Diabetes Coordinators-Data entry –PharmD
- **Accreditation:** N/A
- **Funding:** IHS
- **Upcoming Dates:** March 5-7, June 4-6, September 24-26, December 3-5, 2019
- **Contact:** Don Head, Erik Kakuska wtdp@npaihb.org

Training Title: Western Tribal Diabetes NF gathering

- **Topic:** SDPI best practices, clinical component (MI, Tobacco Cessation, Childhood Obesity, Historical Trauma, Data) Round table topics: Traditional food, Physical Activity, Nutrition, Youth programs, healthy cooking, diabetes prevention and a SDPI poster board session
- **Format:** Lecture, hands on, interactive
- **Frequency:** Yearly
- **Audience:** CAC-RN-MA-Diabetes Coordinators-Data entry –PharmD
- **Accreditation:** CNE, RD
- **Funding:** IHS
- **Upcoming Dates:** May 2-3rd, 2019
- **Contact:** Don Head, Erik Kakuska wtdp@npaihb.org

Training Title: NW Tribal Tobacco Prevention Conference

- **Topic:** Tobacco Prevention
- **Format:** Didactic Lecture
- **Frequency:** Yearly
- **Audience:** MD/DO/NP/PA, RN, PharmD, MA, Health Ed, Admin
- **Accreditation:** N/A
- **Funding:** CDC
- **Upcoming Dates:** N/A
- **Contact:** Ryan Sealy rsealy@npaihb.org

Training Title: Prescribing NRT (Nicotine Replacement Therapy) 101 and treating commercial tobacco addiction as a chronic disease – Cervical Cancer Webinar

- **Topic:** Tobacco Cessation and Cervical Cancer
- **Format:** Didactic Lecture
- **Frequency:** N/A
- **Audience:** MD/DO/NP/PA, RN, PharmD, MA, Health Ed, Diabetes Coordinators, Admin
- **Accreditation:** CME, CNE, CPE
- **Funding:** CDC
- **Upcoming Dates:** N/A
- **Contact:** Antoinette Aguirre aaguirre@npaihb.org

Training Title: NTCCP Tobacco Cessation Trainings

- **Topic:** Tobacco Cessation / Clinical and Community Curriculum utilized: Second Wind, 5A's, Basic Tobacco Intervention Skills for AI/AN
- **Format:** Didactic Lecture, interactive curriculum teach back, on site tribal technical assistance
- **Frequency:** Bi-Annually
- **Audience:** MD/DO/NP/PA, RN, PharmD, MA, Health Ed, Admin
- **Accreditation:** N/A
- **Funding:** CDC
- **Upcoming Dates:** June 2019
- **Contact:** Antoinette Aguirre aaguirre@npaihb.org
  Rosa Frutos rfrutos@npaihb.org

Training Title: NTCCP Tribal Cancer Coalition Meetings

- **Topic:** PSE's, Cancer Screening, Women's Health, HPV, Colorectal Cancer, Tobacco Cessation, digital storytelling, survivorship, liver cancer, cancer data, traditional food, electronic health records, patient navigation, healthy life styles, etc.
- **Format:** Didactic Lecture, interactive curriculum, focus groups, on site tribal technical assistance
- **Frequency:** Yearly
- **Audience:** Tobacco Coordinators, Nurses, MD's, PA's, MA's, CHR's, Pharmacists
- **Accreditation:** N/A

- **Funding:** CDC
- **Upcoming Dates:** June 2019
- **Contact:** Antoinette Aguirre aaguirre@npaihb.org
  Rosa Frutos rfrutos@npaihb.org

Training Title: Tribal Clinician's Cancer Update

- **Topic:** Cancer Prevention, screening, treatment, survivorship,
- **Format:** Didactic Lecture, w/ Q&A
- **Frequency:** Yearly
- **Audience:** MD/DO/NP/PA, RN
- **Accreditation:** CME, CNE
- **Funding:** CDC
- **Upcoming Dates:** April 25, 2019
- **Contact:** Rosa Frutos rfrutos@npaihb.org

Training Title: Minimally Invasive Dentistry

- **Topic:** Dental
- **Format:** Hands on Skills
- **Frequency:** Yearly
- **Audience:** DDS, DMD, Dental Programs
- **Accreditation:** CDE
- **Funding:** Arcora Foundation
- **Upcoming Dates:** N/A
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Portland Area Dental Meeting

- **Topic:** various Dental
- **Format:** Didactic Lecture, w/ Q&A, interactive workgroups
- **Frequency:** Yearly
- **Audience:** DMD, DDS, Dental Hygiene, Dental Health Aid, Dental Assistant, Dental Program staff
- **Accreditation:** CDE
- **Funding:** IHS
- **Upcoming Dates:** May 14-16, 2019
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Elder Initiative Workgroup

- **Topic:** Dental
- **Format:** Didactic Lecture, w/ Q&A
- **Frequency:** Quarterly
- **Audience:** DDS, DMD, Dental Clinics
- **Accreditation:** CDE
- **Funding:** IHS and Arcora Foundation

- **Upcoming Dates:** various
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Baby Teeth Matter

- **Topic:** Dental
- **Format:** Didactic Lecture, w/ Q&A
- **Frequency:** quarterly in-person/online
- **Audience:** DDS, DMD, Dental clinics
- **Accreditation:** CDE
- **Funding:** IHS and Arcora Foundation
- **Upcoming Dates:** various
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Dental Site Visits

- **Topic:** Various dental
- **Format:** Didactic Lecture, w/ Q&A
- **Frequency:** as requested
- **Audience:** DMD, DDS, Dental Clinic
- **Accreditation:** CDE
- **Funding:** IHS
- **Upcoming Dates:** various
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Suicide Prevention Trainings

- **Topic:** ASIST – Applied Suicide Intervention Skills Training
  QPR – Question Persuade Refer
  safeTALK – Suicide Awareness For Everyone, Talk. Ask. Listen. Keepsafe.
- **Format:** Didactic Lecture, discussion, and role-plays
  ASIST is a 2-day training, QPR is 1.5-2hrs, safeTALK is 3hrs
- **Frequency:** As requested
- **Audience:** Everyone (over 16 for ASIST without parental consent)
- **Accreditation:** NASW (ASIST)
- **Funding:** IHS, SAMHSA
- **Upcoming Dates:** March 25-26 at Heritage University
- **Contact:** Colbie Caughlan, ccaughlan@npaihb.org, 503-416-3284

Training Title: Substance Use Disorder Training

- **Topic:** Integrating SUD services at your tribe or facility and medications for addictions treatment waiver
- **Format:** In-person, didactics, case presentations

- **Frequency:** Approximately Quarterly
- **Audience:** Clinicians and staff working in Indian Country
- **Accreditation:** CME, CNE
- **Funding:** SAMHSA, OMH
- **Upcoming Dates:** February 28, March 5-6, May 2
- **Contact:** David Stephens, RN, BSN dstephens@npaihb.org

Training Title: Substance Use Disorder ECHO

- **Topics:** Substance use and use disorders
- **Format:** 1-hour virtual telehealth sessions include didactics, case presentations, and treatment recommendations for patients
- **Frequency:** 2x/month
- **Audience:** Clinicians and staff working in Indian Country
- **Accreditation:** CME, CNE
- **Funding:** SAMHSA, OMH
- **Upcoming Dates:** First and third Thursday of every month @11am PST
- **Contact:** David Stephens, RN, BSN dstephens@npaihb.org

Training Title: Hepatitis C Training

- **Topic:** Screening, Treatment and Management of Patients w/ HCV
- **Format:** In-person, didactics, case presentations
- **Frequency:** Approximately Quarterly
- **Audience:** Clinicians and staff working in Indian Country
- **Accreditation:** CME, CNE
- **Funding:** IHS
- **Upcoming Dates:** Jan 31-Feb 1, May 1
- **Contact:** David Stephens, RN, BSN dstephens@npaihb.org

Training Title: Hepatitis C ECHO

- **Topics:** Screening, Treatment and Management of Patients w/ HCV
- **Format:** 1 hour virtual telehealth sessions include didactics, case presentations, and treatment recommendations for patients
- **Frequency:** 6x/month
- **Audience:** Clinicians and staff working in Indian Country
- **Accreditation:** CME, CNE, CPE
- **Funding:** IHS
- **Upcoming Dates:** Jan 23, Feb 6, Feb 12, Feb 14, Feb 20, Feb 27
- **Contact:** David Stephens, RN, BSN dstephens@npaihb.org

Training other organizations offer

- UNM ECHO

- IHS sponsored: Hep C, Chronic Pain
- Many other topics: Cardiology, AIDS, Dementia, Palliative Care, etc
- echo.unm.edu/initiatives/indian-health-services/

- UCSF Warmline
  - HIV/AIDS Management, Hepatitis C Treatment, Substance Use/Medication Assisted Treatment, PEP, PrEP
  - https://nccc.ucsf.edu/
- Trauma Informed Oregon
  - OHSU and the Oregon Pediatric Society (OPS)
  - https://traumainformedoregon.org
- Vital Talk
  - Clinician communication skills for serious illness. Nonprofit founded at UW
  - www.vitaltalk.org
- Peer Wellness Specialist
  - Training for Peer Support Specialists
  - https://www.mhaoforegon.org/trainingandevents/

Contact Information

ECHO Project
Jessica Leston, MPH (Tsimshian), Clinical Programs Director
David Stephens, BSN, RN, ECHO Clinical Director
Eric Vinson (Cherokee) Project Manager
Phone: 503-416-3295 Email: evinson@npaihb.org

CHAP BOARD ADVISORY WORK GROUP, SUE STEWARD, CHAP PROJECT DIRECTOR

Purpose:

- To inform and support the strategic direction and development of a Portland Area CHAP Federal Certification Board in accordance with IHS policy (yet to be finalized) as referenced in IHCIA title 25 section 1616L that provides DHAT's, BHA/P's and CHA/P's aka Tribal Health Providers (THP) individual certification as well as review and certification of training centers, curricula, continuing education and manuals that dictate patient care.

CHAP Board Advisory Work Group

Currently we have 36 members but we welcome all interested persons. Voting is limited to one vote per tribe or partner organization.

Project Funding

- Washington tribes provided a percentage of their Medicaid Transformation Funds as detailed in Resolution 18-03-09 for CHAP Area Certification Board project start up.

CHAP TAG
Circular 18-01

- To provide subject matter expertise, program information, innovative solutions, and advice to the I.H.S. to establish a National CHAP.

IHS

- Meetings
  - August 17 in Seattle
    - Version IV
  - October 10 at HQ
    - Version V
- The good news is that the I.H.S. draft now includes tribal participation and has language including ACCB's. Honest conversation was held about what responsibilities a National CB could reasonably execute.
- 11/5/18 CHAP TAG requested that IHS provide an updated policy for discussion. IHS agreed to submit that by the next Friday and reschedule teleconference. That did not happen.
- 12/20/18 Version VI of draft policy was sent out to CHAP TAG with letter that it would be announced at the January 3, 2019 Tribal Leaders and Urban teleconference and a DTLL would be forth coming.
- 12/21/18 Partial Government shut down.
- 1/3/19 No announcement at Tribal and Urban Leaders Teleconference.
- 1/4/19 A letter was prepared by CHAP TAG and sent to IHS under signature of chairperson Dr. Segay's signature expressing CHAP TAGs concern that they did not approve the current draft being sent out for tribal consultation.

Analysis of AK Standards & Procedures

- Our focus is on those sections that relate to DHATs;
- We have completed review and legal analysis of the first 5 chapters;
- Our next face to face meeting is Thursday Noon to 4 PM to review the remainder of the AK S&P for DHATs needing certification to practice in June.
- June 2019 we celebrate the return of 7 graduating DHATs
  - (1) Coeur d'Alene (Idaho)
  - (1) NARA (Oregon)
  - (1) Colville (Washington)
  - (2) Lummi (Washington)

  - (2) Swinomish (Washington)
- The Alaska standards and procedures were develop for Alaskans by Alaskans after many years of CHA training and education.

Plan B

- The partial shutdown of the U.S. Government may delay the release of an IHS Interim CHAP Policy;
- Temporary Solutions
  - Swinomish Licensing
  - Alaska CHAP Certification Board

Costs

- A Portland Area feasibility study will need to be completed, but we know this about the AK CB costs;
  - Current certification is about 600;
  - This amounts to about 150K annually;
  - Certification costs $500.00 q 2 years

Draft PACCB Resolution

- We are targeting April QBM to introduce a Resolution to create and seat Portland Area Federal Certification Board

Next Steps

- Finalize the draft Resolution;
- Submit it to the Policy Committee;
- Suggest membership

LUNCH

January 22 - 24, 2019
MINUTES

2019 POLICY AND LEGISLATIVE PRIORITIES, LAURA PLATERO, DIRECTOR OF GOVERNMENT AFFAIRS, AND SARAH SULLIVAN, HEALTH POLICY ANALYST

Summary of 2019 Legislative and Policy Priorities
January 23, 2019

Votes	Area	Request
18	Elders	Funding for elders to pay for and receive in home care by family members (7) Conduct study to show where funding is needed for in home care (3) Need assisted living because not all tribes have it (4) Create-in patient encounter rate and provide hospice care (4) Funding for eyeglass purchases (0) Conduct study to provide all services (dental, podiatry) (0)
16	Legislation & Policy	Preserve Medicaid/CHIP & 100% FMAP (6) Equal Access for AI/AN under Medicaid (6) Ensure inclusion of tribes in Medicaid initiatives (4)
15	Behavioral Health	Regional Residential Treatment Centers for youth substance use/mental health (aftercare and transitional living)
14	Policy & Behavioral Health	IHS Health IT Modernization (11) Identify EHR systems with funding assistance for start up (3)
14	Legislation & Appropriations (IHS)	Preserve the Indian Health Care Improvement Act and Indian-Specific Protections in the ACA (7) Fully fund IHCIA- provider recruitment, BH and long term care (7) [New: Research needed to determine if regional residential treatment centers for youth substance use should be added as a requested amendment to ICHIA]
13	Veterans	Streamline the process for establishing MOUs/MOAs between the VA and I/T/U clinics (6) New (Andrew): Request that tribal clinics with Medicaid eligibility meet the requirements to enter into a VA reimbursement agreement (not Medicare only) Reimbursement for PRC (4) Conduct a tribal-specific needs assessment -- We cannot address Native veterans issues without knowing them (1) Create/expand transition services for soldiers leaving the military (1) Preserve reimbursement agreements in legislation (1)

January 22 - 24, 2019
MINUTES

Votes	Area	Request
		Pass legislation creating a VA TAC (0) New (Marilyn): Coordinate regional VA efforts between states, VISN, ATNI, and tribes. New (Kim): VA requires a clearinghouse, needs to open up to be added.
12	Appropriations (IHS)	Fully fund IHS
11	Appropriations (IHS)	Fully fund small ambulatory facilities with staffing packages (6) Fund regional referral specialty care centers (5)
10	Legislation	Exempt IHS from Sequestration
10	Youth	Include youth in all HHS initiatives
9	Public Health	Create Public Health Emergency Fund at HHS that tribes access for tribally declared emergency.
9	Behavioral Health, Appropriations (IHS) & Policy	Nationalize and Fund CHAP- BHAs and DHATs
9	Behavioral Health	Need peer counselors for SUD (3) For MAT, need more data waivers to have providers be able to prescribe more MAT (currently there is a limit). (2) Add MAT/Saboxone alternatives and other modalities, including traditional healing. Clear guidance on 42 CFR and how information can be shared. (2) Develop training for increased midlevel SUD providers (2)
8	Legislation	Support transfer of IHS Appropriations from jurisdiction of Interior, Environment & Related Appropriations to Labor, Health and Human Services, Education and Related Appropriations
7	Appropriations & Policy	Fund HCV treatment (on IHS RX formulary, no funds) (3) Fund HIV/HCV treatment (HHS SMAIF) (3) Increase Medicaid Access to HCV Treatment (1)
7	Public Health	Support tribal public health infrastructure (4) Social determinants of health- Equity in funding to address social/economic factors that impact health across agencies (tribal/federal/state/local) (2) Environment and Health Effects- Asthma & Housing contamination and others (1)
6	Legislation	Advance Appropriations for IHS
3	Legislation	Permanently Reauthorize the Special Diabetes Program for Indians

Votes	Area	Request
3	Appropriations (IHS)	Increase funding for IHS scholarship program, include mid-level providers.
2	Legislation	Mandatory funding for IHS
2	Appropriations (IHS)	Market pay increases for providers (direct service tribes)
2	Appropriations (IHS)	Increase funding for sanitation and maintenance and improvement
2	Appropriations (HHS)	Increase funding for Native American Center for Excellence
1	Legislation	Require IHS to provide detailed breakdown of IHS funding nationally and to areas
0	Legislation	Equity in Health Care Facility Funding

PUBLIC HEALTH EMERGENCY PREPAREDNESS WORK, LOU SCHMITZ, AMERICAN INDIAN HEALTH COMMISSION (AIHC) CONSULTANT

AIHC's PHEPR Priorities

•Strengthening Tribal Capacity

–Tribal Community Emergency Preparedness Toolbox (2016)–Facilitated Community preparedness Self-Assessments (2018)

–Medical Countermeasures Distribution Tabletop Exercises (2018)

–Proposed Legislation –Washington Emergency Management Council Representation (2019)

–Emergency Vaccine Distribution Planning Meetings (2016)

–Emergency Vaccine Distribution Tabletops (2016)

–Tribal PHEPR Needs Assessments (2015)

–Training and Technical Assistance (Ongoing)

AIHC's PHEPR Priorities

•Strengthening Relationships with PHEPR Partners

–Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State (2017)

–Cross-Jurisdictional Collaboration Planning Meetings (2018)

–Advocacy with CDC on Medical Countermeasures Distribution to Tribes (2018)

–Emergency Vaccine Distribution Planning (2016)

–Training and Technical Assistance (Ongoing)

AIHC's PHEPR Work -National Efforts

•National Public Health Law Conference 2018
•National Academy of Science –Evidence-Based Public Health Emergency Preparedness Study •Department of Homeland Security –Smart Cities Assessment Project
•National Indian Health Board –Public Health Emergency Preparedness and Response Initiative, January 30 Webinar

Work Ahead

•Develop draft language for CDC/ASPR
–Clarify roles and responsibilities for CDC/ASPR, states, local governments, tribes
–Clarify process for tribes who choose to work directly with CDC/ASPR
•Develop draft language for DOH
–MCM Distribution to Tribes Guidance Document
–Annex 9 revisions

Work Ahead

•Develop draft language for LHJs' plans
–Process for including tribes in communication, decision-making and coordination of response actions during responses
•Develop Model Tribal MCM Plan
–Host training webinar

Work Ahead

•Analyze WA State Pharmacy MOU
–Determine whether it is a viable mechanism for tribes to access MCM

–If not, develop a more appropriate alternative
•Develop system for tribes and other PHEPR partners to share essential information for public health emergency responses

Work Ahead

•Develop curriculum and provide training to tribes and urban programs on Point of Dispensing (POD) planning and operations

•Provide information and technical support for tribes to participate in the statewide T-Rex MCM distribution exercise

•Host MCM distribution planning meetings for each of the 9 regions with tribes, LHJs, DOH and other PHEPR partners

•Host a Mutual Aid Agreement workshop for the tribes and LHJs in Region 9 (Colville, Kalispel, Public Health Improvement and Program Planning Spokane)

PUBLIC HEALTH IMPROVEMENT AND PROGRAM PLANNING, BRIDGET CANNIFF, PUBLIC HEALTH IMPROVEMENT & TRAINING PROJECT DIRECTOR

Public Health Improvement & Training

- Tribal Public Health Capacity Building & Quality Improvement (QI)
- Oregon State Health Improvement Plan (SHIP)
- Tribal Public Health Emergency Preparedness

Foundational Public Health Services

See PowerPoint for additional graphics

Quality Improvement (QI) in Public Health

"**Quality improvement in public health** is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measureable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community."

Public Health Improvement: QI, PM, WFD

Performance Management

- Systematic process which helps an organization achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining decision making

Workforce Development

- Attempt to improve health outcomes (→ healthier people) by enhancing the training, skills, and performance of public health workers

Public Health Accreditation

Goal: Improve & protect the health of the public by advancing the quality & performance of Tribal, state, local, & territorial public health departments

- Measurement of health department performance against a set of standards
- Issuance of recognition of achievement of accreditation

- Continual development, revision, & distribution of public health standards

Public Health Improvement Resources

- American Public Health Association apha.org
- Public Health Accreditation Board phaboard.org
- Public Health Foundation phf.org
- National Network of Public Health Institutes & Public Health Learning Network nnphi.org
- Public Health Institutes & Regional Public Health Training Center: Oregon Public Health Institute ophi.org, Northwest Center for Public Health Practice nwcphp.org
- State Health Departments (WA DOH, OHA, ID DHW)
- Seven Directions, Indigenous Voices for Public Health indigenousphi.org
- National Indian Health Board nihb.org

Public Health Capacity Building & QI

- NEW funding: CDC Tribal Public Health Capacity Building & QI umbrella grant
  - $22K for public health capacity & QI training/TA
  - $258K for opioid response strategic planning
  - $2.6M for national death index data linkages
- Provide technical assistance (TA) and training to Northwest Tribes
  - Discussion group: public health infrastructure & improvement, QI, accreditation readiness
  - Training: 1 session in FY2019 – date, location, topic(s) TBD
    - What's on your tribe's wishlist?

OR State Health Improvement Plan

- NPAIHB: 1 of 7 community organizations receiving mini-grants from Oregon Health Authority (OHA)
- Survey outreach to AI/AN residents of Oregon
  - Tribes, Tribal/Urban Indian Organizations, other Native-serving groups
- One week left to respond – help spread the word! Visit NPAIHB Facebook page or bit.ly/2020SHIP
- Report due to OHA January 31

Public Health Emergency Preparedness

- 2019 NW Tribal Public Health Emergency Preparedness Conference & Training
- Early June, exact dates & location TBA
- Funded by WA DOH, OHA, NPAIHB/NWTEC

- In partnership with NW Tribes, AIHC, NW Center for Public Health Practice
  - Tribal reps needed for planning committee!

NPAIHB Staff Contacts
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CHAIRMAN'S REPORT, ANDY JOSEPH, JR.

I hope that you all enjoyed the holidays with your families. I wish that 2019 had not started off in a partial government shutdown. It is our people that suffer when a shutdown occurs which is why we need Congress to approve advance appropriations for the Indian Health Service. The federal government must honor its trust responsibility so that our people never experience lapses in care. We must also keep advocating for full funding for the Indian Health Service.

Since this issue is focused on behavioral health, we must also continue to ask for continued increases and flexible funding for behavioral health services. Many of our people are afflicted with complex mental health issues and substance use issues much of it a result of the harmful federal policies implemented over many generations. These policies displaced many of our people and disconnected them from our traditional ways and ceremonies. Our traditional interventions are critical to the healing process and should always be considered for funding and reimbursement because they work for us.

Serving on the Substance Abuse Mental Health Services Administration (SAMHSA) Tribal Technical Advisory Committee (SAMSHA TTAC) and Community Health Aide Program Workgroup has allowed me to be a strong voice for behavioral health needs. On the SAMHSA TTAC I have been able to advocate for our people to SAMHSA leadership. In 2018, I was pleased to see the significant funding to address the opioid epidemic and SAMHSA's new approach to getting tribes funded. It is not perfect, but it is a start. I am also glad to sit on the Community Health Aide Program (CHAP) Workgroup and look forward, in the future, to having Behavioral Health Aides (BHAs) as part of our care system in the Northwest.

I appreciate all the people, the departments, and our board for all the work that you do. Your work saves the lives of many of our people both on reservations and in urban communities. I am honored to serve as your Chairman and wish you all a happy and healthy 2019.

CROSSWALK COMPARISON OF COMMUNITY & BEHAVIORAL HEALTH AIDES AND EXISTING PROVIDERS IN WASHINGTON STATE, TESS ABRAHAMSON-RICHARDS, MPH RESEARCH ASSOCIATE

Introducing Community and Behavioral Health Aide Services in Washington State: A Gap Analysis - Assessing mid-level provider staffing needs in tribal and urban Indian health and behavioral health clinics in Washington State

Background

Why a Gap Analysis?

- Describing the existing landscape of Washington tribal medical and behavioral health services
- Understanding the need for additional training and licensing pathways for mid-level providers in tribal communities
- Getting from where we are to where we want to be

Overview of Gap Analysis Methodology

- Determining where there is a need, deficit, or breakdown (i.e. a gap) between the current and ideal situation
- Determine the root causes of the gap
- Analyze proposed solutions; And/Or,
- Identify root causes that are more versus less subject to influence based on things like: character of the issue, time and monetary parameters, available solutions

Goals of this Gap Analysis

1. Understand what underlying factors contribute to the need for mid-level medical and behavioral health providers in Washington Tribal and urban Indian communities
2. Describe specific data points and qualitative information characterizing this regional demand, meaning how do we know there's a shortage and what does it look like on the ground?
3. Analyze the potential of the Community and Behavioral Health Aide program to address the provider shortage

A quick footnote

- What do the terms "mid-level" and "paraprofessional" refer to?
- Both terms can be used to refer to positions in the medical and behavioral health field that do not require graduate degrees, such as nurses, nurse assistants, mental health counselors, chemical dependency professionals, etc. We use "mid-level" in this analysis and presentation.

- "Mid-level provider" has in the past been used by some in the medical field to refer to Nurse Practitioner and Physician Assistant providers, but those professionals are now commonly referred to as "Advance Practice Providers."

Gap Analysis Overview
- Community Health Aides (CHA/Ps)
- Behavioral Health Aides (BHA/Ps)

Methods
- Tiered data collection strategy
  - Review of existing data
  - Tribal and urban clinic outreach
  - Key informant inquiries

Existing Data Sources
- Health Provider Shortage data
- BHA Program Roll Out Feasibility Report conducted by Cumming
- AIHC Health Profiles
- Data from the Alaska CHA/P & BHA/P Programs

Tribal and Urban Clinic Outreach
- Clinics/programs were sampled in order to reflect a diversity of: geography, proximity to urban area; service population size; IHS vs. tribally-run
- We asked program personnel about: Current staffing levels; Turnover; Ease of filling open positions; Capacity to meet service demands; Factors influencing overall capacity to provide services

Key Informant Interviews
- Clinic/Program Managers
- Consultants
- Advisory Committee Members

Findings

Aim 1 - Understand what underlying factors contribute to the need for mid-level medical and behavioral health providers in Washington Tribal and urban Indian communities

Aim 1 Overview
- Background Aim
- Establishing considerations underpinning Aims 2 & 3
- Drawing on existing data from key informants closely involved in CHAP implementation

Identifying Underlying Issues

- We will present information related to current provider shortages; however, identifying the underlying factors contributing to these shortages is key to understanding how the addition of Community and Behavioral Health Aide providers and the associated training and funding infrastructure can address these shortages.

These issues include:

- A Trained Workforce
- Community/ Clinic Infrastructure
- Position Funding

A Trained Workforce

- Training that is affordable, culturally and contextually specific, and accessible for tribal students can be very challenging
- The CHA/P and BHA/P program implementation is working towards an accompanying community-partnered education training program through a local tribal college and/or community college partnership

Community/Clinic Infrastructure

- It is critical that infrastructure to support new providers is developed alongside the positions themselves in order for providers and programs to benefit
- Programs will be developed in partnership and support NPAIHB, and funding structures will be in place for program implementation as well as ongoing services and administration.

Position Funding

- New positions must be able to bill against existing funding sources or access new revenue streams
- Exact billing details have not been finalized for the CHA/P and BHA/P programs, but they will be an essential component of implementation

Aim 2 - Describe specific data points and qualitative information characterizing this regional demand

Aim 2 Overview

- Central component of this gap analysis
- Examining concrete metrics and on-the-ground expertise
- Triangulating quantitative and qualitative data sources to gather a richer picture of regional provider demand

Health Provider Shortage Areas

- A Health Provider Shortage Area (HPSA) is a regional designation that indicates practitioner shortages in dental health, behavioral health, or primary care.
- The National Health Service Corps developed a HPSA scoring system to determine regional-level health provider shortages and to thereby prioritize areas of greatest need.
- Scores range from 1 to 26, with 26 being the highest priority.
- A such, we categorized programs into low (1-9), moderate (10-16), and severe (17+) HPSA score groups, indicated by light, medium, and dark blue dots on the following maps

WA Tribal and UIHP Clinic Medical Provider HPSA Designations

- 1-9 low
- 10-16 med
- 17+ high

Notable Findings from the Cumming Report on BHA rollout

- AIAN individuals and communities experience a large unmet need for providers and access to providers
    - "Of those with a mental [health] disorder, only 32 percent had received mental health or substance abuse services."
    - Nationally, AIAN individuals have access to 42% fewer providers per 100,000 populations than whites
- Demand projections suggest that most tribes in WA could use 1 BHA provider initially, with larger communities eventually adding a 2nd BHA provider
- List of BHA training and program needs in the Cumming Report offer a starting point, but will need to be further updated for Washington's program
- The forthcoming demonstration project with 3-6 students starting later this year will provide key insights for continued planning and roll-out activities

American Indian Health Commission Data

- Data on current behavioral health staffing was a starting point for sampling and outreach to programs (CHAP-comparable provider data not available)
- Service population data provides greater specificity than census or other sources
    - Most programs serve a broader population than solely their tribal members
- Overview of range of services provided
    - Primary and emergency care
    - Obstetrics

- Youth and elder specific programs
- Physical therapy
- Community health services
- Case management, home-based, and care coordination services
- Outpatient and Inpatient treatment
- Individual, family, and group counseling
- Psychiatric care
- Suicide prevention

Qualitative Interview Findings

- Behavioral health integration is a key contextual issue when thinking about existing and new providers' roles and capacity
- There is interest in CHA/Ps and BHA/Ps at some facilities because these providers can meet a wide range of service needs whereas other providers may need to be more honed in on a certain scope of practice
- Similarly, there are many instances where current providers *are* practicing beyond the scope of their core duties (e.g. offering transportation, conducting community or home-based outreach, etc.) and that limits their ability to fully do their assigned job or serve more patients
- Varies from agency-to-agency, but both finding and retaining qualified providers at the mid-level is an issue for many agencies
- Other related issues tribal and urban medical and behavioral health programs face include working to offer attractive/competitive salaries, infrastructure barriers to adding providers (e.g. space, funding, equipment),
- Connection to community and service orientation helps retention
- Patient and community outreach benefit health outcomes; asks more of providers and other staff, but is effective for getting patients through the door

Aim 3 - Analyze the potential of the Community and Behavioral Health Aide program to address the provider shortage

Aim 3 Overview - Understanding how the CHAP program may be able to address the underlying issues established in Aim 1 and the shortage described in Aim 2
Drawing on data from the Alaska program and Key Informant consultation with those closely involved with CHAP implementation

Advantages of CHA/P and BHA/P staffing in tribal clinics

- Growing our own

- Training/educational investment promotes retention
- Filling a needed service gap

Successes in Alaska

- Increased access to care and provision of services: 550 CHAs in over 170 villages
  - CHA/Ps offer consistent local access to primary care and local emergency response
- Health outcomes have improved in a variety of metrics since CHAP introduction (access to care, infant mortality, life expectancy, hospitalization rates)
- Patients and providers report very favorably about their experiences with CHA/Ps and the impact of their work
- Cost savings related to transport and contract care
- Sources: Akchap.org
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3417638/
- https://www.uaa.alaska.edu/academics/college-of-health/departments/ACRHHW/dataandreportspages/_documents/2004%20The%20Alaska%20Community%20Health%20Aide%20Program_An%20Integrative%20Literature%20Review%20and%20Visions%20for%20Future%20Research.pdf

Resources and Partnerships to Support the Programs' Success

- Training and education program structure
- NPAIHB CHAP Project
- Alaska program resources, AK CHAP staff, and the Alaska CHAP certification board
- Washington Dental Health Aide Therapy Program

Outstanding Areas to Address

- Certification
- Funding and billing
- Training program curriculum

Limitations

- Staffing data more limited at the mid-level
- Employment numbers and service gaps are in a state of constant flux
- Staffing need is more complicated than vacancies; funding and billing specifics also play an important role

Conclusions

- The need for mid-level medical and behavioral health providers in tribal and UIH programs is well supported by available data

- The broader structure of the Community and Behavioral Health Programs will be critical to their success and merits uniquely focused attention alongside the tasks of recruiting, training, placing, and supporting individual providers

NW JUVENILE JUSTICE ALLIANCE, DANICA BROWN, BEHAVIORAL HEALTH MANAGER

Tribal-Researcher Capacity Building Grant

- U.S. Department of Justice (DOJ)
- Office of Justice Programs (OJP)
- National Institute of Justice (NIJ)
- Northwest Portland Area Indian Health Board

Planning Grant: Will form a new inter-tribal workgroup
NW Tribal Juvenile Justice Alliance (NW TJJA)
Dates: 01/01/19 - 06/30/2020

Aim: Facilitate a strategic planning process

While AI/AN youth in the region experience disproportionate rates of juvenile justice involvement, no planning body is presently convening decision-makers to elevate these important health and safety research questions in AI/AN communities.

Juvenile Justice: A Public Health Issue

Risk Factors:
Historical trauma
Poverty
Victimization and violence
Mental health and suicide
Substance abuse and dependency
HepC and HIV

Establish Tribal-Researcher Partnerships to:

- Identify, test and expand best practices that improve Juvenile Justice systems for Tribes in the Pacific Northwest,
- Ensure that non-Native justice systems are improving life outcomes for AI/AN youth who interact with their services, and
- Build tribal capacity to access and utilize data that support quality improvement at the community-level.

Aims for the NW Tribal Juvenile Justice Alliance:

AIM 1: Convene, monitor, and support collaborative research and surveillance activities carried out by a network of research partners and community experts, by planning and facilitating 6 regional planning meetings and quarterly NPAIHB Board Meetings.

AIM 2: Support bi-directional communication between research partners, NW Tribes, local tribal governments, OJJDP grantees, topical experts and other regional stakeholders.

AIM 3: Design and submit a DOJ study, aimed to improve Juvenile Justice systems for Tribes and AI/AN youth in the Pacific Northwest.

Partners

The Northwest Portland Area Indian Health Board (lead)
Tribes in the Pacific Northwest (Oregon, Washington, and Idaho)

- Confederated Tribes of the Colville Reservation, WA
- Confederated Tribes of the Umatilla Indian Reservation, OR
- Cowlitz Indian Tribe, WA
- Kooteni Tribe of Idaho, ID
- Confederated Tribes of Warm Springs, OR
- Shoalwater Bay Indian Tribe, WA
- Spokane Tribe of Indians, WA
- Lower Elwha Klallam Tribe, WA
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians, OR

Other Member-Tribes of the NPAIHB, during QBM updates
NPC Research (Topical Expert)
State Juvenile Justice Departments in the Pacific Northwest

Create and Administer Data Collection Tools (with NPC) to:

Identify **Data Sources** that could inform our understanding of Juvenile justice disparities or concerns for our NW Tribes

Identify **Best Practices** & **Research Priorities**:

- Literature Review
- Stakeholder Surveys
- Key Informant Interviews

Planning Deliverables

- **Final Research Report:** The NPAIHB will prepare and submit a final research proposal that complies with the instructions provided in Section D, based on the funding criteria provided in Section E.
- **Special Report:** The NPAIHB will also prepare and submit a special report detailing the tribal-research partnership. The report will thoroughly capture the process and substance of the collaboration, including: lessons learned, challenges and successes experienced, and overall reflections. The special report will map out key issues that can help inform existing or future partnerships of a similar nature.
- **Required Data Sets and Associated Files and Documentation:** The NPAIHB will submit to the National Archive of Criminal Justice Data (NACJD) all data sets that result in whole or in part from the work funded by the award, and will enter into data-sharing agreements with the DOJ that protect the rights and welfare of NW Tribal data.
- **Publications:** The team will disseminate research findings to the DOJ and the scientific community, through scholarly publications.

Danica Love Brown, MSW, PhD
Choctaw Nation of Oklahoma
Northwest Portland Area Indian Health Board
Behavioral Health Manger
503-416-3291
dbrown@npaihb.org

5:10 p.m. Recess

QUARTERLY BOARD MEETING

Suquamish Clearwater Casino Resort
15347 NE Suquamish Way
Suquamish, WA 98392

January 22 - 24, 2019
MINUTES

THURSDAY JANUARY 24, 2019

Call to Order: Andy Joseph, Chairman, called meeting to order at 8:35 am.

Invocation: Andy Joseph

Committee Reports

Elders Committee – Theresa Lehman, Jamestown S'Klallam (A copy of the report is attached)

Veterans – Jim Steinruck, Tulalip (A copy of the report is attached)

Public Health – Andrew Showgren, Squamish (A copy of the report is attached)

Behavioral Health – None (A copy of the report is attached)

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

Youth – **Tana Atchley-Culbertson, NPAIHB** (A copy of the report is attached)

Finance Report: Eugene Mostofi motion to approve: **by Andrew Shogren (Suquamish) 2nd Debra Jones (Samish Nation); MOTION PASSES**

Minutes: Motion to approve: **by Greg Abrahamson (Spokane) 2nd by Shawna Gavin (Umatilla); MOTION PASSES**

Legislative/Resolution Committee – Laura Platero (A copy of the report is attached)

RESOLUTIONS:

We R Native: "How Can Technology Support AI/AN Adolescent Mental Wellness?"

Needs to be ratified: Motion by Cheryle Kennedy, Grand Ronde, 2nd by Shawna Gavin, Umatilla**: MOTION PASSES**

Advance Appropriations for Indian Health Service

Motion by Shawna Gavin, Umatilla, 2nd by Cassie Sellards-Reck, Cowlitz; **MOTION PASSES**

QUARTERLY BOARD MEETING

Suquamish Clearwater Casino Resort
15347 NE Suquamish Way
Suquamish, WA 98392

January 22 - 24, 2019
MINUTES

Formal Recognition of Tribal Youth Delegate Program

Motion by Shawna Gavin, Umatilla, 2nd Kim Thompson, Shoalwater Bay; **MOTION PASSES**

Meeting ADJOURN at 9:22 am Motion to adjourn Shawna Gavin, Umatilla, 2nd by Kim Thompson, Shoalwater Bay

_____ _____

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

_____ _____

Reviewed by Joe Finkbonner, RPh, MHA, **Date**
NPAIHB Executive Director

_____ _____

Approved by Greg Abrahamson,
NPAIHB Secretary **Date**

QUARTERLY BOARD MEETING

Suquamish Clearwater Casino Resort
15347 NE Suquamish Way
Suquamish, WA 98392

January 22-24, 2019

AGENDA

MONDAY JANUARY 21, 2019 (DEER ROOM B)

9 am – 5 pm - Youth Delegates Meeting

TUESDAY JANUARY 22, 2019 (SALMON HALL)

9 am – 12 pm - Youth Delegates Meeting (DEER ROOM B)
12 pm – 5pm - Joining the Quarterly Board Meeting

7:30 AM	**Executive Committee Meeting**	
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call	Andy Joseph, Chairman Suquamish Tribal Council Suquamish Veterans Color Guard Shawna Gavin, Treasurer
9:15 AM	Executive Director Report **(1)**	Joe Finkbonner, NPAIHB Executive Director
9:30 AM	NPAIHB Committee Updates (National, IHS, State)	Committee Members
10:15 AM	Policy and Legislative Update **(2)** & Review of 2018 Policy and Legislative Priorities **(3)**	Laura Platero, Government Affairs/Policy Director and Sarah Sullivan, Health Policy Analyst
11:15 AM	NW Native American Research Center for Health (NW NARCH) & Prevention Research Center Update **(4)**	Dr. Tom Becker, NW NARCH Project Director
11:45 AM	Election of Officers • Vice-Chairman • Treasure • Sergeant-At-Arms	
	LUNCH	
12:00 PM	Committee Meetings *(working lunch)*	
	1. Elders	Staff: Clarice Charging
	2. Veterans	Staff: Don Head
	3. Public Health	Staff: Victoria Warren-Mears
	4. Behavioral Health	Staff: Stephanie Craig

QUARTERLY BOARD MEETING

Suquamish Clearwater Casino Resort
15347 NE Suquamish Way
Suquamish, WA 98392

January 22-24, 2019

AGENDA

	5. Personnel 6. Legislative/Resolution 7. Youth	Staff: Andra Wagner Staff: Laura Platero Staff: Tana Atchley
1:30 PM	Area Director Report **(5)**	Dean Seyler, Portland Area IHS Director
2:00 PM	Opioid Update **(6)**	Colbie M. Caughlan, MPH Project Director – THRIVE & Response Circles & Jessica Leston, MPH HIV/STI/HCV Clinical Programs Director
2:45 PM	Behavioral Health Aide Program **(7)**	Sue Steward, CHAP Project Director
3:30 PM	**BREAK**	
3:45 PM	Human Trafficking **(8)**	Jeri Moomaw, Executive Director Innovations HTC
4:30 PM	Executive Session	

WEDNESDAY JANUARY 23, 2018 (SALMON HALL)

9:00 AM	Call to Order Invocation	Vice-Chairman
9:15 AM	I-Lead - Youth Ambassador Update **(9)**	Tana Atchley, Youth Engagement Coordinator & Tommy Ghost Dog, We R Native Project Coordinator & Youth Delegates
9:45 AM	HRSA Shortage Designation Modernization Project – ***via teleconference*** **(10)**	Dr. Janelle McCutchen, Chief of BHW's Shortage Designation Branch- Health Resources and Services Administration (HRSA)
10:30 AM	Clinicians Update **(11)**	Eric Vinson, ECHO Project Manager
11:15 AM	Community Health Aide Program **(12)**	Sue Steward, CHAP Project Director &

QUARTERLY BOARD MEETING

Suquamish Clearwater Casino Resort
15347 NE Suquamish Way
Suquamish, WA 98392

January 22-24, 2019

AGENDA

		Andrew Shogren, Health Clinic Director Suquamish Tribe – CHAP Board Chair
12:00 PM	**LUNCH MEETINGS –** ***Cultural Presentation & Lunch <u>for ALL</u> (tentative)*** ***LOCATION TBD*** *and* *By invitation Oregon Tribes Pilot Project Luncheon - Location TBD*	
1:30 PM	2019 Policy and Legislative Priorities **(13)**	Laura Platero, Director of Government Affairs, and Sarah Sullivan Health Policy Analyst
2:30 PM	Public Health Emergency Preparedness Work **(14)**	Lou Schmitz, American Indian Health Commission (AIHC) Consultant
3:15 PM	Quality Improvement **(15)**	Bridget Canniff, Injury Prevention/Public Health Improvement & Training Project Director
3:45 PM	Crosswalk Comparison of Community & Behavioral Health Aides and Existing Providers in Washington State **(16)**	Tess Abrahamson-Richards, MPH Research Associate. James Bell Associates, Inc.
4:30 PM	**Tribal Updates** 1. Squaxin Island 2. Suquamish 3. Upper Skagit	
4:45 PM	NW Juvenile Justice Alliance **(17)**	Danica Brown, Behavioral Health Manager

QUARTERLY BOARD MEETING

Suquamish Clearwater Casino Resort
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January 22-24, 2019

AGENDA

THURSDAY JANUARY 24, 2018 (SALMON HALL)

8:30 AM	Call to Order Invocation	Andy Joseph, Chairman
8:45 AM	Chair's Report	Andy Joseph, Chairman
9:00 AM	Committee Reports: 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution 7. Youth	
9:30 AM	Unfinished/New Business 1. Finance Report 2. Approval of Minutes • October 2018 3. Resolutions 4. Future Board Meeting Sites: • *April 16-18, 2019 ~ La Conner, WA (Swinomish)* • *July 15-19, 2019 ~ Joint Meeting with CRIHB, (tentative dates, location TBD)* • *October 15-17, 2019 ~ Pendleton, OR (Umatilla Tribe)* • *January 21-23, 2019 ~ (TBD)*	Eugene Mostofi
12:00 PM	Adjourn	

THURSDAY JANUARY 24, 2018

CHAP Board Advisory Meeting, *after* the conclusion of the Board meeting

Northwest Portland Area Indian Health Board

Executive Director Report

Suquamish Clearwater Casino Resort
Suquamish, WA 98392
January 22, 2018

Joe Finkbonner, RPh, MHA

Northwest Portland Area Indian Health Board

Personnel

NEW HIRES:

ASHLEY THOMAS
NARCH Cancer Project Coordinator

MEGAN WOODBURY
Opioid Project Coordinator

PAIGE SMITH
(Klamath)
THRIVE & RC Coordinator

Northwest Portland Area Indian Health Board

Personnel

NEW HIRES:

Rosa Frutos
(Confederated Tribes of Warms Springs)
Cancer Project Coordinator

HEIDI LOVEJOY
Substance Use Epidemiologist

Michelle Singer
(Navajo)
Healthy Native Youth Project Manager

WELCOME TO QBM

- **Mattie Tomeo-Palmanteer**,
  (Confederated Tribes of Colville/Yakama Nation descendent)
  NARCH Asthma Project Coordinator
- **Karuna Tirumala**, IDEA-NW Biostatistician
- **Chelsea Jensen**, *(Confederated Tribes of Warm Springs)*
  WEAVE Project Assistant

Personnel

PROMOTIONS/TRANSFER:

- **Christina Peters**, TCHP Project Director
- **Nicole Smith,** Senior Biostatistician 1
- **Candice Jimenez**, (Confederated Tribes of Warm Springs) Research Manager
- **Danica Brown**, Manger(Choctaw Nation of Oklahoma), Behavioral Health Program

Personnel

TEMPS & INTERNS:

- Morgan Thomas
- Zoe Watson

Northwest Portland Area Indian Health Board

Personnel

RECOGNITION:

- **Clarice Charging**
  - **15 Years of Service Recognition**

- **Nora Frank-Buckner**
  - **2018 Employee of the Year**

Northwest Portland Area Indian Health Board

Meetings

NOVEMBER

- Public Health Leader Panel & Speed Mentoring, UW, Seattle, WA (11/6)
- 2018 American Indian Health Commission for Washington State's Tribal and State Leaders Health Summit, Suquamish, WA (11/8)
- EHS Presentation Shoshone-Bannock, Fort Hall, ID (11/13)
- 2021 PA Budget Formulation Meeting, Portland, OR (11/15)

Northwest Portland Area Indian Health Board

Meetings

NOVEMBER Cont.

- PHAB Board of Director's Meeting ~ Washington, DC (11/28-11/29)

DECEMBER

- NPAIHB Holiday Party ~ Friday December 7th, Grand Central Bowl (12/7)
- WA State Medicaid DHAT Spa Hearing, Seattle, WA (12/17)

Upcoming Meetings

JANUARY

- ANTI – Portland, OR (1/28-1/31)

FEBRUARY

- NCAI – Washington, DC (2/11-2/14)
  - **IHCIF**
  - **DSTAC**
  - **2021 Budget Formulation**

Upcoming Meetings

FEBRUARY Cont.

- Hill Visits (tentatively), Washington, DC (2/25-2/28)

MARCH

- Arcora Foundation Board Meeting, Seattle, WA (3/8)

Upcoming Meetings

MARCH Cont.

- PHAB Board Meeting, Washington, DC (3/19 - /3/20)

APRIL

- IHS Tribal Self-Governance Annual Consultation Conference, Traverse City, MI (4/1-4/4)

Northwest Portland Area Indian Health Board

Youth Delegates

The Tribal Youth Delegates will be joining the Legislative Committee at lunch to present a resolution for formal recognition by the Board.

Northwest Portland Area Indian Health Board

Youth Delegates

- They will also be working with a film crew to develop some recruitment videos for the Youth Delegate Program.
- If there are any Delegates who are interested in being a part of this video project, they can learn more at the Youth Committee meeting.

Northwest Portland Area Indian Health Board

Youth Delegates

Youth Delegates attending will be:

- **Sadie Olsen** (Lummi)
- **William Lucero** (Lummi)
- **Jedah DeZurney** (Siletz)
- **Adilia Hart** (Umatilla)
- **Lindsey Pasena Little Sky** (Umatilla Rep - Pueblo of San Felipe)
- **Cheydon Herkshan** (Warm Springs)
- **Josiah Spino** (Warm Springs)
- **Lark Moses** (Umatilla)

Northwest Tribal Epidemiolgy Center Survey

- The EpiCenter and it's WEAVE NW project are requesting Tribal delegate assistance in completing a The EpiCenter Priorities survey which also includes questions about chronic disease policies in your Tribal community. This survey was last administered in 2015/2016.
- We ask that this survey is completed by March 1st. All those that do complete their survey by that date will be entered into a drawing for a Tribal blanket.

Survey is on your IPad

Questions…?

National and Regional Committee Updates

Hosted by the Suquamish Tribe
Suquamish Clearwater Casino Resort
January 22, 2019

National and Regional Committees

- U.S. Department of Health and Human Services (HHS)
- Indian Health Service (IHS)
- Substance Abuse Mental Health Services Administration (SAMHSA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- National Institutes of Health (NIH)

HHS Secretary's Tribal Advisory Committee (STAC)

- Primary purpose of HHS Secretary's Tribal Advisory Committee (STAC) is to seek consensus, exchange views, 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 Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Gail Hatcher, Klamath (Alternate)
- Meetings:
  - Last meeting: HHS Updates December 11-12 in Washington, D.C
  - **Next meeting: February 7-8 in Washington, D.C.**

HHS STAC Discussion Items

- HHS Workgroup on Workforce Development
- National Advisory Committee on Rural Health and Human Services Overview and Update
- HHS Reimagine "Re-Invent Grants Management" Overview
- HHS Tribal Advisory Committee Discussion
- President's Council on Physical Fitness

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 Representatives:
  - Cassandra Sellards-Reck, Cowlitz (Primary)
  - Sharon Stanphill, Cow Creek (Alternate)
- Conference calls-Third Wednesday of every month 1-2pm PST.
- Last meeting: December 12-13 in Tucson, AZ
- **Next meeting: March 19-20, 2019 in Washington, D.C. (proposed)**

IHS 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.
- Portland Area Representatives:
  - Workgroup Co-Chair, Andy Joseph, Jr., Colville
  - Steve Kutz, Cowlitz Tribe
- FY 2021 National Budget Formulation Meeting:
  - **Next meeting: February 14-15 in Crystal City, VA**

IHS PRC Workgroup

- The charge of the IHS Director's Workgroup is to provide recommendations to the Director on strategies to improve the agency's PRC programs. Reviews input received to improve PRC program, evaluates the existing formula for distributing PRC funds, and recommends improvements in the way PRC operations are conducted within the IHS and Indian Health System.
- Portland Area Representatives:
  - Andy Joseph, Jr., Colville (Primary)
  - John Stephens, Swinomish (Alternate)
- Meetings:
  - Last meeting: October 16-17, 2018 in Portland, OR
  - Next meeting: **TBD**

IHS CSC Workgroup

- The CSC Workgroup meets to further the federal government's administration of CSC within the IHS. The agency is in active participation with Tribes, has developed a comprehensive CSC policy to implement the statutory provisions of ISDA.
- Portland Area Representative:
  - Tribal Co-Chair, Andy Joseph, Jr., Colville
- Meetings:
  - Last meeting: April 23, 2018 12:00pm-1:30pm in Albuquerque, NM
  - Next meeting: **TBD**

IHS 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 Representatives:
  - Janice Clements, Warm Springs (Primary)
  - Greg Abrahamson, Spokane (Alternate)
- Meetings:
  - Last meeting: October 1-3, 2018 in Washington D.C.
  - **Next meeting: Postponed**

IHS 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 Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Tyson Johnston, Quinault (Alternate)
- Meetings:
  - Last quarterly meeting: October 1-4, 2018 in Washington D.C.
  - **Next quarterly meeting: Rescheduled for April 24-25, 2019 in Washington D.C.**
  - 2019 TSGAC Annual Conference: March 31-April 4, 2018 in Traverse City, MI.

IHS IHCIF Workgroup

- Indian Health Care Improvement Fund (IHCIF) Workgroup was established in anticipation of a FY 2018 IHCIF appropriation to assess the impact of past allocations to address inequities, effects of the current health care environment, and make recommendations that will be sent out for tribal consultation.
- Portland Area Representatives:
  - Gail Hatcher, Klamath (Primary)
  - Steve Kutz, Cowlitz (Alternate)
- Meetings:
  - Last meeting: December 12-13, 2018 in Rockville, MD.
  - **Next meeting: Postponed**

IHS IHCIF Workgroup Decisions

- Consideration of a second bucket of funding that would allocate funding based on health disparities and access to care.
- Main bucket would go through formula but second bucket could potentially provide funding to all Areas based on these new factors and funds would then get distributed to Areas with highest need.
- Congress has questioned why all Areas didn't get funding. IHS is exploring what data could be used for these new factors and will present back to workgroup by phone/webinar before the next meeting.

Northwest Portland Area Indian Health Board

IHS IHCIF Sub-Workgroup Decisions

Benchmark Workgroup:

•Finished their work and transferred the facility factor, to the access to care workgroup.

User Population Workgroup:

•Fractionalization analysis still outstanding

Alternate Resources Workgroup:

•waiting for evaluation on NDW data and whether this can be used. Preference of workgroup is to use this data but without analysis of the data, the workgroup can't make a decision.

Access to Care Workgroup:

•Unable to pinpoint a solid factor to move forward for access to care. This resulted in discussion and decision to look at another budget that could include access issues.

Northwest Portland Area Indian Health Board

IHS CHAP TAG

- The Community Health Aide Program (CHAP) Tribal Advisory Group (TAG) will provide subject matter expertise, program information, innovative solutions, and advice to the Indian Health Service (IHS) to establish a national CHAP.
- Portland Area Representatives:
  - John Stephens, Swinomish (Primary)
  - Andy Joseph, Jr., Colville (Alternate)
- Meetings:
  - Last meeting: October 10, 2018 in Rockville, MD.
  - Next meeting: **TBD**

Northwest Portland Area Indian Health Board

IHS CHAP TAG Updates

November 5:

•CHAP TAG requested that IHS provide an updated policy for discussion.

December 20:

•Version VI of the draft policy was sent out to CHAP TAG with letter that it would be announced January 3, 2019 on the IHS Tribal Leaders and Urban Conferees monthly call, but it wasn't.

January 1:

•CHAP TAG submitted a letter to IHS expressing concern that the most current draft policy was not approved by the TAG prior to being finalized for tribal consultation

In Process:

•NPAIHB is preparing a separate letter to IHS

IHS NTAC

- The National Tribal Advisory Committee (NTAC) on Behavioral Health acts as an advisory body to the Division of Behavioral Health and to the Director of the Indian Health Service, with the aim of providing guidance and recommendations on programmatic issues that affect the delivery of behavioral health care for American Indian and Alaska Natives.
- Portland Area Representatives:
  - Cassandra Sellards Reck, Cowlitz (Primary)
  - Cheryl Sanders, Lummi (Alternate)
- Last meeting: December 12-13 in Tucson, AZ
- **Next meeting: Week of March 11, 2019 in California (proposed)**

IHS NTAC Updates

- For past two meetings, NTAC has been discussing proposed changes to the IHS behavioral health program initiatives funding mechanisms.
- NTAC spent much of the 2-day meeting in Tribal Caucus to formulate their recommendation to Admiral Weahkee, calling IHS staff in as needed for information.
- NTAC tribal representatives worked on a letter to Admiral Weahkee with recommendations on funding for SASPP, DVPP, and ZSI.

IHS FAAB

- Facilities Advisory Appropriation Board (FAAB) is charged with evaluating existing facilities' policies, procedures, and guidelines for recommending changes, if necessary. Participates in the development and evaluation of any proposed new policies, procedures, and guidelines of facilities construction priorities.
- Portland Area Representatives:
  - Tim Ballew, Lummi (Primary)
  - Andy Joseph, Jr., Colville (Alternate)
- Meetings:
  - **Next meeting: February 5-6, 2019 or February 20-21, 2019 in Washington, D.C.**

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 Representatives:
  - Vacant (Primary)
  - Steve Kutz, Cowlitz (Alternate) and Cassandra Sellard-Recks, Cowlitz (Alternate)
- Meetings:
  - Last meeting: March 13-14, 2018 TAC cancelled; instead, Tribal Public Health Workgroup had a collaborative work session with CDC.
  - Next meeting: **February 4-5, 2019 in Atlanta, GA.**

SAMHSA TTAC

- SAMHSA formed the Tribal Technical Advisory Group (TTAC) in recognition of 2008 Presidential Executive Orders and Memorandum of Tribal Consultation to enhance the government-to-government relationship to honor the federal trust responsibility and obligations to tribes and AI/AN.
- Portland Area Representative:
  - Jeremiah Julius, Lummi (primary)
  - Nickolaus Lewis, Lummi (alternate)
- At-Large Member:
  - Andy Joseph, Jr., Colville
- Meetings:
  - Last meeting (virtual): December 18, 2018
  - Next meeting: **March 13-14, 2019 in California**

Northwest Portland Area Indian Health Board

CMS TTAG

- The CMS Tribal Technical Advisory Group (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 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 Representatives:
  - John Stephens, Swinomish (Primary)
  - Nickolaus Lewis, Lummi (Alternate)
- Meetings:
  - Last meeting: November 15-16, 2018 in Washington D.C.
  - Last conference call: January 9, 2019
  - **Next meeting: February 20-21, 2019 in Washington D.C.**

Northwest Portland Area Indian Health Board

Northwest Portland Area Indian Health Board

CMS TTAG Updates

- Tribal Consultation
- Medicaid work requirements
- Care for Kids (InCK) and Maternal Opioid Misuse (MOM) Models Grant Opportunity
- Rural Health Strategy Initiative
- Managed Care issues in tribal communities
- Medicare Rule to Require Hospitals to Post Standard Charges Online (January 1)

MMPC

- The Medicare, Medicaid and Health Reform Policy Committee (MMPC) is a standing committee of the National Indian Health Board. The committee is 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 IHS.
- Meetings:
  - Last meeting: November 14, 2018 in Washington D.C.
  - Last conference call: January 8, 2019
  - **Next meeting: February 19, 2019 in Washington D.C.**

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:
  - Robyn Sigo, Suquamish (Primary)
  - Jeromy Sylvan, Port Gamble S'Klallam (Alternate)
- Meetings
  - Last meeting: October 3-4, 2018 in Oklahoma City, OK
  - Next meeting: **Week of March 21-22, 2019 in Bethesda, MD**

Other Meetings

- IHS Information Systems Advisory Committee (ISAC)
- IHS Strategic Plan Workgroup
- IHS Catastrophic Health Emergency Fund (CHEF) Workgroup
- IHS Health Promotion/Disease Prevention Policy Advisory Committee (HP/DP)
- IHS Health Research Advisory Council (HRAC)
- Portland Area Fund Distribution Workgroup (FDWG)
- Portland Area Facilities Advisory Committee (PAFAC)

Questions and Discussion

Northwest Tribal Epidemiology Center
(*The EpiCenter*)
October-December 2018 Quarterly Report

Northwest Tribal Epidemiology Center Projects' Reports Include:

- **Adolescent Health**
- **Clinical Programs-STI/HIV/HCV**
- **Epicenter Biostatistician**
- **Epicenter National Evaluation Project**
- **Immunization and IRB**
- **Injury Prevention Program (IPP)/Public Health Improvement & Training (PHIT)**
- **Medical Epidemiologist**
- **Native Children Always Ride Safe (Native CARS) Study/TOTS to Tweens Study**
- **Northwest Native American Research Center for Health (NARCH)**
- **Northwest Tribal Cancer Control Project**
- **Northwest Tribal Dental Support Center**
- **Northwest Tribal Registry Project-Improving Data and Enhancing Access (IDEA-NW)**
- **Response Circles-Domestic & Sexual Violence Prevention**
- **THRIVE (Tribal Health: Reaching out InVoices Everyone)**
- **Tribal Opioid Response (TOR) Consortium**
- **Wellness for Every American Indian to View and Achieve Health Equity (WEAVE)**
- **Western Tribal Diabetes Project**

Adolescent Behavioral Health

Stephanie Craig Rushing, PhD, MPH, Principal Investigator
Jessica Leston, MPH, PhD(c) Project Director
Colbie Caughlan, MPH, THRIVE Project Director
David Stephens, RN, ECHO Director
Danica Brown, MSW, PhD, Behavioral Health Manager
Michelle Singer, HNY Manager
Celena McCray, THRIVE Project Coordinator
Tommy Ghost Dog, WRN Project Coordinator
Tana Atchley, Youth Engagement Coordinator
Paige Smith, THRIVE/DVPI Coordinator
Corey Begay, Multimedia Specialist
Eric Vinson, ECHO Specialist
Contractor: Amanda Gaston, MAT, Native IYG

Technical Assistance and Training

Tribal Site Visits

- Post Gamble S'Klallam Tribe: Quarterly Board Meeting, October 16, 2018. Approximately 35 delegates in attendance.
- Swinomish Tribe: Youth Spirit Site Visit. November 13, 2018
- Tulalip: Youth Spirit Site Visit. November 13, 2018
- Agua Caliente Reservation: Presentation on We R Native, 2018 Biennial National Tribal Youth Conference, OJJDP, Coachella Valley, CA, December 3-5, 2018.

October Technical Assistance Requests

- 2 Tribal TA Requests = 2 (Maniilaq, Hopi)
- 3 (OHSU, IHS, Northwestern)

November Technical Assistance Requests

- 2 Tribal TA Requests = 2 (Maniilaq, Hopi)
- 1 (Northwestern)

December Technical Assistance Requests

- 1 Tribal TA Requests = Maniilaq
- 3 = IHS MPSI; Johns Hopkins; SPRC

Project Red Talon / We R Native / Native VOICES

During the quarter, Project Red Talon staff participated in four planning calls, one partner meeting, and facilitated or presented during three conferences/webinars, including:

- Meeting: CHOICES AIY-C – Teen Pregnancy + Alcohol Intervention, University of Colorado. December 11-12, 2018.
- Presentation: on We R Native, CDC Preventive Grand Rounds, October 3, 2018. Approximately 60 people in attendance.

- Presentation: We R Native, 2018 Biennial National Tribal Youth Conference, OJJDP. Agua Caliente Reservation, Coachella Valley, CA, December 3-5, 2018. Approximately 60 people in attendance.
- Webinar: Hosted by NMAC – HIV in Indian Country + We R Native, November 28, 2018.

Gen I / Bootcamps

- Bootcamp: Matika re: Indigenous People's Day MSPI Bootcamp at NAYA. October 4-7, 2018.
- In December we released a new bootcamp video, which had 12,500 video views and 42 shares: https://www.facebook.com/weRnative/videos/295769727740319/?referrer=page_insights_tab_button

Youth Spirit Evaluation

During the quarter, Project staff participated in seven planning Zoom calls and one site visit:

- DUE: OMH QPR, October 31, 2018
- Call: Project Director, Nov 12, 2018
- Meeting: Face-to-Face, November 13-14, 2018

Parenting Teens – WA DOH

During the quarter, Project staff participated in seven planning calls and one presentation:

- Presentation: Quarterly Board Meeting, Post Gamble S'Klallam Tribe, October 16, 2018. Approximately 35 delegates in attendance.

Native It's Your Game and Healthy Native Youth

During the quarter, *Native It's Your Game* staff participated in two planning calls with study partners, and the following trainings/events:

- Meeting: Healthy Native Youth Strategic Planning Session, Houston, Texas, Nov 7-8, 2018.
- Presentation: Concerning Social Media Posts Training, Alaska Conference on Child Maltreatment, Anchorage, AK, Nov 14, 2018. Approximately 15 adults in attendance.
- Presentation: Concerning Social Media Posts Training, APHA Conference, San Diego, CA, Nov 2018.
- Presentation: Healthy Native Youth, National Indian Education Conference, Hartford, CT. Oct 12, 2018. Approximately 50 adults in attendance.
- Zoom: Community of Practice: Session #2 – Building Community Support, Oct 10, 2018. Approximately 5 adult educators in attendance. Recorded trainings are available at: https://www.healthynativeyouth.org/community-of-practice-sessions
- Zoom: Community of Practice: Session #3 – Implementation Planning, Nov 14, 2018. Approximately 16 adult educators in attendance. Recorded trainings are available at: https://www.healthynativeyouth.org/community-of-practice-sessions
- Zoom: Community of Practice: Session #4 – Parent Engagement, Dec 12, 2018. Approximately 4 adult educators were in attendance. Recorded trainings are available at: https://www.healthynativeyouth.org/community-of-practice-sessions

OHSU Native American Center of Excellence and SIP

During the quarter, staff participated in nine planning calls with study partners, and submitted one IRB amendment:

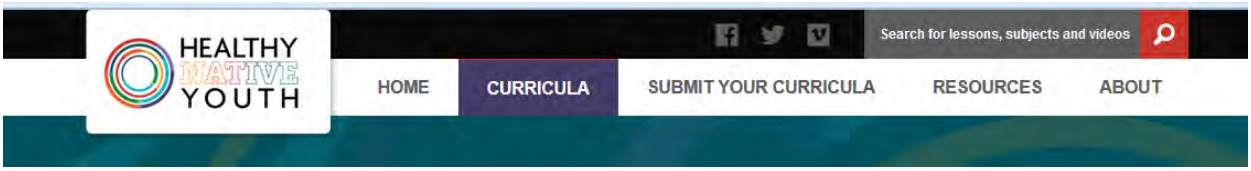
- NNACOE: Tribal Scholars IRB Resubmission.

ANA – I-LEAD

During the quarter, staff participated in one grantee call, eleven SMS text mentoring chats with 262 "healer" participants," and the following I-LEAD meetings and activities:

- Meeting: Strategic Planning Annual Retreat, October 29-30, 2018.Leadership Training: WRN Youth Ambassador Monthly Zoom: *Making Your Voice Heard*. Oct 25, 2018. The meeting included 5 youth participants; the recorded video is available at: https://www.wernative.org/ambassadors/ambassador-training
- Leadership Training: WRN Youth Ambassador Monthly Zoom: *Indigenous Pride*. Nov 29, 2018. The meeting included 4 youth participants and a guest speaker (Steven Paul Judd); the recorded video is available at: https://www.wernative.org/ambassadors/ambassador-training
- Youth Committee: Quarterly Board Meeting, Post Gamble S'Klallam Tribe, October 16, 2018. Approximately 10 delegates in attendance.
- Youth Committee: Check-in call, Nov 4, 2018. Approximately 3 delegates in attendance.
- Youth Delegates: Check-in call, December 9, 2018. Approximately 2 delegates in attendance. Recorded video is available at: https://youtu.be/WKM3-TyxWNg
- Presentation: We R Native and Healthy Native Youth, ANA Grantees Meeting, Washington DC, November 29, 2018. Approximately 35 adults in attendance.

Health Promotion and Disease Prevention



Website: The Healthy Native Youth website launched on August 15, 2016: www.healthynativeyouth.org

Last month, the **Healthy Native Youth** website received:

- Page views = 2,432
- Sessions = 584
- Users = 381
- Average session duration = 5:28

WE R NATIVE

Website: The We R Native website launched on September 28, 2012: www.weRnative.org

In December, our monthly reach across the We R Native Channel: **144,010** (4,645/day)

In December, the **We R Native** website received:

- Page views = 16,377
- Sessions = 10,851

- Users = **9,910**
- Percentage of new visitors = 92%
- Average visit duration = 2:31
- Pages per session =1.51

Twitter Followers = 6,097 **(14,000 Impressions)**

YouTube: The project currently has 692 uploaded videos, has had 334,962 video views, with 452,333 estimated minutes watched. **(12,417 views last month)**

Facebook: By the end of the month, the page had 49,211 followers.

Instagram: By the end of the month, the page had 8,047 followers. **(20,380 reach)**

Text Message Service:

- *Northwest Portland Area Indian Health Board* has 7,481 active subscribers.
- *We R Native* has 5,538 active subscribers.
- The *Text 4 Sex Ed* service currently has 377 active subscribers, 622 total profiles. Broken down by opt-in path:
    - Sex (Facebook): 278
    - Condom (Text Message): 184
    - Love (Text Message): 186
    - Snag, Banana (Instagram): 36
    - Hook up (twitter): 4
- *We R Healers* has 262 subscribers.
- *STEM* has 476 subscribers.
- *Youth Spirit* has 30 subscribers.
- *We R Navajo* has 69 subscribers.
- *I Know Mine* has 611 subscribers.
- *Native Fitness* has 696 subscribers.
- *Hepatitis C Patient and ECHO* project has 244 subscribers.
- *Healthy Native Youth* has 429 total profiles.
- *THRIVE-DBT* has 34 active subscribers.

October Social Media Messages: Number/Reach of We R Native messages addressing…

- Bootcamp PSAs = 13 posts, 0 text message, 3,772 people reached
- Concerning Social Media Post Tips = 2 posts, 0 text message, 7,350 people reached
- Sexual health/Healthy Relationships = 4 posts, 0 text message, 18,411 people reached
- DVPI = 0 posts, 0 text message, 0 people reached
- Sexual Assault Campaign (to be created this year) = 1 posts, 0 text message, 17,200 people reached
- Substance prevention = 3 post, 1 text message, 8,021 people reached
- Suicide (general) = 4 posts, 0 text message, 8,813 people reached
    - #WeNeedYouHere Campaign (specifically THRIVE) = 0 posts, 0 text message, 0 people reached
    - #WeNeedYouHere - LGBT2S = 0 post, 0 text message, 0 people reached

  - #WeNeedYouHere – Veterans = 0 post, 0 text message, 0 people reached
- Mental health = 3 posts, 0 text messages, 9,990 people reached
- Youth leadership/empowerment = 13 posts, 3 text messages, 51,097 people reached

November Social Media Messages: Number/Reach of We R Native messages addressing…

- Bootcamp PSAs = 0 posts, 0 text message, 0 people reached
- Concerning Social Media Post Tips = 0 posts, 0 text message, 0 people reached
- Sexual health/Healthy Relationships = 0 posts, 0 text message, 0 people reached
- DVPI = 0 posts, 0 text message, 0 people reached
- Sexual Assault Campaign (to be created this year) = 0 posts, 0 text message, 0 people reached
- Substance prevention = 2 post, 0 text message, 3,700 people reached
- Suicide (general) = 6 posts, 0 text message, 8,443 people reached
  - #WeNeedYouHere Campaign (specifically THRIVE) = 0 posts, 0 text message, 0 people reached
  - #WeNeedYouHere - LGBT2S = 0 post, 0 text message, 0 people reached
  - #WeNeedYouHere – Veterans = 0 post, 0 text message, 0 people reached
- Mental health = 6 posts, 1 text messages, 22,599 people reached
- Youth leadership/empowerment = 13 posts, 0 text messages, 28,409 people reached

December Social Media Messages: Number/Reach of We R Native messages addressing…

- Bootcamp PSAs = 1 posts, 0 text message, **20,300** people reached
- Concerning Social Media Post Tips = 0 posts, 0 text message, **0** people reached
- Sexual health/Healthy Relationships = 2 post, 0 text message, 1,**825** people reached
  - DVPI = 0 posts, 0 text message, 0 people reached
  - Sexual Assault Campaign (to be created this year) = 0 posts, 0 text message, 0 people reached
- Substance prevention = 6 post, 0 text message, **15,438** people reached
- Suicide (general) = 5 posts, 0 text message, **7,427** people reached
  - #WeNeedYouHere Campaign (specifically THRIVE) = 0 posts, 0 text message, 0 people reached
  - #WeNeedYouHere - LGBT2S = 1 post, 0 text message, 3,500 people reached
  - #WeNeedYouHere – Veterans = 0 post, 0 text message, 0 people reached
- Mental health = 7 posts, 2 text messages, 1**9,970** people reached
- Youth leadership/empowerment = 9 posts, 2 text messages, **22,343** people reached

Native VOICES (not updated post September 2018): Since their release, the Native VOICES videos have been viewed 3,993 times on YouTube and reached 2,233,910 people on Facebook.

Surveillance and Research

Concerning Social Media: The NPAIHB has partnered with the Social Media Adolescent Health Research Team at Seattle Children's Hospital to design educational tools to address concerning posts on social media. We are currently writing a paper that describes the evaluation of the video intervention for adults who work with Native youth.

Violence Prevention Messages: We R Native partnered with Steven Hafner to carryout formative research to design a violence prevention intervention that will be delivered to Native young men via Facebook. The team recently completed a pilot test of the intervention and is making improvements to the SMS series based on their feedback.

Other Administrative Responsibilities

Publications

- Title: Sexual Health, STI and HIV Risk, and Risk Perceptions Among American Indian and Alaska Native Emerging Adults, Journal: Prevention Science, 1-11, DOI: 10.1007/s11121-018-0920-7
  Your article is available as 'Online First':
  http://link.springer.com/article/10.1007/s11121-018-0920-7

- Community Case Study in Front. Public Health, 17 August 2018 |
  https://doi.org/10.3389/fpubh.2018.00225
  Healthy Native Youth: Improving Access to Effective, Culturally-Relevant Sexual Health Curricula

Reports/Grants Submitted

- MSPI Annual Report
- ANA Semi-Annual Report
- Prepared an Application for: https://tamprogram.org/

Administrative Duties: Budget tracking and maintenance; Managed Project Invoices and Subcontracts; Staff oversight and evaluations.

Clinical Programs-STI/HIV/HCV

Jessica Leston, MPH, Clinical Programs Director - Tsimshian
David Stephens, RN ECHO Clinic Director
Eric Vinson, BA, ECHO Clinic Manager – Cherokee
Megan Woodbury – Opioid Program Coordinator
Danica Love Brown – Behavioral Health Manager - Choctaw
Contractors: Brigg Reilley, MPH
Carolyn Crisp, MPH
Crystal Lee, PhD – Navajo

Technical Assistance and Training

NW Tribal Site Visits

- Muckleshoot – NW Tribal Opiate Summit, November 16, 2018

Out of Area Tribal Site Visits

- Meeting: Billings Area HCV Training (Crow/Northern Cheyenne, Lame Deer, Fort Peck, Rocky Boy, Browning, Wind River, Rapid City)
- CA CRIHB Training, December 11-12, 201

October Technical Assistance Requests
- Tribal TA Requests = 5 (Jessica), 5 (David), 7 (Brigg), (0) Eric
- Other Agency Requests = 6 (CDC, IHS, USET, GPTCHB, WA, CRIHB)

November Technical Assistance Requests
- Tribal TA Requests = 7 (Jessica), 9 (David), (28) Eric
- Other Agency Requests = 6 (SAMHSA, IHS, GPTCHB, WA, AZ, CRIHB, GLITC)

December Technical Assistance Requests
Technical Assistance Requests
- Tribal TA Requests = 5 (Jessica), 5 (David), (6) Eric
- Other Agency Requests = 6 (CDC, OMB, SAMHSA, IHS, GPTCHB, WA, OR, AZ, CRIHB, GLITC)

During the quarter, project staff participated in sixty technical assistance calls and requests.

Health Promotion and Disease Prevention

Overview: Hepatitis C Virus (HCV) is a common infection, with an estimated 3.5 million persons chronically infected in the United States. According to the Centers for Disease Control and Prevention, American Indian and Alaska Native people have the highest mortality rate from hepatitis C of any race or ethnicity. But Hepatitis C can be cured and our Portland Area IHS, Tribal and Urban Indian primary care clinics have the capacity to provide this cure. Some of these clinics have already initiated HCV screening and treatment resulting in patients cured and earning greatly deserved gratitude from the communities they serve.

Goals: HCV has historically been difficult to treat, with highly toxic drug regimens and low cure rates. In recent years, however, medical options have vastly improved: current treatments have few side effects, are taken by mouth, and have cure rates of over 90%. Curing a patient of HCV greatly reduces their risk of developing liver cancer and liver failure. Early detection of HCV infection through routine and targeted screening is critical to the success of treating HCV with these new drug regimens.

It is estimated that as many as 120,000 AI/ANs are currently infected with HCV. Sadly, the vast majority of these people have not been treated. By treating at the primary care level, we can begin to eradicate this disease. Our aim is to provide resources and expertise to make successful treatment and cure of HCV infection a reality in Northwest IHS, Tribal and Urban Indian primary care clinics. More at www.npaihb.org/hcv

Currently, the program has strategic partnerships with: Alaska Native Tribal Health Consortium, University of New Mexico, Cherokee Nation, Norther Tier Initiative for Hepatitis C Elimination, Oklahoma IHS Area, United Southern and Eastern Tribes TEC, Rocky Mountain TEC, Great Plains Tribal Chairmans Health Board and TEC, Great Lakes Inter Tribal Council TEC, and IHS.

HCV ECHO: Each month, the Northwest Portland Area Indian Health Board offers multiple teleECHO clinics with specialists focusing on the management and treatment of patients with HCV. The 1 hour long clinic includes an opportunity to present cases, receive recommendations from a specialist, engage in a didactic session and become part of a learning community. Together, we will manage patient cases so that every patient gets the care they need.

A total of 425 patients have received recommendations via the NPAIHB ECHO HUB.

Text Message service/email marketing: To date, the project has sent 12,073 and received 2,074 messages from 297 text message subscribers. The project sent 3 marketing emails and had a reach of 985 through constant contact in the month of December.

Example of text message received in November 2018: "*Thank you. I don't know if I am able to respond to you but I'm responding anyway. I just want to express my sincere appreciation for all you do. My CIHA (Cherokee Indian Hospital Authority) colleagues and I are energized with the possibility that we can eradicate Hep C in our community. We are meeting weekly to discuss Hep C treatment, patients, issues, ideas and complaints. We are, or I am preparing a presentation for one of our private recovery centers. Our goal in this is to reach out to as many people as we can to educate and spread awareness on all things Hep C. I am preparing the presentation because I am the performance improvement person for our primary care. The nurses are busy caring for our patients. I am also creating a hep B lab guide for our nursing staff to try and eliminate confusion over the hep B labs. I am by education an CLS(clinical laboratory scientist) formerly known as an MT (medical technologist). I went to school to be a lab tech. Not just drawing blood but running the tests. So for once I am excited because the lab part of all this is right up my alley. My comfort zone, you could say."*

HCV Print & Video Campaign: In 2017, the project disseminated the Hepatitis C is Everybody's Responsibility Campaign http://www.npaihb.org/hcv/#Community-Resources To date, 6,000 items (posters, rack cards, pamphlets) have been printed, and the campaign (print + video) has received 547 video views on YouTube, and reached 5,515 on Facebook.

Surveillance and Research

STD/HIV/HCV Data Project: The project is monitoring STD/HIV GPRA measures for IHS sites throughout Indian Country. Infographics are generated to provide visual feedback data to all 66 IHS sites, 13 Urban sites and any tribal site that provides access. PRT staff are assessing local strengths and weaknesses (administrative, staffing, clinical, and data) that influence screening.

Annual data on HCV screening for IHS sites nationwide has shown strong improvement, with an increase to 54% from 46% the prior year.

PWID Study: To capture the heterogeneous experience of AI/AN PWID and PWHID, this project is being conducted in four geographically dispersed AI/AN communities in the United States using semi-structure interviews. The project is based on indigenous ways of knowing, community-based participatory research principles and implementation science.

Other Administrative Responsibilities

Publications

- Mera J, Reilley B, Leston J Stephens D. (2018) In a Critical State: Ongoing Barriers to Treatment for Hepatitis C Virus (HCV). The American Journal of Medicine.
  doi: https://doi.org/10.1016/j.amjmed.2018.10.031
- Medicaid Access Paper accepted to American Medical Journal
- AI/AN Methods Paper on PWID Project accepted to Public Health
- Working on AI/AN PWID Results Paper
- Working on OUD Indicators Paper with CDC

Reports/Grants Submitted

- Awarded for FYI 2019: SAMHSA ECHO – 524,000
- Awarded for FYI 2019: OMH ECHO – 350,000
- Awarded for FYI 2019: CDC Opioid Response Strategy – 265,000
- Awarded for FYI 2019: SAMHSA TOR – 3.5 Million
- Awarded for FYI 2019: IHS SMAIF HIV 1.3 Million

Administrative Duties

- Budget tracking and maintenance: Ongoing
- Managed Project Invoices: Ongoing
- Managed Project Subcontracts: Ongoing
- Staff oversight and annual evaluation

Epicenter Biostatistician

Nancy Bennett

Conference Calls:

- TPHEP 2018 conf planning committee call bi-weekly
- eMars conference call w/ Cayuse to discuss project
- Call with Rhapsody people regarding their product

NPAIHB Meetings:

- All staff meeting – monthly
- Biostat meeting – bi-weekly
- Meeting at Embasy Suites to view venue for EP conf
- Onboarding committee meeting
- Safety meeting fire alarm
- Christmas Party
- 2019 TPHEP conference planning
  - Scouted for venue location and dates

Conferences/QBMs/Out of area Meetings

- APHA Conference, San Diego, CA
  - Worked at TEC booth
  - Attended conference

Miscellaneous

Reports:

- Warm Springs PowerPoint BRFSS report

Site Visits:

- none

Epicenter National Evaluation Project

Birdie Wermy, Project Specialist

Technical Assistance via telephone/email

July – September

- Ongoing communication with NPAIHB EpiCenter Director
- Ongoing communication with Tribal sites regarding project updates, information and technical assistance
- Email correspondence with Tribes regarding T.A., reporting and program implementation

Reporting

October

- Good Health and Wellness in Indian Country (GHWIC) quarterly call on 10.03 @ 10am
- Good Health and Wellness in Indian Country (GHWIC) TEC call on 10.10 @ 10am
- MSPI Area Project Officer (APO) call on 10.17 @ 9am
- DVPI Area Project Officer (APO) call on 10.17 @ 11am
- Good Health and Wellness in Indian Country (GHWIC) C2 call on 10.24 @ 12pm

November

- Good Health and Wellness in Indian Country (GHWIC) TEC ¼ evaluation call on 11.15 @ 10am
- Good Health and Wellness in Indian Country (GHWIC) C2 call on 11.28 @ 12pm

December

- TEC APO call on 12.06 @ 11am
- Portland DVPI call on 12.11 @ 9am
- Portland MSPI call on 12.11 @ 10am
- Good Health and Wellness in Indian Country (GHWIC) TEC workgroup call on 12.11 @ 10am
- Good Health and Wellness in Indian Country (GHWIC) C2 call on 12.19 @ 12pm

Updates

Birdie – continuing to provide evaluation TA to MSPI/DVPI service areas and GHWIC NW WEAVE Project.

- Evaluation T.A provided to seven Tribes regarding their local data collection plan and annual progress report (APR).
- Sent an email reminder to all MSPI/DVPI programs regarding evaluation T.A. on 10.24 and 10.31 deadline reminder.
- Evaluation T.A. provided to three Tribes via phone call.
- As of 11.01 all Portland area DVPI programs (8) submitted their APR. Four outstanding reports were “in progress” for all MSPI Portland area programs.

- Evaluation T.A provided to three Tribes regarding their local data collection plan and annual progress report (APR).
- Evaluation T.A. provided to three Tribes via phone call.
- As of 11.20 all Portland area DVPI and MSPI Portland area programs submitted their APR.
- Evaluation T.A provided to one Tribe regarding their local data collection plan and annual progress report (APR).
- Evaluation T.A. provided to one Tribe via phone call.

Challenges/Opportunities/Milestones

- One program reached out to me during the month of October, a new coordinator who has been in their position for one month and was not left with any guidance on how to complete the APR. I advised him to meet with the Director on how to proceed with gathering the information and if there was contact information for the previous coordinator and request an extension if need be from the APO.
- Another MSPI program reached out to me during the month of October regarding the APR and their data person they get all of the information from suffered a death in the family, I advised her to reach out the APO and explain the situation.
- An MSPI program reached out to me during November to review their upcoming fiscal year LDCP.
- Government shut down as of 12.22.18 – no contact with area project officer and staff at headquarters. All calls with IHS have been cancelled.

Meetings/Trainings

- MSPI call w/ Puyallup on 10.01 @ 9am
- MSPI call w/ Makah on 10.01 @ 12pm
- MSPI call w/ Marimn Health on 10.10 @ 8:15am
- MSPI call w/ Cow Creek on 10.09 @ 10am
- NPAIHB Wellness Meeting on 10.11 @10:30am
- Suicide Surveillance conference call on 10.23 @ 8:45am
- NPAIHB All Staff Harassment training on 10.23 @ 12pm
- DVPI Call w/ Healing Lodge on 10.26 @ 9:30am
- DVPI Webinar on 10.29 @ 11am
- “Place Matters” Conference 10.29-10.30 in Portland, Or.
- DVPI Webinar “This is your brain on drugs” on 10.31 @ 8am
- DVPI call w/ Siletz on 11.01 @ 10am
- DVPI call w/ Nez Perce on 11.05 @ 1:30pm
- DVPI webinar on 11.21 @ 11am
- APHA Livestream on 11.12 @ 1pm
- Suicide Surveillance conference call on 11.13 @ 12pm
- Opioid webinar on 11.14 @ 12pm
- TEC APO call on 12.06 @ 11am
- APO DVPI call on 12.11 @ 9am
- APO MSPI call on 12.11 @ 10am
- GHWIC TEC Workgroup call on 12.12 @ 10am

- Wellness Meeting on 12.13 @10am
- Webinar on 12.13 @ 12pm
- GHWIC C2 call on 12.19 @ 12pm

Site Visits

- None

Upcoming Calls/Meetings/Travel

- TEC APO Call on 1.03.19 – CANCELLED due to Gov't shutdown
- GHWIC ALL HANDS call on 1.09 @ 10am
- Mandatory Security Training on 1.10 @ 11am
- NPAIHB Project Presentations 1.14 @ 10am
- EpiCenter all-staff meeting on 1.16 @ 9am
- GHWIC C2 call on 1.23 @ 12pm
- QBM on 1.22-1.23 @ Suquamish, Wa.
- Wellness Meeting on 1.28 @ 10am
- ATNI Conference on 1.28-1.31 @ Portland, Or.
- Suicide Prevention Meeting on 1.29 @ 10am
- NARCH Luncheon presentation on 1.30 @ 12pm

Publications

- NONE

Immunization and IRB

Clarice Charging, Project Coordinator

Meetings:

NPAIHB all-staff meeting, October 1, 2018
Breast Friends Luncheon October 27, 2018
NPAIHB staff benefits, October 30, 2018
Immunization Partners Action Team (IPAT), December 6, 2018, Oregon DOH, Portland, OR

Quarterly board meetings/conferences/site visits:

NPAIHB quarterly Tribal Health Directors (THD), meeting, The Point Casino and Hotel, October 15, 2018, Kingston, WA.
NPAIHB quarterly board meeting, Port Gamble S'Klallam Tribal Long House, October 16-17, 2018, Port Gamble, WA
National Council of American Indians (NCAI), Hyatt at Denver Convention Center, Denver, CO, October 21-25, 2018
PRIMR (IRB) Conference, San Diego Convention Center, San Diego, CA, November 13-17, 2018

Conference Calls:

IHS Area Immunization Coordinators call, November 1, 2018

Portland Area (PA) Indian Health Service (IHS) Institutional Review Board (IRB):

PA IRB Meetings:
Katie Johnson, IHS project planning, October 2, 2018
Portland Area IHS IRB committee, November 14, 2018

During the period of July 1 – September 30, Portland Area IRBNet program has 162 registered participants, received 7 new electronic submissions, processed 14 protocol revision approvals, approved 3 publications/presentations and closed out 2 projects.

Provided IT and IRB regulation assistance to Primary Investigators from:
1) Confederated Tribes of the Umatilla Indian Reservation
2) Shoshone Bannock Tribe
3) NPAIHB
4) Confederated Tribes of Warm Springs Indian Reservation
5) OHSU
6) Swinomish Tribe
7) Shoalwater Bay Tribe
8) University of Colorado
9) Confederated Tribes of the Yakama Nation
10) Healing Lodge of the Seven Nations

Injury Prevention Project/Public Health Improvement & Training

Bridget Canniff, Project Director
Luella Azule, Project Coordinator
Taylor Ellis, Project Specialist

Meetings/Calls/Conferences/Presentations

- 10/3 Preventative Medicine Grand Rounds: NPAIHB (Taylor)
- 10/4 West Coast Epi Conference (Taylor)
- 10/11 PartnerSHIP meeting at OHA (Bridget)
- 10/11 CDC/NCIPC injury prevention quarterly call with TECs (Luella and Taylor)
- 10/17 TIPCAP update presentation at QBM (Taylor)
- 10/25 SHIP mini-grant kick off meeting at OHA (Bridget and Taylor)
- 11/13 WA Firearm Tragedy Prevention Meeting (Taylor)
- 11/30 PHAP Tribal Workgroup call (Taylor)
- 11/30 SHIP mini-grant call with OHA (Taylor, Bridget)
- 12/3 NWCPHP Regional Network Steering Committee call (Bridget)

Trainings/Webinars

- 10/23 Grand Rounds: Safe Sleep for Infants webinar (Taylor)

- 11/14 Objective Review Panel for CDC (Taylor)
- 11/2 CSTE Webinar: How to write a successful abstract for a public health conference (Taylor)
- 11/7 RPE Objective Review Training (Taylor)
- 11/14 APHA Dying too Soon: A Look at Women's Health (Taylor)
- 11/28 Addressing the Needs of People with Disabilities in Public Health Emergencies webinar (Taylor)
- 11/29 Responding to Sexual Assault Victims of Color webinar (Taylor)
- 12/4 Improving Outcomes for Pregnant Women and Infants Affected by the Opioid Crisis webinar (Taylor)
- 12/6 Fall Prevention & TBI Among Older Adults webinar (Taylor)
- 12/11 Health Literacy 101 webinar for PHAPs (Taylor)

Funding

- 10/26 SHIP mini-grant contract form returned to OHA - $7,000, project period 10/1/2018-9/30/2019
- 11/30 Submitted TIPCAP annual report (Bridget, Luella, Taylor)

Technical Assistance

- Sent key contact information to tribal/state Elder Fall contacts for future collaboration and information exchange (Bridget)
- EHR Survey – Assisted Sarah and Katie with an EHR survey for all health clinic directors by adapting previously written survey questions to optimize participation then creating the survey in Survey Monkey for distribution (Taylor, Bridget)
- Received request for QI program resources and updates – Bridget scheduled to address this and related Public Health Improvement/Accreditation Readiness at January QBM on 1/23

Other Core Activities

Luella

Injury Prevention:

- Finalize and distribute Elder Falls Toolkit module conference call Notes from October call
- **E-News:** NCOA (Vaccines, medications and falling), CDC (Promoting Well-being and Independence in Older Adults, BRFSS, Fall prevention awareness day, NIHB Opioid Legislation Analysis, ACA impact on Tribes and Tribal Health programs, NIHB WA Report 18-37 to 39, OPHI insights, OHSU research newsletter, Wisdom of Elders
- **Forward to CPS techs, Tribal Injury Prevention Contacts, Tribal Injury Prevention Contacts:** Lifesaver Conference Information
- **Other:** Review SAIL (Stay Active and Independent for Life) online video

Taylor

Tribal Injury Prevention Toolkit:

- Firearm Safety Module:

  - Sent the Firearm Safety module to 12 individuals across all three states to receive feedback, and updated module accordingly
- Traumatic Brain Injury (TBI) Prevention module:
  - Sent module to 3 individuals, including a subject matter expert, and updated module accordingly
  - Added more emphasis on going to a PCP after a head injury across all TBI materials, even if a helmet was worn
  - Added more emphasis on the importance of adults wearing helmets too
  - Followed up with contact at Washington VA to look for programs that provide helmets for free or at a reduced cost
  - After input from WA VA contact, reviewed additional research on TBI and edited materials to reflect suggestions made, including emphasizing the need to seek medical attention after a head injury
  - Attended WA Firearm Tragedy Prevention Meeting to learn about updates on existing firearm safety projects and resources that could be used for the firearm safety module
- Home Safety module:
  - Added more information on CO alarms
  - Added new material on grease fires and kitchen safety information after noticing a gap in the existing materials

OHA SHIP Mini-Grant:

- Modified OHA's community survey to better reflect the language used in AI/AN communities and added questions that could be useful to NPAIHB and tribal planning efforts
- Contacted 9 tribal staff members to provide an update on SHIP efforts and determine the main contact for each tribe
- Incorporated feedback from other NPAIHB staff on SHIP focus group question and survey
- Held SHIP information/collaboration calls with contacts from Umatilla and Cow Creek
- Submitted an exemption application for Portland IHS IRB, which included an informational letter for tribal government/council, listening session consent form and protocol, and a demographics questionnaire for listening session participants; IRB exemption approved in early December
- Finalized SHIP survey and launched on December 12 – survey and outreach materials sent to contacts at all Oregon tribes and other AI/AN serving organizations throughout Oregon. Follow-up and outreach to continue through the end of January 2019. Created paper-based version of survey for distribution as needed, and provided summary of initial results to OHA.

Bridget

- Advance coordination for next TEC Environmental Health Tracking project call with GLITEC, AASTEC
- Connected students interested in working with NPAIHB/NW Tribes to info re: UW NWCPHP student stipends for field placements and student/faculty projects
- Planning and coordination for for OHA SHIP mini-grant project kickoff, in collaboration with Taylor (see above)
- Initial planning for 2019 Tribal Public Health Emergency Preparedness (TPHEP) Conference, including site visit to potential venue and scheduling of initial kickoff call for January 2019

Northwest Tribal Epidemiology Center
(*The EpiCenter*)
October-December 2018 Quarterly Report

Travel/Site Visits

Tribe: Port Gamble S'Klallam **Date:** 10/15-18 **Purpose:** QBM **Who:** Bridget and Taylor	**Tribe:** Chehalis **Date:** 10/23-24/2018 **Purpose:** Elders' Caregivers Conference **Who:** Luella

Medical Epidemiologist

Thomas Weiser, Epidemiologist (IHS)

Projects:
*Opioid Epidemic
*Hepatitis C
*Immunization Program-routine immunization monitoring
*IRB
*Children with Disabilities (CWDA)
*EIS Supervision
*MCH Assessment
* Suicide surveillance and Prevention

Travel/Training:
*West Coast Epidemiology Meeting, October 4-5 (Portland); QBM, October 15-17 (Kingston, WA); ACIP Meeting, October 23-25 (Atlanta, GA); Pals Renewal, 10/26/18 OHSU;
*Clinic Director's meeting November 8th (Portland); Portland Area Budget Formulation Meeting, November 15th (Portland); Clinic Duty, November 23rd (Chemawa); IHS Opioid Strategic Planning Meeting, November 26-28, 2018 (Rockville, MD)

Opportunities:
*IRB met in November. During the 3 month period we reviewed 7 new protocols, approved 14 protocol revision submissions, 3 publications/presentations and 4 annual renewals. Two projects were also closed out.
*Immunization Coordinator call was held on November 20th. There were 6 Immunization Coordinators on the call. Discussion centered on Acute Flaccid Myelitis outbreak, ACIP updates and flu updates.
*EIS Surveillance Project: Preliminary analysis of death certificate data focusing on suicide and other causes of death in the State of Washington completed and abstract submitted to CDC for clearance for EIS and CSTE conferences. Surveillance evaluation was also written up for discussion at EIS Fall Course.
*Children With Disabilities project: No new progress on this project.
*Opioid Epidemic: Attended the IHS opioid strategic planning meeting in Rockville.
*MCH Assessment: Facilitated data request for OR PRAMS data.
*Hepatitis C: Sarah Hatcher's paper on HCV mortality was accepted for publication in Public Health Reports, pending revisions.

*Suicide Surveillance and Prevention: EISO (Alex) and I met with stakeholders regarding the evaluation of suicide reporting and referrals and gathered information for recommendations.

Publications:
*HCV Mortality paper accepted, MMWR on opioid-related deaths (Sujata Joshi first author) accepted.

*HCV Manuscript (Sarah Hatcher, first author) revisions were addressed and the manuscript is now in final cross-clearance at CDC.

Milestones:
*IHS/NPAIHB DSA to obtain records for NTR from IHS NDW passed review by IHS.

Native CARS & PTOTS

Tam Lutz, Co-Investigator/Project Director (Native CARS), Co-PI (TOTS to Tweens)
Nicole Smith, Biostatistician (Native CARS and TOTS to Tweens)
Candice Jimenez, Research Coordinator (Native CARS and TOTS to Tweens)
Jodi Lapidus, PI (Native CARS), Co-Investigator (TOTS to Tweens)
Thomas Becker, Co-PI (TOTS to Tweens)
Nichole Hildebrandt, Temp Site Coordinator (TOTS to Tweens)
Kai Lei, Temp Data Analyst (TOTS to Tweens)

Native CARS Study

Background

In 2003, with funding from the Indian Health Service's Native American Research Centers for Health (NARCH, grant 1U269400013-01), six Northwest tribes conducted a child safety seat survey. We found that child safety seat use ranged from 25% to 55% by tribe. Forty percent of children were completely unrestrained in the vehicle, which was much higher than the 12% of unrestrained children in the general population in these same states. We concluded that culturally-appropriate efforts were needed to address child restraint use in the Northwest tribes. At the tribes' request, the EpiCenter pursued funding for child safety seat interventions.

The Native CARS study was initially funded in 2008 by the National Institute on Minority Health and Health Disparities (NIMHHD), and is a partnership with the NPAIHB, University of Washington, and the six Northwest tribes. This partnership aims to design and evaluate interventions to improve child safety seat use in tribal communities.

Between 2009-2013, during the intervention phase of this NIH-funded study, all six participating tribes received funding to implement community-based interventions.
All six tribes implemented intervention activities, but in a staggered design. Three tribes designed and implemented interventions from 2009-2011 and three tribes did so from 2011-2013. This gave us an evaluation time point in 2011 to compare child safety seat use in intervention tribes to tribes that had not yet implemented interventions. We evaluated child safety seat use again in 2013 to see if the

interventions had a lasting impact in the first group and to see if child safety seat use increased in the second group of tribes.

Tribes planned their intervention efforts according to the data they collected from their community from surveys, interviews, and focus groups. Intervention activities included media campaigns, health education, car seat programs, getting child passenger safety technicians trained, community outreach, and even changing tribal policies or passing a tribal child passenger safety law.

By 2011, the percentage of kids riding in an age- and size-appropriate restraint increased by 50% in tribes that had implemented interventions, compared to an 11% increase in those that had not yet conducted child safety seat activities. In 2013, the increases we saw in the first group of intervention tribes were mostly sustained, and the percentage of completely unrestrained children continued to decrease. Round 2 tribes also saw an increase in proper child restraint after their intervention activities.

The goal of the Native Children Always Ride Safe (Native CARS) project is to prevent early childhood vehicle collision morbidity and mortality in American Indian Alaskan Native children through the use of community base participatory model that incorporated tribal differences in cultural beliefs, family and community structure, geographic location, law enforcement and economic factors.

Objective/Aims of Dissemination Phase
Because of the demonstrated success of the Native CARS Study, in 2014 the study was award additional funds for a dissemination phase of the study, where the protocols, tools and intervention materials were translated for use by other tribes both locally and nationally. These evidence-based tribal interventions were adapted and disseminated via plans guided by a dissemination framework that leveraged and expanded upon tribal capacity built during the previous Native CARS intervention phase, by engaging the tribal participants as experts throughout this dissemination phase. Demonstrating the translation potential of Native CARS interventions into other tribal communities is an essential step toward reducing the disparity in motor vehicle injuries and fatalities experienced by American Indian and Alaska Native children in the United States.

During the current *dissemination* phase, we specifically:

- Developed the Native CARS Atlas (http://www.nativecars.org), a toolkit to assist tribes in implementing and evaluating evidence-based interventions to improve child passenger restraint use on or near tribal lands.

- Facilitated the use of the Native CARS Atlas (link to http://www.nativecars.org) in the six tribes that participated in the original initiative, to help sustain improvements in child passenger restraint use achieved during the intervention phase and provide lessons on use of the toolkit for other tribes.

- Used the Native CARS Atlas (link to http://www.nativecars.org) to assist 5 new tribes in the Northwest and 1 in Montana with demonstrated readiness to implement interventions to improve child passenger restraint use in their communities

Northwest Tribal Epidemiology Center
(*The EpiCenter*)
October-December 2018 Quarterly Report

Project News & Activities

Granting Writing and Funding Activity

Last quarter we submitted a funding proposal to Centers for Disease Control and Prevention to disseminate Native CARS more widely to a national audience with a proposal that would fund two Child Passenger Safety Specialists in data collection and analysis and intervention development expertise to support Tribes, provide national level trainings and provide site specific intervention funding. This quarter we heard back that that funding was not awarded.

However last quarter we did receive a funding award from National Institute on Minority Health and Health Disparities to further pursue improving the use of Motor Vehicle Data. Native CARS will work in partnership with Oregon Health Sciences University (OHSU) and Northwest Washington Indian Health Board. This newly awarded focus will be continuing the partnership of Co-PI's Jodi Lapidus and Tam Lutz, as well as current Biostatistician Nicole Smith and Project Coordinator, Candice Jimenez all of which have been part of Native CARS. In addition, the Native CARS will bring on an OHSU Co-Investigator with expertise in informatics and NWWIHB Co-Investigator in Injury Prevention and a new Motor Vehicle Data Biostatistician, Meena Patil who will begin working for the NPAIHB in March 2019. Early preparation and planning have begun on this grant award.

Disseminating
Back at the office Native CARS staff has keep the Native CARS Atlas updated and respond to individual tribal site and local tribal organization requests. Much of our time has been spent drafting three new papers (main outcome, CBPR and Qualitative findings) to disseminate to peer reviewed journal. Native CARS have continued investigate and prepare for future regional and national venues, such as an upcoming poster and oral presentation in early April at the National Lifesavers Conference, to get the word out that the Native CARS Atlas is up and running at www.nativecars.org.

Feature Story
This quarter a short feature article in the UW School of Public Health magazine that shared information about Native CARS and the NW Tribal EpiCenter was published . This feature story can be found be found in the Fall 2018 publication at the following link:
http://www.northwestpublichealth.org/sites/www.northwestpublichealth.org/files/pdf/2018/NPH_Mag_20181010_web.pdf

Specific activities of the Portland Native CARS team are as follow:

Native CARS Activities

Meetings - Conference Calls – Presentations – Trainings

- Staff Meetings – each Monday
- Meeting with one Tribal Sites
- Meeting with section co-presenters from other areas for MCH Epi Conference
- NIH Seminar, October 16-20, San Francisco, CA
- MV Biostatistician Interview UW School of Public Health Feature Story meeting
- One community car seat clinic with Tom Sargent Safety Center

Program Support or Technical Assistance

- Updated job descriptions to reflect new grant activities
- Drafted sub award contract for subawardee
- Drafted letter to sub award and other partners
- Quarterly Report
- Subscribed to Tableau software and online training
- Registered for Lifesavers Conference
- Communication with Warm Springs Early Childhood/MCH Program for Native CARS mini grant funding (remaining budget) and grant tools to fund child safety seats
- Motor Vehicle data grant meeting scheduling
- Motor Vehicle data grant letter to advisory members
- Native CARS Project update preparation
- Motor Vehicle Project Timeline Preparation
- Lifesavers Highway Safety Conference Prep
- Email Communication with funder (Tam)

TOT2Tweens Study

A staggering proportion, 3 of 4 American Indian/Alaska Native (AI/AN) children between the ages of 2-5, have experienced tooth decay, over two-thirds have untreated decay, and over half have severe tooth decay. While this may politely be referred to as a "health disparity," it could more aptly be termed a "health disaster." Many AI/AN children experience tooth decay before the age of two. Tooth decay in that age group leads to further tooth decay and other oral health problems later in childhood.

The TOTS to Tweens Study is a follow up study to *The TOTS Study (Toddler Obesity and Tooth Decay) Study)* an early childhood obesity and tooth decay prevention program. The goal of this study is to survey and conduct dental screenings with the original group of toddlers to test whether interventions delivered in the TOTS will influence the prevalence tooth decay in older children. Through qualitative approaches, the study will also assess current community, environmental and familial factors that can influence oral health in children to understand any maintenance of preventive behaviors over the last ten years within the entire family.

The TOTS2Tween Study is administered through the NW NARCH program at the NPAIHB. The *TOTS2TWEENS* Study is led by Co-Principal Investigators, Thomas Becker, MD, PhD and Tam Lutz, MPH, MHA.

Project News & Activities

This quarter the TOTS2Tweens Study staff (Lutz, Jimenez, Hildebrant) completed the qualitative phase of the study. TOTS2Tweens staff completed final preparations for the collection of remaining qualitative interviews at Lummi and Makah partner sites. Early preparation of the qualitative transcripts has begun to prepare for qualitative analysis. TOTS2Tweens Study team also temporary data analyst Kai Lei continued to help with data management, cleaning and assisted Biostatistician Nicole Smith in

conducting analysis of quantitative data collected to preparation for manuscript preparation and individual Tribal reports.

For more information about the TOTS to Tweens Study, contact Tam Lutz at tlutz@npaihb.org

Meetings - Conference Calls – Presentations – Trainings

- Project Meetings – Every Wednesday
- Site specific meetings – as needed
- Quinault and Makah Elicitation phone Interviews

Program Support or Technical Assistance

- Email and Phone communications scheduling Makah, Quinault, Lummi and final Shoshone-Bannock elicitation interviews
- T2T Poisson Modeling
- Planning and tracking sheet updates for remaining interviews
- Communication and submission of recordings for transcription service of tribal community elicitation interviews for Quinault and Makah
- Transcription preparation of Nez Perce elicitation interviews due to recording quality from written recorder notes
- KAB Data entry and cleaning
- Communication with Makah and Lummi dental departments on T2T project
- Parent contact research for remaining Makah elicitation interviews
- Final coordination with Makah tribal coordinators for elicitation interviews contact information for parents who did not show for in-person elicitation interviews
- Gift card incentive planning and inventory assessment
- Met with T2T investigators to discuss preliminary analyses and next steps
- Gathered possible data storytelling tool to share with T2T group for analyses
- Bought and sent T2T incentive gift cards for Quinault and Makah elicitation interview participants
- T2T KAB migration for analyses
- Prepared and mailed incentive gift cards for Quinault and Makah elicitation interview participants
- Adjusted figures in dental tables for age and tooth count
- Transcription review for typographical/voice errors
- Child Assent/Parent Consent review of T2T documents for Asthma project
- Progress Report Summary for grant continuation
- Cleaning of Merged Data File
- Wrote Analysis Plan for Access to Care Outcome per conversation with Maxine
- Recodes for Access to Care Plan; sealants as percent of sound teeth
- Outlined Tribe-specific Reports

No. of Requests Responded to for Technical Assistance, including the following: Data Requests to Tribal and Urban Organizations, Communities or AI/AN Individuals

How many requested: 4
How Many NW Tribe Specific: 4
Email Assisting with: CDA CARS Mini Grant, Warm Springs

Phone assisting with:
How Many Responded To: 4

No. of Tribal Epidemiology Center-Sponsored Trainings and Technical Assistance Events Provided to Build Tribal Public Health Capacity

Number of project trainings: 0
Training Titles: N/A
Number of individuals in attendance: 0

SITE VISITS

- None

Project Contact Information

Jodi Lapidus, Principal Investigator
lapidusj@ohsu.edu

Tam Lutz, Project Director, Co-Investigator, Co-PI
503-416-3271, tlutz@npaihb.org

Nicole Smith, Biostatistician
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Candice Jimenez, Research Coordinator
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Nichole Hildebrandt, TOTS to Tweens Site Coordinator
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Tom Becker, Co-PI
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Kai Lei, TOTS to Tweens Temp Data Analyst
klei@npaihb.org

Northwest Native American Research Center for Health (NARCH)

Tom Becker, PI
Victoria Warren-Mears, Director
Celeste Davis, Project Director
Tom Weiser, Medical Epidemiologist
Ashley Thomas, Project Coordinator
Grazia Cunningham, Project Coordinator
Mattie Tomeo-Palmanteer

Jacqueline Left Hand Bull

The Northwest Native American Research Center for Health (NARCH) is a long-standing federal program that the Board has supported for almost 15 years. It has been the largest, and possibly the most successful, of all those NARCH programs funded nationwide. The active components are described below.

Asthma Project
Principal investigator, Tom Becker
Project Director, Celeste Davis
Project Coordinator, Mattie Tomeo-Palmanteer

The Asthma project is researching how health providers such as nurses, pharmacists, and environmental health specialists can work with AI/AN parents to better control asthma for AI/AN children.

The Portland Area Institutional Review Board approval was obtained 12/17/2018 and timeline planning is currently being drafted. Supplies for environmental home visits are now in the process of being ordered after receiving recommendations from the Indian Health Service, Environmental Protection Agency and Housing and Urban Development. At this time the project is looking to explore the possibility of project expansion. We are seeking additional volunteer NW tribes and/or Urban Indian Centers. Please see Mattie or email Mattie if you are interested at asthma@npaihb.org in obtaining more information.

Cancer Prevention and Control Research in AI/ANs
Tom Becker, PI
Victoria Warren-Mears, Director
Tom Weiser, Medical Epidemiologist
Ashley Thomas, Project Coordinator
Jacqueline Left Hand Bull

The Tribal Researchers Cancer Control Fellowship Program has completed all three weeks of in person training for the first cohort of ten fellows. Distance learning curriculum development and follow-up evaluations are underway. We have begun recruitment for the second cohort by advertising this opportunity on our newly developed webpage, through various national Tribal health organizations and programs, and through our networks. The 2019 application is available now at www.npaihb.org.

Dissertation Support Program for Tribal Graduate Students
Tom Becker, PI
Victoria Warren-Mears, Director
Tom Weiser, Medical Epidemiologist
Grazia Cunningham, Coordinator
Jacqueline Left Hand Bull

We are excited to share that we are supporting four AI graduate students as they conduct scientific research necessary to complete their degrees. We will continue to advertise this opportunity and look forward to supporting four more students in 2019.

Fellowship Support Program for Tribal Graduate Students
Tom Becker, PI
Victoria Warren-Mears, Director
Tom Weiser, Medical Epidemiologist
Grazia Cunningham, Coordinator
Jacqueline Left Hand Bull

We continue to support three Fellows with monthly stipends associated with their dissertation coursework and five Board Scholars with expenses associated with their graduate coursework. Each Fellow is making great progress toward the completion of their degrees in the next two years.

Ms. Cunningham is currently conducting a survey of all NARCH trainees to follow-up on their career progress to date. She and Dr. Becker will write a manuscript for submission by early Spring 2019.

Summer Research Training Institute and Travel Scholarships
Tom Becker, PI
Victoria Warren-Mears, Director
Tom Weiser, Medical Epidemiologist
Grazia Cunningham, Coordinator
Jacqueline Left Hand Bull

We offered travel support to seventy-five 2018 Summer Research Institute (SI) attendees. To date, only a handful of individuals have reached out to receive support. We have awarded scholarships to nine (all who applied) SI attendees. We continue to advertise this opportunity with students and expect more applications in the coming months.

Dr. Becker and Ms. Cunningham have conducted a six-month follow up with 2018 SI trainees and will summarize results in a manuscript to be submitted by early Spring 2019.

Northwest Tribal Comprehensive Cancer Control Project

Kerri Lopez, Director
Antoinette Aguirre, Cancer Prevention Coordinator

Training

- NARA Tobacco 101 Presentation
    - Topics covered: traditional and commercial tobacco, secondhand smoke, third hand smoke, smokeless tobacco, e-cigarettes, AI/AN specific rates, dangers, marketing and targeting AI/AN
- Food Sovereignty Assessment Training

Technical Assistance

- Share resources and training opportunities with Oregon Tribal TPEP coordinators; *all month*
- [HPV Roundtable] Communications Committee
- Burns Paiute: Follow-up from Tribal TPEP call with smoke-free tribal housing policy samples and templates along with list of Oregon Tribal TPEP coordinators contact information of tribes who have passed tribal housing policies or in the process
- Cowlitz:- information on clinic flow prepare for site visit; drafting the position description, educational materials, smoke-free signs, and tobacco dependence medication/NRT (Nicotine Replacement Therapy).
- HPV follow up for NARA – January**;** HPV information to immunization coordinator
- Klamath: Assist in cancer resources and information about assistance and income support.
- Port Gamble - Assist funding for tobacco education, educational materials, smoke-free signs, and tobacco dependence medication/NRT (Nicotine Replacement Therapy)
- Siletz: smoking cessation information and discussion, cessation information for H2O monitor
- Tribal TPEP/NTCCP Bi-Monthly Call

Special projects

- Lung cancer round table meeting
    - Alaska, AIHC, IHS, NPAIHB, Navajo represented
    - OHSU, Hospice, Telemedicine
- Oregon Prevention Coordinators Meeting
    - Discussion of new project and contract with tribes
    - Will set a preliminary meeting with Caroline, Shane, John
    - Presentation on Policy Guide
- NTCCP January ECHO Webinar NRT Tobacco/Chronic disease
    - Development of survey monkey registration link
    - Assist in the development of the Save the Date flyer
    - Recruitment to all Tribal Cancer Coalition members, Clinical Directors, Tribal TPEP coordinators, and participants at NTCCP last tobacco cessation training (Chehalis)
    - Coordination and assistance with continuing education communication with staff, presenter, content reviewer, and Cardea
    - Monitor registration
    - Send email confirmation to all registered participants
    - Final presentation input – Katie
    - Schedule pilot test run
- On-going follow-up with Oregon and Washington tribes on 2015 EpiCenter and PSE survey for tobacco cessation and policy for the policy resource library
- On-going updates to Youth Tobacco 101 PowerPoint presentation
- ECHO Webinar discussion

  - Assessment
  - Reach out locally
  - Logistics for moving forward
- Hire for NTCCP coordinator
  - Offer made and accepted, starting in January
- Optum meeting with Northwest Portland Area Indian Health Board
  - Development of plan for AI/AN quit line in Oregon
- ORCHWA
  - Discussion of survey for tobacco cessation
  - How to get stream of funding to tribes
- Updated Tobacco 101 PowerPoint for NARA presentation
- Assist in updating Tobacco Jeopardy Game and PowerPoint presentation for Port Gamble youth training
- Interview panel for the Cancer Project position
- On-going development of new factsheet *The Real Cost of Commercial Tobacco*
  - Average price of tobacco for NW area (ID, OR, WA)
  - Health care cost for NW area
  - Big tobacco expenditures for marking in the NW area
  - Annual average amount adult smoker saved by quitting in the NW area
- Prep for Place Matters Conference Panel questions
  - Panel presentation on NW tribal policy work
  - Received award for NPAIHB organization
- OHA Contract Meeting
  - SOW, Budget
- Optum/OHA/NPAIHB Meeting about AI/AN Quit Coach Pilot
  - AI/AN Quit Coach Pilot Meeting
- Tribal BRFSS Overview Meeting
- CRC Taskforce Meeting: Underserved Populations
- All Staff: Preventing Harassment and Discrimination Training

Meetings/Conferences

- All Staff Xmas Party
- NPAIHB Staffing (2)
- Project directors (2)
- Tribal Policy Guide Meeting (NTCCP, WEAVE, and NICWA)
- CRC Taskforce Meeting: Underserved Populations (2)
- Oregon Cancer Leadership Meeting
- NW Tribal Breastfeeding Coalition meeting
- Cardea Continuing Education call

- Tribal TPEP/NTCCP bi-monthly call
- Cardea Continuing Education call
- NARA Planning Meeting

Conference / Webinar calls

- HPV Roundtable Communications Committee
- 2morrow App Health Meeting
- BRFSS Review : WS & NPAIHB
- CCCTAT Steering Committee Quarterly Call
- CDC/CCC TA Call
- CDMIS APR Training
- DCPC Tribal Bi-Monthly Calls
- E-cigarettes: Unintended consequences or strategic marketing
- George Washington NW Tribal Comp Cancer Coalition Interview
    - HPCDP Webinar: Public Use of Cannabis
- Knight Scholars Advisory Committee kickoff call
- Liver cancer screening call Idaho and Cherokee nation pilots
- NCCCP Awardee Panel
- NIHB Cancer Screening Pilot Presentations
- NNN Webinar: The Sacred Circle of Tobacco Youth Curriculum
- NWIHB CCC TA Call
- OHA August Cancer Leadership Team Meeting
- OR Prevention Coordinators Meeting
- Place Matters Session Planning Call
- Quills to Cessation
    - The Impact of Sexual Violence on Men and Boys
- Tribal TPEP/NTCCP Bi-Monthly Call
- Truth initiative e cigarettes
- USPHS Dentist Webinar: Tobacco Use and E-cigarettes
- WA HPV Task Force-

Northwest Tribal Dental Support Center

Ticey Mason, Project Director
Bonnie Bruerd, Prevention Consultant
Bruce Johnson, Clinical Consultant
Kathy Phipps, Epidemiology Consultant
Joe Finkbonner, NPAIHB Executive Director

The Northwest Tribal Dental Support Center (NTDSC) is in their 19th year of funding. The overall goals of NTDSC are to provide training, quality improvement, and technical assistance to the IHS/Tribal Dental programs, and to ensure that the services of the NTDSC result in measurable improvement in the oral health status of the AI/AN people served in the Portland Area. NTDSC activities are listed in categories corresponding to the current grant objectives.

Ensure quality and efficient care is provided in Portland Area dental programs through standardization of care and implementation of public health principles to improve dental access and oral health outcomes.

- NTDSC staff and consultants, in coordination with the Indian Health Service Area Dental Consultant (ADC), have provided 6 site visits this past quarter. NTDSC consultants visited Umatilla (Yellowhawk clinic), Chehalis, and Squaxin Island and NTDSC staff visited the Port Gamble S'Klallam tribe. Dr. Sixkiller (ADC) visited Fort Hall and Chemawa to provide a dental assistant course.

Expand and support clinical and community-based oral health promotion/ disease prevention initiatives in high-risk groups to improve oral health.

- The work with ARCORA (The Foundation of Delta Dental of Washington) on our Baby Teeth Matter Initiative (BTM) is continuing with 7 dental programs. The first in-person meeting was October 17, 2019 and noon webinar on December 19, 2018. NTDSC is currently developing a program manual for new programs.

- The Elder Initiative is continuing with 12 dental programs and the in-person meeting was October 24, 2019. Participants included dental staff and Elder Coordinators from various tribes.

Implement an Area-wide surveillance system to track oral health status.
Data from the surveillance system will be used to identify vulnerable populations and plan/evaluate clinical and community-based prevention programs.

- Dental programs are currently surveying 0-5 year olds in medical and community settings. We encouraged all IHS and tribal dental programs to participate in this survey although many have opted not to participate.

Provide continuing dental education to all Portland Area dental staff at a level that approaches state requirements.

CDE: NTDSC tracks the number of participants and CDE credits provided through the Update on Prevention Course provided during site visits, BTM and Elders Initiatives, NTDSC yearly orientation and full meeting, and the addition of the clinical MID course.

NTDSC consultants participate in email correspondence, national conference calls, and respond to all requests for input on local, Portland Area, and national issues.

NTDSC staff is assisting with the national Indian Health Service Dental Updates meeting on agenda topics and presenters. NTDSC staff notifies our regional area about this meeting, which also provides CDE to our dental programs.

The Portland Area exceeded the dental GPRA objectives for FY 2018. Congratulations to the dental programs for their hard work and commitment to dental access and prevention!

Northwest Tribal Registry Project-Improving Data and Enhancing Access (IDEA)

Victoria Warren-Mears, Principal Investigator
Sujata Joshi, Project Director
Chiao-Wen Lan, Epidemiologist
Heidi Lovejoy, Substance Use Epidemiologist
Joshua Smith, Health Communications Specialist
Karuna Tirumala, Project Biostatistician
Natalie Roese, Project Intern
Email: IdeaNW@npaihb.org

Staff Updates

- Karuna Tirumala started her position as IDEA-NW Biostatistician on 10/1.
- Heidi Lovejoy joined the team as a Substance Use Epidemiologist on 11/13.

Current status of data linkage, analysis, and partnership activities

Northwest Tribal Registry (NTR) data linkages

- Completed linkage with Oregon State Cancer Registry (OSCaR) 1996-2017 records
- Completed linkage with Washington CHARS (hospital discharge) 2016 records
- Completed linkage with Washington State Cancer Registry (WSCR) 1992-2017 records

Dataset Preparation

- Birth Certificates
  - Completed cleaning and preparing Oregon birth certificate records (2008-2017) for analysis; prepared Data Dictionary
- Hospital Discharge
  - Began cleaning and preparation of Washington CHARS 2015 and 2016 records
- Death Certificates
  - Began cleaning of Oregon 2014-2017 death certificates/matched infant death records
- Washington Communicable Diseases
  - STD Data
    - Communicated with WA STD staff to clarify dataset information

        - Completed data cleaning, prepared SAS analytic dataset, and updated dataset tip sheet
    - General Communicable Disease Data
        - Worked on checking and recoding Washington General Communicable Diseases 2007-2016 data and preparing data dictionary

Data Analysis and Report Preparation Projects

- Tribal Health Profiles project
    - Washington Diabetes Profile
        - Continued preparing report in In-Design
    - Washington Cardiovascular Disease Profile
        - Worked on finalizing report in In-Design
    - Washington Substance Abuse Profile
        - Continued analysis of CHARS 2011–2014 for acute drug overdose and acute opioids overdose
    - Maternal & Child Health Data Profiles - Oregon
        - Analyzed 2008-2012 and 2013-2017 birth certificate data with AI/AN and NHW comparisons and 5 year cohort comparisons.
        - Created tables and figures describing (1) maternal characteristics, (2) maternal risk factors and (3) birth outcomes.
        - Began work on first draft of data profile
- Tobacco and Cardiovascular disease deaths
    - Conducted preliminary literature review on death records analysis, and cardiovascular death and its intersection with tobacco use to prepare for death certificate analysis
- Tableau
    - Completed first draft of IDEA-NW Tableau dashboard
    - Completed Karuna's training in Tableau Desktop
- Colville Tribes' Community Household Health Assessment analysis
    - Completed health needs survey dataset cleaning and preparation for analysis, along with in-code and independent documentation of reasoning behind
    - Prepared analysis report with results, summarizing findings of analysis and outlining analysis challenges/limitations, further potential analysis, and measures that can be taken to improve data collection protocol in the future
    - Considered health system recommendations based on analysis to include in report and meeting with the tribe
    - Created data dictionary for cleaned health needs survey dataset
    - Scheduled meeting with Colville staff to review report and future steps for project
    - Shared preliminary analysis, figures, recommendations, report, and materials with Tribe
        - Responded to request for acquiring SAS licenses from IHS
        - Discussed developing a long-term relationship to help address turnover at Colville
        - Received request for documents outlining the data cleaning process
    - Continued work to adapt data dictionary to reflect conversation with CCT
    - Began transforming report into an adaptable template for subsequent analyses with other tribes
- TEC-PHI Supplement Journal Article on Identifying AI/AN in public health datasets

  - Completed analysis and manuscript comparing different definitions of AI/AN in Washington death records
  - Prepared and submitted an abstract for the 2019 CSTE conference on identifying AI/AN in public health datasets
- Substance Use Analyses
  - Revised and resubmitted manuscript on drug and opioid overdose deaths among AI/AN in Washington to Morbidity and Mortality Weekly Review
  - Submitted abstract to 2019 International Meeting on Indigenous Child Health, titled "Maternal substance use disorders and infant withdrawal syndromes in hospital deliveries among American Indians and Alaska Natives in Washington"
  - Prepared CSTE 2019 conference abstract, titled "Racial disparities in substance use disorders and self-inflicted injury among youth in Washington, 2011 – 2014"
  - Submitted abstract to 2019 Oregon Conference on Opioids, Pain, and Addition Treatment, titled "Disparities of opioid use disorder hospitalizations among American Indian and Alaska Natives in Oregon, 2010 – 2014".
  - Prepared NPAIHB January 2019 newsletter, titled "Substance use disorders and self-harm among Native youth"
  - Prepared analysis for CHARS 2011-2016 manuscript on substance use comorbidities

Suicide Surveillance Project

- Suicide data profiles
  - Began preparing SAS code for analysis of death certificates
- Suicide Monitoring Planning Projects
  - Presented information on Funding Opportunity Announcement at October QBM
  - Provided technical assistance on application to Chehalis Tribe via phone call
  - Reviewed three applications for tribal suicide monitoring planning projects and compiled list of proposed modifications to workplan, activities, and budgets
  - Sent emails to Tribes with notice of intent to fund pending revisions to workplan/budgets
  - Submitted contractor approval requests to CDC for three applicant Tribes
  - Began work on developing contracts for each Tribe

Maternal & Child Health (MCH) Workgroup

- Shared list of research ideas to brainstorm collaborations and future analysis
- Discussed the use of PRAMS/PRAMS2 as a potential source of MCH indicators
- Discussed maternal mortality analysis using death certificate data set
- Assisted with preparing proposal to request Oregon PRAMS/PRAMS2 data
- Began WA PRAMS analysis on maternal social support and utilization of healthcare services

NWTEC Public Health Infrastructure (TEC-PHI) Grant Activities

- BioStat Core Meetings
  - Continued bi-weekly meetings
- Health Communications/Evaluation Specialist
  - Completed the updated Health Data Literacy Mapping module

        - Gave the mapping session at the Umatilla Health Data Literacy Training
    - Provided feedback on Cayuse eMAR meeting
    - Began compiling evaluation data for Year 1 national TEC-PHI evaluation reporting
    - Developed content for infographics session for TEC-PHI evaluation workshop
    - Worked on developing infographic describing EpiCenter Opioid work
    - Completed the year 1 TEC-PHI evaluation reporting
    - Conducted infographic session at TEC-PHI evaluation workshop
    - Developed infographic describing EpiCenter Opioid work
- Health Data Literacy Trainings
    - Finalized logistics and content for HDL training at Yellowhawk Tribal Health Center
    - Outlined proposed changes to mapping/ GIS HDL module
    - Began planning and logistics for February HDL course at Yakama Nation
- TEC-PHI Workgroups and Meetings
    - Continued attending TEC-PHI community of practice meetings and webinars
- Other
    - Held interviews for Substance Use Epidemiologist position
    - Prepared slides for NPAIHB project presentations
    - Onboarding for Karuna
        - Met with Board admin staff and project directors for onboarding
        - Completed HIPAA and CITI recertification trainings
        - Read TEC-PHI grant and other project-related documentation for familiarization with project
        - Secured access to NIH Library, Washington CHAT, and Oregon PHAT
    - CDC 1803 Linkage grant
        - Began planning for AI/AN Mortality Data Analysis course

Data requests/Technical assistance

- Provided links to data resources on youth tobacco/tobacco products use for AI/AN in Oregon to Corey Strong (Siletz Tribe)
- Provided infographic advice and Tableau limitations/ uses to Nicole Smith for Native CARs
- Created a fact sheet for Kerri Lopez
- Provided information on partnership and TEC's use of ESSENCE data on call with Great Plains TEC re: TEC access to syndromic surveillance data
- Provided data on diabetes and heart disease rates for AI/AN and non-Hispanic Whites in Skagit County to Jamie Donatuto and Kyra Herzberger (Swinomish Tribe)
- Reviewed and provided comments on Alex Wu's EIS abstract submission
- Sent Alex Wu information and SAS code on coding drug and opioid overdose deaths
- Provided data summary for Colville Tribe Health Needs Assessment
- Helped the Domestic and Sexual Violence Prevention Project (Paige Smith) update links and text on the NPAIHB website
- Provided examples of data sharing agreements to Taylor Ellis to provide to Yellowhawk Clinic

Presentations & Results Dissemination

- CDC Preventive Medicine Grand Rounds - presentation on misclassification and IDEA-NW project, Webinar, 10/3

- 2018 Oregon Public Health Association Conference, "Five year prevalence and trends of alcohol use disorder hospitalizations in American Indians/Alaska Natives: Oregon, 2010 – 2014", 10/9
- 2018 Oregon Public Health Association Conference, "Suicide deaths among American Indians & Alaska Natives: Oregon, 2009-2013", 10/9
- Manuscript "Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives — Washington, 1999–2015" published in Morbidity and Mortality Weekly Review, December 20th issue

Trainings Provided to Tribes/Tribal Programs

- Provided training to 19 participants during a Health Data Literacy Training at Yellowhawk Tribal Health Center, 10/10-10/11

Institutional Review Board (IRB) applications and approvals/Protocol development

- Submitted data request and received approval for access to AI/AN records in Oregon's Violent Death Reporting System
- Received executed contract for linkage between Washington Medicaid and NTR
- Submitted and received approval for continuation application request to Washington State IRB for Trauma Registry linkages
- Submitted and received approval for continuation application and study amendment request to Washington State IRB for linkages with Washington birth certificates
- Reviewed draft Data Sharing Agreement for requesting identified EpiDataMart data for creation of Northwest Tribal Registry
- Worked on updating trainings/confidentiality pledges for Oregon ORPHEUS data sharing agreement

Grant Administration and Reporting

- Revised and submitted workplan and budget for core TEC-PHI Year 2 grant
- Revised and submitted budget for TEC-PHI Opioid Supplement
- Submitted no cost extension for unspent Year 1 TEC-PHI funds
- Compiled and prepared TEC-PHI Year 1 evaluation report for TEC-PHI evaluation workshop
- Revised CDC 1803 Linkage budget

Travel

Site Visits

- Health Data Literacy Training at Confederated Tribes of the Umatilla Indian Reservation 10/9-10/11

Linkages

- Oregon State Cancer Registry, Portland, OR 10/4

- Washington State Cancer Registry, Olympia, WA 11/4

Other

- 2018 Oregon Public Health Association Annual Meeting, Corvallis, OR 10/8-9
- TEC-PHI Evaluation Workshop, Albuquerque, NM 12/3 – 12/4
- Tableau Accelerated Desktop Training, Seattle, WA 12/19-12/21

Data reports, fact sheets, and presentations are posted to our project website as they are completed:
http://www.npaihb.org/idea-nw/
Please feel free to contact us any time with specific data requests.
Email: sjoshi@npaihb.org or IdeaNW@npaihb.org
Phone: (503) 416-3261

TEC-PHI Opioid Supplement

Coordination and Partnership Activities

- Connected with WA DOH opioid epi, tribal epi, and Injury Violence & Prevention program manager
- Completed AMIA Health Informatics Practice Analysis Validation Survey
- Held EpiCenter Opioid Workgroup meeting to discuss concurrent opioid projects, coordination between grants, and communication with tribes
- Created draft matrix of grant funding, activities, staffing
- Attended Northwest Tribes Appreciative Inquiry & Strategic Planning Workshop to meet key tribal partners in opioid work and gain familiarity with opioid-related data needs
- Attended Indian Country ECHO Substance Use Disorders Clinical Training Workshop to gain familiarity with clinical methods and current opioid and substance use projects and needs
- Discussed TA ideas; plan to request access to clinical data systems and develop how-to guides for clinics to pull opioid data as needed

Data Analysis, Visualization, and Report Preparation

- Started WA death certificates analysis (1999-2016) to examine fatal opioid overdose indicators for Washington State Substance Use Profile

Data Requests/Technical Assistance

- Provided input on the needs assessment survey for the Appreciative Inquiry workshop

Grant Administration and Reporting

- Submitted revised project work plan (minor edits to Components 3 and 4) to Molly and Danielle at CDC

Other Activities

- Submitted abstract with Chiao-Wen to 2019 Oregon Conference on Opioids + Other Drugs, Pain + Addiction Treatment (OPAT), titled "Disparities of opioid use disorder hospitalizations among American Indian and Alaska Natives in Oregon, 2010 – 2014"
- Provided input on CSTE abstract draft "Racial Disparities in Substance Use Disorder and Self-Inflicted Injury among Youth in Washington, 2011 – 2014"
- Discussed Rhapsody use with WA DOH 12/6
- Completed SAS 1 training, began SAS 2 training, found SAS Introduction to ANOVA, Regression, and Logistic Regression training (next training)
- Completed IRBNet Registration
- Submitted confidentiality agreement needed for Oregon's communicable disease reporting system (ORPHEUS)
- On-boarding activities for Heidi

Response Circles-Domestic & Sexual Violence Prevention

Colbie Caughlan, MPH, Project Director – THRIVE and Response Circles
Paige Smith, Project Coordinator – THRIVE and Response Circles

Site Visits

Tribal Site Visits

- None during this reporting period.

Out of Area Travel

- Advanced Domestic Violence (DV) and Sexual Assault (SA) Training, Las Vegas, NV – Dec. 4-7

Technical Assistance & Training

During the quarter, project staff:

- Participated in 8 meetings and conference calls with program partners.
- Outlined a plan to promote and improve the project during grant year two.

During the quarter, Response Circles (RC) staff provided or participated in the following presentations, webinars and/or trainings:

- Training (2) – Attended the Advanced Domestic Violence (DV) and Sexual Assault (SA) Training in Las Vegas and a virtual training for Healing and Wellness.
- Presentation/Update (1): Gave an update on the RC project at the OR 9 Tribes Quarterly Prevention Meetings in Portland, OR.
- Webinar (3) – Attended three webinars for the DV or SA to become more knowledgeable about the topics.

During the quarter, the RC project responded to over 8 phone or email requests for domestic or sexual violence prevention, or media campaign-related technical assistance, trainings, or presentations.

Health Promotion and Disease Prevention

Response Circles Media Campaign: All RC promotional materials (including the almost completed updated materials) are available on the web. Materials include: posters, brochures, tip cards, and radio PSAs.

Other Administrative Responsibilities

Staff Meetings

- EpiCenter meetings
- All-staff meetings
- Project Director meetings
- Wellness Committee – monthly meetings and events

Publications

- None during this reporting period.

Reports/Grants

- Submitted the financial report for year 1 quarter 4 of the Domestic Violence Prevention Initiative (DVPI) grant.
- Submitted the year 1 annual report for the DVPI grant.

Administrative Duties

- Budget tracking and maintenance: Ongoing.
- Managed Project Invoices: Ongoing.
- Staff/Intern oversight and annual evaluations: Ongoing.
- Managed Project Subcontracts: Ongoing

THRIVE (Tribal Health: Reaching out InVolves Everyone)

Colbie Caughlan, MPH, Project Director – THRIVE, TOR, & RC
Celena McCray, MPH(c), B.S.Ed., THRIVE Project Coordinator
Paige Smith, THRIVE & RC Project Coordinator

Site Visits

Tribal Site Visits

- QBM, Port Gamble S'Klallam Tribe, Kingston, WA – October 16-17
- Healing of the Canoe Training, Cowlitz Indian Tribe, Longview, WA- November 16

Out of Area Travel

- American Public Health Association (APHA) annual conference, San Diego, CA – November 11-14

Technical Assistance & Training

During the quarter, project staff:

- Participated in 45 meetings and conference calls with program partners.
- Disseminated 70+ packages of the suicide prevention campaign(s) for #WeNeedYouHere.

During the quarter, THRIVE provided or participated in the following presentations and trainings:

- Presentations (5)– Presented on suicide surveillance pilot projects at the QBM, 65+ attendees, Kingston, WA; poster presentation on the *Concerning Post Webinar* at the APHA annual conference, 16 people stopped by, San Diego, CA; THRIVE project update at the OR 9 Tribes Quarterly Suicide Prevention meeting, 50 attendees, Portland, OR; 2 presentations on peer support specialists for substance use disorders at the Data Waiver training, 27 attendees, Portland, OR
- Facilitation/Training (2) – Attended a Question Persuade Refer (QPR) training for trainers in Portland, OR and attended a Healing of the Canoe booster training at the Cowlitz Tribe in Longview, WA

During the quarter, the THRIVE project responded to over 94 phone or email requests for suicide, bullying, Zero Suicide Model, or media campaign-related technical assistance, trainings, or presentations.

Health Promotion and Disease Prevention

THRIVE Media Campaign: All THRIVE promotional materials are available on the web. Materials include: posters, informational rack and tip cards, t-shirts, radio PSAs, and Lived Experience videos.

GLS Messages October & December: Number/Reach of We R Native Facebook messages addressing…

- Suicide (general) = 9 posts, 0 text message, **16,240** people reached
- #WeNeedYouHere - LGBT2S = 1 post, 0 text message, **3,500** people reached

Other Administrative Responsibilities

Staff Meetings

- EpiCenter meetings
- All-staff meetings
- Project Director meetings
- Wellness Committee – monthly meetings and events

Publications

- 2018 THRIVE Conference article in the October NPAIHB Quarterly News & Notes
- Bullying Prevention Resources article in the October NPAIHB Quarterly News & Notes

Reports/Grants

- Submitted the year 3 MSPI PA 2 annual report during this reporting month and a year 3 quarter 4 financial report
- Submitted the GLS year 4 annual financial and progress reports

Administrative Duties

- Budget tracking and maintenance: Ongoing.
- Managed Project Invoices: Ongoing.
- Staff/Intern oversight and annual evaluations: Ongoing.
- Managed Project Subcontracts: Ongoing

Tribal Opioid Response (TOR) Consortium

Colbie Caughlan, MPH, Project Director – THRIVE, TOR, & RC
Megan Woodbury, Opioid Project Coordinator

Site Visits

Tribal Site Visits

- Tribal Opioid Summit, hosted by the Muckleshoot Indian Tribe and located at the Puyallup Tribe, Tacoma, WA – November 15

Out of Area Travel

- American Public Health Association (APHA) annual conference, San Diego, CA – November 11-14

Technical Assistance & Training

During the quarter, project staff:

- Participated in 13 meetings and conference calls with program partners.
- Hosted and presented on a regional video conference calls around the TOR Consortium grant deliverables and scope of work options for the 22 consortium tribes, 18 attendees.
- Attended 2 webinars during the reporting period: *Medication-Assisted Treatment (MAT) Outpatient Clinics: Using Behavioral Telehealth* and *SOR/TOR Grantee Reporting Requirements.*

During the quarter, the TOR consortium project responded to over 81 phone or email requests for opioid and substance use disorder prevention, education, medication, grant requirements, etc.

Health Promotion and Disease Prevention

The TOR Consortium staff work closely with many other Opioid Prevention projects at the NPAIHB and together these projects have developed a draft Substance Use Disorder e-newsletter which will go out for the first time in early 2019 and in February there will also be a Harm Reduction ECHO series via the Zoom video conferencing software which will be open for all of Indian Country to learn about successful tribal opioid prevention and treatment projects. These will also focus on resources and opportunities that may be helpful for tribal communities and tribal organizations to know about and connect with.

Other Administrative Responsibilities

Staff Meetings

- EpiCenter meetings
- All-staff meetings
- Project Director meetings
- Wellness Committee – monthly meetings and events

Publications

- None during this reporting period.

Reports/Grants

- Submitted a required Strategic Plan for Opioid Response to SAMHSA as required by the TOR grant special conditions.
- Submitted a revised budget to SAMHSA as required by the TOR grant special conditions.

Northwest Tribal Epidemiology Center
(*The EpiCenter*)
October-December 2018 Quarterly Report

Administrative Duties

- Budget tracking and maintenance: Ongoing.
- Managed Project Invoices: Ongoing.
- Staff/Intern oversight and annual evaluations: Ongoing.
- Managed Project Subcontracts: Ongoing

Wellness for Every American Indian to View and Achieve Health Equity (WEAVE)

Victoria Warren Mears, PI
Tam Lutz, Project Director
Jenine Dankovchik, Evaluation Project Specialist
Nora Frank, Health Educator
Ryan Sealy, Tobacco Specialist
Birdie Wermy, National Evaluator
Chelsea Jensen, Project Assistant

BACKGROUND

WEAVE-NW is a program of the Northwest Tribal Epidemiology Center, funded through the CDC's Good Health and Wellness in Indian Country (GHWIC) initiative. The overall objective is to establish or strengthen and broaden the reach and impact of effective chronic disease prevention programs that improve the health of tribal members and communities.

The project has built capacity and created lasting change through training, technical assistance and collaborative support to aid Northwest tribes in creating policy, systems and environment changes that encourage healthy lifestyles.

Meetings (excluding internal)

Conference/committee: 1
Tribal Community: 5
Funding Agency: 6
Sub-Awardee: 0
Community (non-tribal): 1
Government Partner: 2
Other: 9

Total Meetings: *24*

Site Visits

Date(s)	Tribe	Short Summary
10/17/18	Port Gamble S'Klallam Tribe	Tobacco Meeting
10/22/18	Umatilla Tribe	Site visit and program check in
11/05/18	Non-NPAIHB Tribe (specify)	Attended Tend, Gather, Grow session (an implementation funding recipient) to observe

Total number of site visits this quarter: 3

Northwest Tribal Epidemiology Center
(*The EpiCenter*)
October-December 2018 Quarterly Report

Presentations
WEAVE-NW gave a total of 2 presentations this quarter

Publications
WEAVE-NW completed 1 publication this quarter

Professional Development
WEAVE-NW staff completed a total of 7 professional development activities this quarter

Technical Assistance Given
WEAVE-NW responded to 8 requests for technical assistance this quarter

Trainings
In-Person

- 10/10/2018 Health Data Literacy
- 11/7/2018 Food Sovereignty Assessment Tool Training
- 12/7/2018 Tobacco 101

Total number of trainings given this quarter: 3

Western Tribal Diabetes Project

Kerri Lopez, Director
Don Head, Project Specialist
Erik Kakuska, Project Specialist

Trainings

- NARA –tobacco cessation training
- NARA – youth treatment center Youth tobacco 101 planning in place

Technical Assistance:

- Ongoing for updating new program staff
- Cowlitz, (3) TA capturing ACE/ARB prescriptions, capturing ACE/ARB prescriptions;
- Great Plains (2) IHS, inquiry about our availability for training in February; request for offsite training in February
- Isleta Pueblo Clinic, asked about the DMS training in December,
- Nez Perce - help to find CAC training. Informatacist
- Nimiipuu Health; requesting help to find CAC training. Asked what requirements are needed for CAC degree. Referred to Katie Johnson who stated that there is a degree, called an Informatics.
- Reno Sparks Tribal Health Center; TA for follow up RPMS
- Siletz follow up for tobacco cessation protocol
- Skokomish (2) – TA with CPT codes needed to be entered for nutrition education, TA about CPT codes needed to be entered for nutrition education, so that the reminders would be turned off

for patients who received. Since reminders is an EHR thing, I referred her question to NPAIHB CAC

- Skokomish, TA for use iCare for mail merge
- Snoqualmie, request for training information; emailed them our agenda and our registration flier, as well as a link to register online
- Snoqualmie, TA requesting information about our training
- Umatilla (4)- requesting help with generating reports for dental team. Needed to know the population, as well as how many visits. Sent QMAN exercises practiced in DMS class; QMAN to generate a report for childre, TA on our QMAN exercises to assist DC with finding a group of patients; ta generating reports for dental team. Needed to know the population, as well as how many visits. Went over QMAN exercises practiced in DMS class; TA to connect and walk through QMAN to generate a report for children who had a dental visit between Jan. 1, 2018-June 30, 2018; Also generated a report for the total dental population.
- Dissemination to WTDP SDPI programs for December training
- <u>Special Projects:</u>
- Native Fitness 2018 September 6 and 7 – Bo Jackson Center and TWC
    - 185 participants – still outstanding invoices for 40 participants
    - Final invoicing for TWC and transportation
- OHA Place Matters
    - Attended
    - Presented on policy panel
    - NPAIHB received Organizational Award
- OHA A&D contract
    - Final scope of work
    - Final budget
- National Congress of American Indians
    - Plenary
    - Health, youth, and opioid sessions
-
- Created Save the Date flyers for NARA
- Created Save the Date flyers for Nicotine replacement webinar
- Updated Asthma flyer
- Holiday Food Planning group (visit to Holiday Bowl)
- Started work on the NPAIHB Newsletter (2)
- Worked on a presentation update for the Audit and DMS
- Emailed PAO IHS about the possibility of getting the new DMS if they had the software, that will get us access to the DMS soon
- Set up new Adobe contract

Northwest Tribal Epidemiology Center
(*The EpiCenter*)
October-December 2018 Quarterly Report

- Working with IHS – ADC for audit data
- ENDO Echo – discussion of future direction; assessment, local connections, tribes that have made commitment
- NPAIHB Newsletter
    - Layout, Design, Edits

Partnerships and collaborations

- Oregon Prevention Coordinators Meeting
    - Discussion of new project and contract with tribes
    - Will set a preliminary meeting with Caroline, Shane, John
    - Presentation on Policy Guide
- NTCCP January ECHO Webinar NRT Tobacco/Chronic disease
    - Continued recruitment
    - Coordination and assistance with continuing education communication with staff, presenter, content reviewer, and Cardea
    - Monitor registration
    - Send email confirmation to all registered participants
    - Final presentation input – Katie
    - Schedule pilot test run
- Oregon Health Authority
    - Optum meeting about AI/AN quit line
- Ongoing follow-up with Oregon and Washington tribes on PSE survey for tobacco cessation and policy for the policy resource library
- Created Save the Date flyers for Nicotine replacement webinar
- Endo Echo – discussion of training WTDP specialist
- NNACOE/NPAIHB Tribal Engagement Team
    - Annual meeting
    - Project introductions
- WS BRFSS Project
    - Modifying summary report
    - Identifying areas of interest and concern

Meetings and Conferences

- NPAIHB Staff meeting (3)
- NPAIHB Monthly meetings (3)
- ECHO training – ABQ
- Non-RPMS webinar with ADC's
- Attended the PAO Diabetes meeting
- Policy Guide Meeting

- NCO Meeting
- Obesity coalition leadership planning meeting
- Adobe Connect session
    - IHS Roll and Scroll changes
- Meeting with Ann Bullock – EndoEcho discussion
- QBM, Oct 16-17
- NPAIHB Veteran's Committee Meeting
- National Congress of American Indians

Conference Calls:

- Non-RPMS webinar with ADC's
- E-cigarettes: Unintended consequences or strategic marketing?
- NNN Webinar: The Sacred Circle of Tobacco Youth Curriculum
- Cardea, planning for CEU's for NRT call in January
    - Sent out invitations to diabetes coordinators
- Improving Health Care Delivery Data Project: Steering Committee meeting

Legislative & Policy Update

Quarterly Board Meeting
Hosted by the Suquamish Tribe
January 22, 2018

Report Overview

1. 2018 Mid Term Elections
2. Legislation
3. GAO Reports
4. IHS Budget Formulation Process
5. Current & Pending Federal Policies
6. Litigation
7. Upcoming National/Regional Meetings

2018 Mid Term Elections

2018 Midterm Elections

- 116th Congress
  - Senate: Republican Majority
    - 53 Republicans, 47 Democrats
  - House: Democratic Majority
    - 235 Democrats, 199 Republicans
- Governor Races: 23 Democratic Governors, 27 Republican Governors.
- Medicaid Expansion: Idaho (61%)- will expand coverage for 2,500 AI/ANs

Legislation

5

IHS Appropriations FY 2019

- In Partial Government Shutdown
  - Continuing resolution expired 12/21/18
- H.R. 266 -- Department of Interior, Environment, and Related Agencies Appropriations Act, 2019
  - Introduced by Rep. Betty McCollum (D-MN-4) on 1/8/19.
  - Passed House on 1/11/19 (240-179)
  - Status: Senate Legislative Calendar
- H.R. 21 – Consolidated Appropriations Act
  - Passed House on 1/3/19 (241-190)

Pay Our Doctors Act of 2019 (H.R. 195)

- Introduced by Rep. Markwayne Mullin (R-OK-2) on 1/3/19; 13 co-sponsors.
- Provides funding at the FY 2018 level for IHS in the absence of a continuing resolution from Congress.
- Would end the lapse in funding for IHS, tribal and urban Indian facilities and allow to continued operations.
- Referred to House Committee on Appropriations on 1/3/19.

To Be Introduced
Equal Access To Medicaid for All AI/AN

- Tribal Self-Governance Advisory Committee initiative
- The aim is to *fix gaps in access to high-quality health care services* under Medicaid for low- and moderate-income American Indians and Alaska Natives (AI/ANs) across all states.
- Approach:
  - Do no harm.
  - Build on existing administrative infrastructure.
    - Indian health care providers (IHCPs) are defined in federal regulations.
    - Most services to AI/ANs by IHCPs are currently supported with 100% federal funding.
  - Establish new authorities as either "requirements" or "options" based on assessment of: (a) ability to achieve policy goal and (b) ability to enact legislation.

To Be Introduced
Equal Access to Medicaid for All AI/AN

- Would authorize Indian Health Care Providers (IHCPs) in all states to receive Medicaid reimbursement for a federally-defined set of health care services—referred to as Qualified Indian Provider Services (QIPS)—when delivered to AI/ANs.
- Would create the option for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level (FPL).
- Would extend full federal funding (through 100% FMAP) and the IHS encounter rate to Medicaid services furnished by *urban* Indian health programs to AI/ANs.
- Would clarify federal law and regulations related to AI/AN specific policies.
- Would Address the "four walls" limitations on IHCP "clinic" services.

House E&C Indian Health Task Force

Photo (L) : July 23 prep meeting with staff
Photo (R): July 24 meeting with members of Task Force (NIHB photo)

- House Energy & Commerce Committee established the IHS Task Force in 2017.
- Tribes and tribal organizations across Indian country, including NPAIHB, provided input to the Task Force on ways to reform IHS so that it can better serve AI/AN.
- Task Force conducted a survey to tribes in the fall.
- Task Force has not disseminated results of their findings.

GAO Reports

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GAO Report for IHS Advance Appropriations

- On 9/13/18, GAO issued a report titled, "Indian Health Service: Considerations Related to Providing Advance Appropriation Authority" – GAO-18-652.
- GAO makes recommendations for policy makers to consider
- *Next steps*: In-person testimony, letters, Hill and IHS meetings, tribal conference gatherings - that the FY 2020 Interior and Related Agencies appropriations bill include FY 2021 advance appropriations for the IHS.
- Report available at www.gao.gov

GAO Report on the Affordable Care Act - Pending

- Government Accountability Office (GAO) conducting a study on the effects of the Affordable Care Act on Indian health facilities and on health insurance coverage for AI/AN.
- Visited Portland Area on December 4, 2018
- Collecting information on Portland Area impacts to facility operations (including patient coverage, collections and use of collections, PRC, etc).

IHS Budget Formulation Process

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FY 2020 IHS Budget

- National Tribal Budget Formulation Workgroup co-chairs presented the recommendations for FY 2020 at the HHS Annual Tribal Consultation in D.C. on March 1 and to HHS Budget Council for the Tribal Budget Formulation in D.C. on April 11.
- Recommends over $7 billion for FY 2020 (36% increase over FY 2017 enacted level).
- Recommends $36.83 billion for tribal needs based budget to be implemented over 12 year period.
- Available at: https://www.nihb.org/legislative/budget_formulation.php

FY 2021 IHS Budget

- Portland Area Budget Formulation Process was on November 15, 2018.
- National Budget Formulation Meeting is scheduled for February 14-15, 2019 in Crystal City.
- Following February meeting, NIHB writes up the recommendation for IHS National Tribal Budget Formulation Workgroup (NTBFW)
- Opportunity for IHS NTBFW to present recommendations at HHS Annual Tribal Consultation scheduled for April 3-4, 2019 in DC.

Current & Pending Federal Policies

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HHS Report: Reforming America's Healthcare System Through Choice and Competition

- Issued: 12/3/18
- Issues Identified:
  - Health Care Workforce and Labor Markets;
  - Health Care Provider Markets;
  - Health Care Insurance Markets; and
  - Consumer-Driven Health Care.
- Examples of Recommendations:
  - Broaden Scope of Practice
  - Improve Workforce Mobility
  - Facilitate Telehealth to Improve Patient Access
  - Positively Realign Incentives through Payment Reform
  - Using Choice to bring a Longer-Term View to Health Care
  - Quality Improvement and the Measurement and Reporting of Quality
  - Facilitate Price Transparency
  - Improve Health IT

HHS Draft Strategy to Reduce Regulatory and Administrative Burden of Health IT and EHRs

- Comments Due: 1/28/2019
- Purpose: With the passage of the 21st Century Cures Act, Congress directed HHS to establish a goal, develop a strategy, and provide recommendations to reduce EHR-related burdens that affect care delivery.
- Burden Reduction Goals:
  - Reduce the effort and time required to record health information in EHRs for clinicians;
  - Reduce the effort and time required to meet regulatory reporting requirements for clinicians, hospitals, and healthcare organizations; and
  - Improve the functionality and ease of use of EHRs.

HHS Draft Report Pain Management Best Practices

- Comments Due: 4/1/19
- Issued by: Office of the Assistant Secretary for Health, HHS (12/31/18)
- Request for Public Comments on the Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations
- The Draft Report highlights the progress made towards identifying, reviewing, and determining whether there are gaps in or inconsistencies between best practices for pain management (including chronic and acute pain) developed or adopted by Federal agencies. It includes the Task Force's proposed updates to best practices and recommendations on addressing gaps or inconsistencies.

OCR/HHS Modification of HIPAA Rules to Improve Coordinated Care

- Comments Due: 2/12/19
- Issued by: Office for Civil Rights (OCR); HHS (12/14/18).
- Request for Information on Modifying HIPAA Rules to Improve Coordinated Care
- Additionally, the RFI is soliciting comments within the HIPAA Privacy Rule in relation to the following items:
  - Encouraging information-sharing for treatment and care coordination.
  - Facilitating parental involvement in care.
  - Addressing the opioid crisis and serious mental illness.
  - Accounting for disclosures of Protected Health Information (PHI) for treatment, payment, and health care operations as required by the Health Information Technology for Economic and Clinical Health (HITECH) Act.
  - Changing the current requirement for network providers to make a good faith effort to obtain an acknowledgement of receipt of the Notice of Privacy Practices.

CDC Tobacco Control Practice

- Comments Due: February 11, 2019
- Agency: CDC
- CDC is seeking input to inform future activities to advance tobacco control practices to prevent initiation of tobacco use among youth and young adults; eliminate exposure to secondhand smoke; and identify and eliminate tobacco-related disparities.
- The information gathered will be used to inform activities that encompass technical assistance and guidance to state tobacco control programs and collaborative work with national governmental and nongovernmental partners, who share CDC's goals to prevent initiation of tobacco use among youth and young adults; eliminate exposure to secondhand smoke; and identify and eliminate tobacco-related disparities.

CMS SMD Letter #18-011 New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services

- Outlines existing and new opportunities for states to design innovative service delivery systems for adults with SMI and children with SED.
- New authority for states to pay for short-term residential treatment services in an IMD for these patients.
- Emphasis that inpatient treatment is just one part of the continuum of care, participating states will be expected to improve community-based mental health care.

CMS Medicaid and CHIP Managed Care Proposed Rule

- Comments Closed: 1/14/2018 (issued 11/18/2018)
- CMS is proposing significant regulatory revisions to streamline the 2016 managed care regulatory framework.
- Reflects a strategy to relieve regulatory burdens, support state flexibility and local leadership, and promotes transparency and innovation.
- Removes barriers that made it difficult to transition new services and populations into managed care.
- No proposed changes to the Indian managed care provisions.
- Our comment letter focused on some of managed care issues raised in our area (access and payments).

CMS Work Requirements Issue

- On 1/17/18, CMS issued a DTLL stating that CMS could not provide an exemption to the work requirements for AI/AN because of civil rights concerns.
- On 5/7/18, CMS updated its position, stating that they would actively consider state proposed accommodations for AI/AN from work requirements on a state by state basis.
- On 9/24/18, at STAC meeting, HHS Deputy Secretary Eric Hargan requested a legal opinion on the AI/AN exemption from work requirements. *Still Pending*
- As of 1/9/19, states with approved work requirement and community engagement waivers include: IN, AR, NH, NC, WI, ME and MI.
- Pending waivers: AZ, MS, OH, OK, SD, UT and VA.

CMS 4 Walls Limitation

- CMS determined that If a Tribal facility is enrolled in the state Medicaid program as a provider of clinical services under 42 CFR 440.90, the Tribal facility may not bill for services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility.
- Per CMS, under FQHC designation there is no requirement that the services be provided within the 4 walls.
- Section 1905 of the SSA recognizes outpatient Tribal clinics as FQHCs.
- CMS FAQ released January 18, 2017.
- Effective Date: January 30, 2021.
- CMS Guidance pending-currently under interval review (over a year).

IHS Indian Health Care Improvement Fund (IHCIF)

- DTLL 6/8/18 Indian Health Care Improvement Fund (IHCIF) Workgroup Recommendations on IHCIF formula changes.
- Comments were due 7/13/18.
- DTLL 8/13/18 with final decisions:
  - Benchmark: National Health Expenditure (was Federal Employee Health Benefits Program)
  - User count: National unduplicated users (was regional)
  - Alternate resources: Statewide averages (was flat 25%)
- Only 3 Portland Area tribes received funding.
- IHCIF Workgroup reconvened to continue phase 2 work for FY 2019
- Last meeting was December 12-13, 2018
- February 11-12 meeting in DC area POSTPONED

Recent IHS DTLLs

- **DTLL on 12/20/18:** IHS notice about IHS Headquarters Reorganization
- **DTLL on 12/11/18:** Update on the Mechanism to Distribute Behavioral Health Initiative Funding
- **DTLL on 11/20/18:** IHS Initiation of Consultation on the PRC program to perform a detailed analysis of PRC implications for the entire State of Arizona to be identified as a PRCDA/CHSDA (Comments were due 1/15/19)
- **DTLL on 11/19/18:** IHS Progress on Certification of Suite of Applications for IHS RPMS to meet Certification Standards in the 2015 Edition Health IT published by the Office of the National Coordinator.

Recent IHS DTLLs Cont'd

- **IHS Blog 11/1**: RADM Michael Toedt, Chief Medical Officer, IHS, announced that IHS has released a new "Internet Eligible Controlled Substance Provider Designation" policy (IHM, Ch. 38, part 3) to increase access to the treatment of opioid use disorder for AI/AN living in rural or remote areas.
- **DTLL on 10/29/18**: Developments related to IHS and Department initiatives to modernize health information technology (consultation is open).

Pending IHS Responses

- **IHS Draft Strategic Plan FY 2018-2022;** DTLL on 7/24/18; comment period closed.
- **Special Diabetes Program for Indians** funding distribution for FY 2019; DTLL issued 7/12/18
  - *Follow-up*: Stated that RADM Weahkee to ask Area Directors to meet with tribal leaders to discuss the Area's proposed budget for its share of the SDPI FY 2019 data infrastructure fund.
- **IHS Sanitation Deficiency System (SDS)**; DTLL on 7/2/18; comment period closed.

Pending IHS Responses Cont'd

- **IHS Manual, PRC Chapter Revisions;** DTLL on 5/18/18; comment period closed.
- **Contract Support Costs – Indian Health Manual, Chapter 3 CSC**, rescission of 97/3 split language; DTLL 4/13/18; comment period closed.
- **CHEF Regulation** / *Redding Rancheria* Case

VA Updates

- Suicide Prevention Initiatives
  - Focus on using prevention approaches that cut across all sectors that Veterans may interact, including states.
- Appeals Modernization
  - Simplification of the appeals process. Veterans will have 3 options for claims and appeals beginning February.
- Mission Act Implementation
- VA Care Coordination Committee
  - Focus on barriers and challenges of care coordination with VA.
- VA TAC bill (S.3269)
  - Will be reintroduced and be pushed forward in 116th Congress.

Litigation

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Brakeen v. Zinke
Challenge to ICWA

- On October 5, 2018, Judge Reed O'Conner (USDC ND Texas) ruled that ICWA is unconstitutional.
- Found that *Morton v. Mancari* rule does not apply because ICWA extends to Indians who are not members of tribes.
- ICWA struck down in violation of equal protection.
- **Current Status**: Decision appealed to the U.S. Court of Appeals for the Fifth Circuit.

Texas v. United States
Challenge to Affordable Care Act

- On December 14, 2018, Judge Reed O'Conner (USDC ND Texas) found that Congress' 2017 elimination of the ACA individual tax penalty for non-compliance with not having health insurance resulted in the mandate invalid.
- Reasoning:
  - In the absence of a tax, Congress has no authority to issue a mandate.
  - Individual mandate essential to the rest of the ACA, not "severable"
- If ACA struck down, then ICHIA could also be struck down.
- **Current Status:**
  - Decision appealed to U.S. Court of Appeals for the Fifth Circuit.
  - No impact to IHCIA during appeal

Opioid Litigation

- All federal court lawsuits have been combined in multi-district litigation under Federal District Judge Dan A. Polster (USDC-ND Ohio)
- More than 1,100 cases were filed against pharmaceutical manufacturers, distributors, and retailors of prescription opiate drugs.
- Nearly 100 tribes and tribal organizations have filed complaints to join the litigation
- Tribal Amicus Brief: 448 tribes and tribal organizations signed on and provided statements of interest (NPAIHB, ATNI, NCAI, and NIHB).
- For each test case, defendants have filed motions to dismiss.
- Judge issued ruling in Track One Cases.
- Judge found that nearly all the claims alleged are sufficient to survive Defendants' motions to dismiss.
- Gives an indication of potential ruling in Tribal Track cases.

Upcoming National/Regional Meetings

January--February 2019

- IHS Tribal Self Governance Advisory Committee, January 22-23, Washington DC (RESCHEDULED to April 24-25)
- ATNI Winter Convention, January 28-31, Portland
- CDC Meeting, February 5-6, Atlanta, GA.
- HHS STAC Meeting, February 7-8, Washington, D.C.
- NCAI Executive Council Winter Session, February 10-14, Washington, D.C.
- DSTAC meeting, February 12-13, Washington, D.C. (POSTPONED)
- IHCIF meeting, February 12-13, Rockville, MD (POSTPONED)

February-March 2019

- National Tribal Budget Formulation Meeting, February 14-15, 2018, Crystal City, VA
- MMPC/TTAC Meetings, February 19-21, Washington, DC
- NIHB Board Meeting, February 24
- SAMHSA TTAC/NTAC, March 11-14, (TBD), California
- TLDC, March 19-20, Washington, DC
- MMPC Strategy Session, March 19-20, Bemidji
- NIH TAC Meeting, March 21-22, Bethesda, MD
- TSGAC Annual Conference, March 31-April 4, Traverse City, MI

Discussion

HHS Secretary's Tribal Advisory Committee (STAC) Meeting, Fairbanks, Alaska, September 2018

Indian Health Service

All Tribal and Urban Indian Organization Leaders Call – Update on Lapse in Appropriations

REAR ADM. MICHAEL WEAHKEE

IHS PRINCIPAL DEPUTY DIRECTOR

JANUARY 10, 2019

Welcome

Rear Adm. Michael Weahkee
Principal Deputy Director, Indian Health Service

Senior Leadership Team

- **Chief Medical Officer –** Rear Adm. Michael Toedt
- **Deputy Director for Management Operations –** Elizabeth Fowler
- **Deputy Director for Intergovernmental Affairs** – Ben Smith
- **Office of Environmental Health and Engineering** – Gary Hartz, Director
- **Office of Resource Access and Partnerships** – Cmdr. John Rael, Director
- **Office of Finance and Accounting** – Ann Church, Acting Director
- **Office of Tribal Self-Governance** – Jennifer Cooper, Director
- **Office of Direct Service and Contracting Tribes** – Roselyn Tso, Director
- **Office of Human Resources** – Lisa Gyorda, Director
- **Office of Urban Indian Health Programs** – Rose Weahkee, Acting Director
- **Division of Acquisition Policy** – Santiago Almaraz, Director
- **Division of Grants Management** – Robert Tarwater, Chief

Updates

- **HHS contingency plan**
- **Work in IHS that may be paused during this lapse in appropriations period includes:**
  - national policy development and issuance,
  - some oversight functions, training,
  - and other work that does not have an immediate effect on the delivery of health care
- **Effect on payments**
  - ISDEAA awards to tribes and tribal organizations
  - Urban Indian organizations authorized by the Indian Health Care Improvement Act
- **Facilities Appropriations Advisory Board**
- **Tribal Self-Governance Advisory Committee**
- **National Budget Formulation Workgroup**

Points of Contact

- **Area Directors**
- **Direct Service Tribes and Title I Self-Determination**
  - Roselyn Tso, Director, Office of Direct Service and Contracting Tribes at 301-443-1104
- **Title V Self-Governance**
  - Jennifer Cooper, Director, Office of Tribal Self-Governance at 301-443-7821
- **Urban Indian Organization Contracts**
  - Rose Weahkee, Acting Director, Office of Urban Indian Health Programs at 301-480-3184
- **Purchased/Referred Care**
  - John Rael, Director, Office of Resource Access and Partnerships at 301-443-0969

Calls will continue during shutdown

Thursdays

3:30 pm Eastern Time

Conference Call: 800-857-5577

Participant Passcode: 6703929

Webinar Adobe Connect: https://ihs.cosocloud.com/r4k6jib09mj/

Participant Password: ihs123

Senior Leadership Team

- **Chief Medical Officer –** Rear Adm. Michael Toedt
- **Deputy Director for Management Operations –** Elizabeth Fowler
- **Deputy Director for Intergovernmental Affairs** – Ben Smith
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INDIAN HEALTH SERVICE
PHS · 1955 ·

DEPARTMENT OF HEALTH & HUMAN SERVICES

2B
Public Health Service

Indian Health Service
Rockville MD 20857

DEC 11 2018

Dear Tribal Leader and Urban Indian Organization Leader:

I am writing to update you on the Tribal Consultation and Urban Confer on the mechanism to distribute behavioral health initiative funding. The enclosure provides a summary of all comments received.

By letter dated May 18, 2018, I initiated Tribal Consultation and Urban Confer on the mechanism to distribute behavioral health initiative funding that is currently distributed through grants. At the request of Tribes and Urban Indian Organizations, I extended the comment period through August 17, 2018, to provide additional time for comments. I want to thank all of the Tribes and Urban Indian Organizations for your input and comments.

The Indian Health Service (IHS) National Tribal Advisory Committee on Behavioral Health (NTAC) met on October 25-26 in Albuquerque, New Mexico, to review comments and formulate recommendations based on your Tribal Consultation and Urban Confer input and comments. During the meeting, the IHS provided an overview of the Tribal Consultation and Urban Confer process to date, including an analysis of the comments received on various topics. To help NTAC members better understand the considerations involved in changing from grant funding to contracts or compacts authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), NTAC members requested additional information from the IHS. Their information requests related to data, funding formulas, and a comparison chart of funding mechanism options.

The NTAC is scheduled to meet again on December 20-21 at the Albuquerque Area IHS located at 4141 Indian School Road NE, Albuquerque, New Mexico, to continue discussing the funding mechanism to distribute behavioral health initiatives. Following this meeting, the NTAC will formally present their recommendations to me for my review and consideration.

Access to the summary report and information on behavioral health initiative funding is available on the IHS Division of Behavioral Health Tribal Consultation and Urban Confer Web site at https://www.ihs.gov/dbh/consultationandconfer/. If you have additional questions, please contact Ms. Miranda Carman, Acting Director, Division of Behavioral Health, IHS, by telephone at (301) 443-2038 or by e-mail at miranda.carman@ihs.gov.

Sincerely,

/Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Principal Deputy Director

Enclosure: Summary of Tribal Consultation and Urban Confer Comments on the Behavioral Health Initiative Funding

Indian Health Service · Office of Clinical and Preventive Services · Division of Behavioral Health
Summary of Tribal Consultation & Urban Confer Comments on the
Behavioral Health Initiative Funding
September 2018

Comment Period: May 18, 2018 – August 17, 2018 (91 days or 3 months)

Background: On May 18 the Indian Health Service (IHS) initiated Tribal Consultation and Urban Confer through a letter to Tribal and Urban Indian Organization (UIO) leaders on the mechanism to distribute behavioral health initiative funding that is currently distributed through grants. The Consolidated Appropriations Act of 2018 explanatory statement encouraged IHS to transfer behavioral health initiative funding through Indian Self-Determination and Education Assistance Act (ISDEAA) compacts and contracts rather than grants to ensure that contract support costs (CSC) are authorized and payable. The IHS appropriation itself authorizes allocation of the funds at the discretion of the IHS Director.

Consultation Components:

1. **Virtual Learning Series:** The IHS Division of Behavioral Health (DBH) hosted four virtual learning sessions to provide information on the:
    i. **Substance Abuse and Suicide Prevention Program** (SASPP, formerly the Methamphetamine and Suicide Prevention Initiative or MSPI) funded through the Alcohol and Substance Abuse budget line;
    ii. **Domestic Violence Prevention Program** (DVPP,formerly the Domestic Violence Prevention Initiative or DVPI) funded through the Hospital & Health Clinics budget line;
    iii. **Zero Suicide Initiative** (ZSI) funded through the Mental Health budget line; and,
    iv. **IHS National Management**.

    There were an average of 14 participants on each learning session.
2. **Virtual Tribal Consultation:** The IHS DBH hosted 2 virtual Tribal Consultations on June 7 and June 20 with an average of 70 participants.
3. **Urban Confer:** The IHS DBH hosted 1 virtual Urban Confer on June 14 with 70 participants. Comments were also received in-person at the 2018 National Council of Urban Indian Health (NCUIH) Annual Leadership Conference on June 27.
4. **Written Comments:** The IHS DBH received written correspondence from 31 entities, representing 6 IHS Areas, including feedback from 14 Tribes and Tribal Organizations, 12 UIOs, and 5 other (including national organizations and individuals) by mail and e-mail.

The following is a summary of all comments received through Tribal Consultation and Urban Confer. This is our best effort to convey in a limited space the major themes of the comments, but is not intended to capture all details.

Distribution Methodologies

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. Continue the national distribution allocation method to fund all 12 IHS Areas permitting Area stakeholders to determine the distribution methodology appropriate to each Area. This includes the distribution of funding associated with IHS National Management (this does not include funds for contracts and cooperative agreements with national organizations since the same Tribes and Tribal Organizations recommend discontinuing those contracts and cooperative agreements).

2. Continue national distribution allocation method to fund all 12 IHS Areas permitting Area stakeholders to determine the distribution methodology appropriate to each Area to distribute funds.
3. Funding should be through noncompetitive formula to be developed via Tribal Consultation.
4. Continue current distribution methodology that includes: 88% to Areas and Tribes, 10% to UIOs, and 2% IHS National set aside.

B. URBAN CONFER RECOMMENDATIONS/COMMENTS:

1. Maintain current distribution methodologies and funding formulas.
2. Methodologies that eliminate or restrict UIOs from accessing funds are contrary to the IHS's commitment to Urban Indian health and do not adequately address the needs of the diverse AI/AN population.

Funding Formulas

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. Utilize the funding formula based on poverty, disease burden, and user population.
2. Utilize the TSA formula for future increases beginning in Fiscal Year (FY) 2020 with a notification to Tribes about their expected distribution amount early in FY 2019.
3. Utilize the TSA formula for future behavioral health initiative funding cycles, beginning in FY 2021 and with a notification to Tribes about their expected distribution amount in FY 2020.

B. OTHER COMMENTS:

1. Tribes currently receiving behavioral health funds could see their funding cut considerably since the behavioral health program awards are not distributed on a formula that is largely based on user population.

Funding for Urban Indian Organizations (UIOs)

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. Continue funding UIO grantees at current level through grants, cooperative agreements, annual contracts, or any other appropriate mechanism available.
2. Allocate 10% of behavioral health funding to UIOs.
3. Continue funding UIO grantees until the grant period initially awarded expires, then funds should be considered for distribution based on the TSA formula.

B. URBAN CONFER RECOMMENDATIONS/COMMENTS:

1. Maintain UIO set aside that was recommended to the IHS and previously accepted through Tribal consultation.
2. Maintain current funding levels at about 10% for UIOs.
3. Establish a 21.7% set aside for UIOs if funding is moved to ISDEAA contracts or compacts.
4. Establish a 25% set aside for UIOs.

Impact on Current Grantees

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

4. Hold all grantees harmless from any behavioral health initiative funding mechanism changes and oppose any decreases in funding for current grantees in order to redistribute funds.
5. Provide the option for current grantees to transfer their funds to an ISDEAA Title I contract or Title V funding agreement.

B. URBAN CONFER RECOMMENDATIONS/COMMENTS:

1. Discontinuing behavioral health grants would have severe implications on urban AI/AN health care. The explanatory statement entirely overlooks the vital nature of these initiatives for urban AI/ANs and caution that this action would exclude UIOs who are ineligible for CSC.
2. IHS must designate sufficient funding to fulfill existing grants through the end of their terms.

Funding Mechanism

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. All funding provided to current grantees should be converted from grants to ISDEAA agreements transferred through Title I contracts or Title V compacts.
2. Provide funding through ISDEAA contracts and compacts rather than grants.
3. Transfer grants to ISDEAA Title I and Title V agreements for FY 2019 and beyond.
4. Grants should be awarded through a non-competitive, streamlined, and simplified grant process for Title I Direct Service Tribal facilities.

B. URBAN CONFER RECOMMENDATIONS/COMMENTS:

1. Behavioral health grant programs were created to help remedy and reduce disparities and expressly include UIOs in the program descriptions and goals. Prohibiting UIOs from accessing funds from these programs would significantly hamper the provision of health care to urban AI/ANs.
2. Grant structure enables UIOs to receive technical assistance (TA) from IHS Area Project Officers, TECs, and IHS Grants Management Specialists that direct programmatic TA. Moving from grants to contracts negates this benefit and limits the effectiveness of these programs.
3. UIOs receive grants through Title V of the Indian Health Care Improvement Act (IHCIA) and do not have access to ISDEAA contracts and compacts.

Demonstrating Effectiveness

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. Continue funding Tribal Epidemiology Centers (TECs) to assist with data reporting, determining national outcomes, and conducting evaluation activities.
2. Area Tribes should retain the option to conduct Area-wide functions, such as continuing the funding to TECs to assist Tribes in their Areas with data reporting, determining national, local, and regional outcomes, and conducting evaluation activities.

B. URBAN CONFER RECOMMENDATIONS/COMMENTS:

1. Continue funding to TECs to assist with technical assistance and data collection, monitoring, and analysis on the UIO behavioral health services system.
2. Establish a line item for TECs in the IHS budget formulation process.

C. OTHER RECOMMENDATIONS/COMMENTS:

1. For Areas where Tribes do not support continued funding for services provided by TECs, Tribes should receive the funding to support their own ways of data analysis and reporting, determining local, regional, and national outcomes, evaluating program effectiveness, and continuing to raise national awareness of behavioral health issues.
2. Self-Governance Tribes have the authority to redesign funding, so it is difficult to require they report data on program services and outcomes.

Advocacy and Raising National Awareness and Visibility

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. Discontinue renewing contracts and cooperative agreements with national organizations and redirect funds for contracts and cooperative agreements with national organizations to Direct Service Tribes.
2. Discontinue current administrative set-asides provided under contracts and cooperative agreements with national organizations and reallocate funds to the Areas using national distribution methodology.
3. Do not renew existing procurement contracts.
4. Continue cooperative agreements with NIHB and NCUIH to maintain health advocacy and awareness.

B. OTHER RECOMMENDATIONS/COMMENTS:

1. Resolution passed requesting IHS continue supporting NIHB.
2. Discontinuing or repurposing NIHB's cooperative agreement would jeopardize the Tribal-based and AI/AN serving providers offering educational and skill-building opportunities, forcing providers to seek opportunities from non-AI/AN entities.

IHS National Management

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. Add any additional funding made available as a result of discontinuing support for IHS National Management to IHS program amounts for IHS, Tribes, and Tribal Organizations.
2. Discontinue national functions and redirect all resources to local behavioral health programs in FY 2021.
3. Provide a breakdown of the $6m that supports IHS National Management.

Funding Increases

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. Request inflation and population grown increases for behavioral health initiatives consistent with manner that such increases are requested for general sub-account line items in IHS appropriation.
2. Advocate for more behavioral health funding to adequately operate Tribal behavioral health departments.
3. Any increases in behavioral health initiative funding provided by Congress in FY 2019 or FY 2020 should be distributed based on the TSA formula instead of an increase in current grant awards.
4. Once recurring funding is allocated, it becomes part of the recurring base and subject to future increases.

B. URBAN CONFER RECOMMENDATIONS/COMMENTS:

1. Keeping UIO funding as a percentile allows for inflation costs to be covered

Contract Support Costs (CSC)

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. CSC needs to be requested in IHS budget process. The IHS should estimate the CSC need and immediately report the amount of funds needed to administer these recurring funds and should request additional CSC funds.
2. The IHS should assess and request additional CSC funds in the President's Budget Request for FY 2020 and beyond to support fully funding CSC needs related to these recurring funds.

Other

A. TRIBAL CONSULTATION RECOMMENDATIONS/COMMENTS:

1. Save a portion of the funding for a community elder/youth wellness/healing conference themed "The Way of Life" to discuss possible solutions for a better, safer place and to remind youth of traditional and family values.
2. Short term options should be implemented during the FY 2018 award cycle and that immediate action taken to implement the long term options by FY 2021.
3. Provide behavioral health initiative funding via competitive grants continues to provide funding to larger Tribal Health Organizations that can afford professional grant writers and grant managers, while putting barriers to small Tribes and Tribal Health Organizations that often need the financial assistance most.
4. Transferring grants to ISDEAA contacts and compacts will allow current grantees to receive CSC funding to assist in covering administrative costs associated with managing behavioral health programs.
5. Tribes experience negative impacts of receiving behavioral health funds via grants that resulted in eliminating positions when the grant was discontinued, utilizing scarce Tribal funds to fill the gaps.
6. Any cost savings from a reduction in grant administrative oversight should be evaluated and made available to contracting and compacting Tribes no later than FY 2022.

B. URBAN CONFER RECOMMENDATIONS/COMMENTS:

1. Some UIOS are the only AI/AN facilities and programs offering services in their communities and states for the AI/AN population.
2. Several UIOs planned to expand behavioral health services over the program years based on the availability of funding, including: increasing the number of days for the youth program in the next year, offering multiple services and outreach to support those in their healing process, and providing services to incarcerated youth. Without behavioral health initiative funding, UIOs would be faced with the decision of whether to continue providing services and may even have to shut down programming.
3. The UIOs support the comments of Tribes and note that it is necessary to preserve the availability of these programs as grants for UIOs and through cooperative agreements like NCUIH in order to fulfill the federal trust responsibility for the provision of health care to AI/ANs.
4. Behavioral health grants are essential to UIO operations and the provision of quality and culturally competent health care services to AI/ANs living in urban areas.
5. Urban Indian Health constitutes only around 1% of the IHS total budget.
6. UIOs rely on other sources of funding, including grants, to provide health care services to AI/AN patients.
7. Any contrary action that restricts the ability of UIOs to provide these critical services to urban AI/ANs is a violation of the Federal Government's trust responsibility.
8. Moving program funding from grants to ISDEAA contracts and compacts excludes UIOs from behavioral health initiative funding and would set an extremely dangerous precedent.
9. The request from Congress in the explanatory statement is non-binding and does not require IHS to take action.
10. Programs and AI/ANs are best served by grants rather than compacts and contracts, which provide little or no monitoring whereas grant funding ensures the program is being run in line with its purpose and is providing the intended benefit.

the withdrawn proposed rule, you may review the Agency's website (*https://www.fda.gov*) for any current information on the matter.

III. References

The following references are on display at the Dockets Management Staff (see **ADDRESSES**) and are available for viewing by interested persons between 9 a.m. and 4 p.m., Monday through Friday; they are also available electronically at *https://www.regulations.gov.* FDA has verified the website addresses, as of the date this document publishes in the **Federal Register**, but websites are subject to change over time.

1. FDA, draft guidance for industry, ''Updating ANDA Labeling After the Marketing Application for the Reference Listed Drug Has Been Withdrawn,'' July 2016 (available at *https://www.fda.gov/ucm/groups/fdagov-public/@fdagov-drugs-gen/documents/document/ucm510240.pdf*).

2. U.S. Department of Health and Human Services, Food and Drug Administration, ''Fiscal Year 2019 Justification of Estimates for Appropriations Committees'' (available at *https://www.fda.gov/downloads/aboutfda/reportsmanualstorms/reports/budgetreports/ucm603315.pdf*).

Dated: December 10, 2018.

Leslie Kux,

Associate Commissioner for Policy.

[FR Doc. 2018–27098 Filed 12–13–18; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Docket No.: HHS–OCR–0945–AA00]

45 CFR Parts 160 and 164

RIN 0945–AA00

Request for Information on Modifying HIPAA Rules To Improve Coordinated Care

AGENCY: Office for Civil Rights (OCR), HHS.

ACTION: Request for information.

SUMMARY: The Office for Civil Rights (OCR) is issuing this Request for Information (RFI) to assist OCR in identifying provisions of the Health Insurance Portability and Accountability Act privacy and security regulations that may impede the transformation to value-based health care or that limit or discourage coordinated care among individuals and covered entities (including hospitals, physicians, and other providers, payors, and insurers), without meaningfully contributing to the protection of the privacy or security of individuals' protected health information. This RFI requests information on whether and how the rules could be revised to promote these goals, while preserving and protecting the privacy and security of such information and individuals' rights with respect to it.

DATES: Comments must be submitted on or before February 12, 2019.

ADDRESSES: You may send comments, identified by RIN 0945–AA00 or Docket HHS–OCR–0945–AA00, by any of the following methods:

- *Federal eRulemaking Portal.* You may submit electronic comments at *http://www.regulations.gov* by searching for the Docket ID number HHS–OCR–0945–AA00. Follow the instructions for sending comments.
- *Hand-Delivery or Regular, Express, or Overnight Mail:* U.S. Department of Health and Human Services, Office for Civil Rights, Attention: RFI, RIN 0945–AA00, Hubert H. Humphrey Building, Room 509F, 200 Independence Avenue SW, Washington, DC 20201.

Instructions: All submissions received must include ''Department of Health and Human Services, Office for Civil Rights RIN 0945–AA00'' for this RFI. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. Further instructions are available under PUBLIC PARTICIPATION.

Docket: For complete access to the docket to read background documents or comments received, go to *http://www.regulations.gov* and search for Docket ID number HHS–OCR–09454–AA00.

FOR FURTHER INFORMATION CONTACT: Marie Meszaros at (800) 368–1019 or (800) 537–7697 (TDD).

SUPPLEMENTARY INFORMATION:

I. Background

This RFI seeks public input on the regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [1] and modified pursuant to, among other laws, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.[2] The HIPAA Privacy and Security Rules protect individuals' medical records and other individually identifiable health information created or received by or on behalf of covered entities, known as ''protected health information'' (PHI).[3] The Privacy and Security Rules limit the circumstances under which covered entities may use and disclose PHI and require covered entities to implement safeguards to protect the privacy and security of PHI. The Privacy Rule also gives individuals rights with respect to their PHI, including the right to access their PHI and to receive adequate notice of a covered entity's privacy practices. In addition, the HIPAA Breach Notification Rule requires HIPAA covered entities to provide notification following a breach of unsecured PHI to individuals and OCR (and, in some instances, the media) and requires business associates to notify the relevant covered entities of such breaches.[4] In this RFI, the Privacy, Security, and Breach Notification Rules will be referenced collectively as the HIPAA Rules.

OCR seeks public input on ways to modify the HIPAA Rules to remove regulatory obstacles and decrease regulatory burdens in order to facilitate efficient care coordination and/or case management and to promote the transformation to value-based health care, while preserving the privacy and security of PHI. Specifically, OCR seeks information on the provisions of the HIPAA Rules that may present obstacles to, or place unnecessary burdens on, the ability of covered entities and business associates to conduct care coordination and/or case management, or that may inhibit the transformation of the health care system to a value-based health care system. Correspondingly, OCR seeks comment on modifications to the HIPAA Rules that would facilitate efficient care coordination and/or case management, and/or promote the transformation to value-based health care. OCR also broadly requests information and perspectives from regulated entities and the public about covered entities' and business associates' technical capabilities, individuals' interests, and ways to achieve these goals.

In addition, OCR seeks comment on aspects of the Privacy Rule that OCR has identified for potential modification to further these goals, specifically:

- Promoting information sharing for treatment and care coordination and/or case management by amending the Privacy Rule to encourage, incentivize,

[1] *See* the Administrative Simplification provisions of title II, subtitle F, of the HIPAA (Pub. L. 104–191), which added a new part C to title XI of the Social Security Act (sections 1171–1179 of the Social Security Act, 42 U.S.C. 1320d–1320d–8) and included section 264, under which HHS has adopted the HIPAA Privacy Rule.

[2] The HITECH Act was enacted as title XIII of division A and title IV of division B of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5).

[3] *See* the HIPAA Privacy and Security Rules at 45 CFR part 160 and Subparts A, C, and E of part 164.

[4] *See* 45 CFR part 160 and part 164, Subparts A and D.

or require covered entities to disclose PHI to other covered entities.

- Encouraging covered entities, particularly providers, to share treatment information with parents, loved ones, and caregivers of adults facing health emergencies, with a particular focus on the opioid crisis.
- Implementing the HITECH Act requirement to include, in an accounting of disclosures, disclosures for treatment, payment, and health care operations (TPO) from an electronic health record (EHR) in a manner that provides helpful information to individuals, while minimizing regulatory burdens and disincentives to the adoption and use of interoperable EHRs.
- Eliminating or modifying the requirement for covered health care providers to make a good faith effort to obtain individuals' written acknowledgment of receipt of providers' Notice of Privacy Practices, to reduce burden and free up resources for covered entities to devote to coordinated care without compromising transparency or an individual's awareness of his or her rights.

II. Solicitation of Comments

OCR is soliciting public comments that offer recommendations for modifying existing regulations or guidance, or developing new guidance, that could further the goals described below.

a. Promoting Information Sharing for Treatment and Care Coordination

The Privacy Rule establishes an individual's right to access and obtain a copy of his or her PHI.[5] The Privacy Rule currently requires a covered entity to provide an individual with access to his or her PHI within 30 days after receipt of a request (with the possibility of one 30-day extension), and requires the covered entity to provide a copy of PHI to a third party, which may be a health care provider, when directed by an individual pursuant to the individual's right of access. These requirements apply equally to health records maintained electronically and in other media (*e.g.,* paper). OCR seeks input on whether potential revisions to the right of access would support and promote care coordination and/or case management by enabling more timely transfer of PHI between covered entities, or between covered entities and other health care providers.

Currently, under the Privacy Rule, the only required disclosures of PHI are (1) to the individual, pursuant to the individual's right to access, 45 CFR 164.524; and (2) to OCR for purposes of determining compliance with the HIPAA Rules. The Privacy Rule permits, but does not require, covered entities to use and disclose PHI for TPO purposes.[6] Further, although the Privacy Rule requires covered entities to provide individuals with access to their PHI within 30 days of receiving a request (with the possibility for one 30-day extension),[7] there is no deadline or requirement to disclose records when requested by another health care provider or other covered entity for purposes of coordinating care or managing cases. This can lead to circumstances where records are not transferred between covered entities (or from a covered entity to another health care provider) in a timely fashion to the detriment of coordinated care and/or case management. OCR seeks public input, including from individuals, covered entities, other health care providers, business associates, and other members of the public, on the scope of this problem, and on whether there are potential revisions to the Privacy Rule to support and promote care coordination and/or case management, including by requiring timely transfer of PHI for this purpose or other purposes, such as when a patient switches medical providers and their new provider requests the transfer of records from the previous provider.

The Privacy Rule generally requires that covered entities use, disclose, or request only the minimum PHI necessary to meet the purpose of the use, disclosure, or request.[8] Disclosures to or requests by health care providers for treatment purposes, including care coordination and case management, are excepted from the minimum necessary requirement.[9] Disclosures by covered entities for care coordination and/or case management activities to covered entities that are not health care providers remain subject to the minimum necessary standard.[10] Similarly, disclosures related to care coordination and/or case management but for non-treatment activities nevertheless remain subject to the minimum necessary standard, such as population-based case management and care coordination activities,[11] claims management, review of health care services for appropriateness of care, utilization reviews,[12] and formulary development.[13] OCR seeks input on whether disclosures of PHI to non-provider covered entities for care coordination and/or case management as part of treatment, and/or health care operations, should be excepted from the minimum necessary standard, and if so, to what extent.

Finally, some individuals, such as those experiencing homelessness or suffering from chronic conditions, including serious mental illness, receive care from a variety of sources including HIPAA covered entities, social service agencies, and community-based support programs. In addition, some jurisdictions have established multi-disciplinary teams that assist in coordinating the full spectrum of care for individuals who need such assistance. Coordinating the care and related services requires sharing PHI among those involved. Although the Privacy Rule permits a covered health care provider to disclose information to a third party for the coordination or management of treatment,[14] some HIPAA covered entities have expressed reluctance to share this information for fear of violating HIPAA. OCR therefore requests input on whether it should modify or otherwise clarify provisions of the Privacy Rule to encourage covered entities to share PHI with non-covered entities when needed to coordinate care and provide related health care services and support for individuals in these situations. This request asks whether an express regulatory permission should be created for HIPAA covered entities to disclose PHI to social service agencies or community-based support programs,

[5] See 45 CFR 164.524.

[6] ''Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.'' 45 CFR 164.501 (definition of ''treatment''); also see 45 CFR 164.502(a)(1)(ii) and 164.506. The definition of ''health care operations'' includes, but is not limited to ''any of the following activities of the covered entity to the extent that the activities are related to covered functions: (1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; . . . .''

[7] 45 CFR 164.524(b)(2)(i).

[8] 45 CFR 164.502(b)(1).

[9] 45 CFR 164.502(b)(2)(i).

[10] Id.

[11] *See* 45 CFR 164.501 (definitions of ''health care operations,'' para. (1)).

[12] *See* 45 CFR 164.501 (definition of ''payment'').

[13] *See* 45 CFR 164.501 (definition of ''health care operations,'' para. (6)).

[14] 45 CFR 164.501 (definition of ''treatment'').

and the requirements or conditions upon which the regulatory permission should be based, including whether covered entities should be required to enter into agreements with such entities that contain provisions similar to the provisions in business associate agreements.[15] For all questions, we request information about any relevant state or other law containing standards that are different from, and perhaps inconsistent with, either existing HIPAA requirements or potential proposed changes to the HIPAA Rules.

OCR requests comment on these issues, including on the following questions:

(1) How long does it take for covered entities to provide an individual with a copy of their PHI when requested pursuant to the individual's right of access at 45 CFR 164.524? How long does it take for covered entities to provide other covered entities copies of records that are not requested pursuant to the individual's right of access? Does the length of time vary based on whether records are maintained electronically or in another form (*e.g.,* paper)? Does the length of time vary based on the type of covered entity? For instance, do some types of health care providers or plans take longer to respond to requests than others?

(2) How feasible is it for covered entities to provide PHI when requested by the individual pursuant to the right of access more rapidly than currently required under the rules? (The Privacy Rule requires covered entities to respond to a request in no more than 30 days, with a possible one-time extension of an additional 30 days.). What is the most appropriate general timeframe for responses? Should any specific purposes or types of access requests by patients be required to have shorter response times?

(3) Should covered entities be required to provide copies of PHI maintained in an electronic record more rapidly than records maintained in other media when responding to an individual's request for access? (The Privacy Rule does not currently distinguish, for timeliness requirements, between providing PHI maintained in electronic media and PHI maintained in other media). If so, what timeframes would be appropriate?

(4) What burdens would a shortened timeframe for responding to access requests place on covered entities? OCR requests specific examples and cost estimates, where available.

(5) Health care clearinghouses typically receive PHI in their role as business associates of other covered entities, and may provide an individual access to that PHI only insofar as required or permitted by their business associate agreement with the other covered entity, just as other covered entities, when performing business associate functions, may also provide access to PHI only as required or permitted by the business associate agreement(s) with the covered entity(ies) for whom they perform business associate functions. Nevertheless, the PHI that clearinghouses possess could provide useful information to individuals. For example, clearinghouses may maintain PHI from a variety of health care providers, which may help individuals obtain their full treatment histories without having to separately request PHI from each health care provider.

(a) How commonly do business associate agreements prevent clearinghouses from providing PHI directly to individuals?

(b) Should health care clearinghouses be subject to the individual access requirements, thereby requiring health care clearinghouses to provide individuals with access to their PHI in a designated record set upon request? Should any limitations apply to this requirement? For example, should health care clearinghouses remain bound by business associate agreements with covered entities that do not permit disclosures of PHI directly to an individual who is the subject of the PHI?

(c) Alternatively, should health care clearinghouses be treated only as covered entities—*i.e.,* be subject to all requirements and prohibitions in the HIPAA Rules concerning the use and disclosure of PHI and the rights of individuals in the same way as other covered entities—and not be considered business associates, or need a business associate agreement with a covered entity, even when performing activities for, or on behalf of, other covered entities? Would this change raise concerns for other covered entities about their inability to limit uses and disclosures of PHI by health care clearinghouses? For example, would this change prevent covered entities from providing assurances to individuals about how their PHI will be used and disclosed? Or would covered entities be able to adequately fulfill individuals' expectations about uses and disclosures through normal contract negotiations with health care clearinghouses, without the need for a HIPAA business associate agreement? Would covered entities be able to impose other contractual limitations on the uses and disclosures of PHI by the health care clearinghouse?

(d) If health care clearinghouses are not required to enter into business associate agreements with the other covered entities for whom they perform business associate functions, should such requirement also be eliminated for other covered entities when they perform business associate functions for other covered entities?

(6) Do health care providers currently face barriers or delays when attempting to obtain PHI from covered entities for treatment purposes? For example, do covered entities ever affirmatively refuse or otherwise fail to share PHI for treatment purposes, require the requesting provider to fill out paperwork not required by the HIPAA Rules to complete the disclosure (*e.g.,* a form representing that the requester is a covered health care provider and is treating the individual about whom the request is made, etc.), or unreasonably delay sharing PHI for treatment purposes? Please provide examples of any common scenarios that may illustrate the problem.

(7) Should covered entities be required to disclose PHI when requested by another covered entity for treatment purposes? Should the requirement extend to disclosures made for payment and/or health care operations purposes generally, or, alternatively, only for specific payment or health care operations purposes?

(a) Would this requirement improve care coordination and/or case management? Would it create unintended burdens for covered entities or individuals? For example, would such a provision require covered entities to establish new procedures to ensure that such requests were managed and fulfilled pursuant to the new regulatory provision and, thus, impose new administrative costs on covered entities? Or would the only new administrative costs arise because covered entities would have to manage and fulfill requests for PHI that previously would not have been fulfilled?

(b) Should any limitation be placed on this requirement? For instance, should disclosures for healthcare operations be treated differently than disclosures for treatment or payment? Or should this requirement only apply to certain limited payment or health care operations purposes? If so, why?

(c) Should business associates be subject to the disclosure requirement? Why or why not?

(8) Should any of the above proposed requirements to disclose PHI apply to all covered entities (*i.e.,* covered health

[15] See 45 CFR 164.502(a)(3), 164.504(e)(2).

care providers, health plans, and health care clearinghouses), or only a subset of covered entities? If so, which entities and why?

(9) Currently, HIPAA covered entities are permitted, but not *required,* to disclose PHI to a health care provider who is not covered by HIPAA (*i.e.,* a health care provider that does not engage in electronic billing or other covered electronic transactions) for treatment and payment purposes of either the covered entity or the non-covered health care provider.[16] Should a HIPAA covered entity be required to disclose PHI to a non-covered health care provider with respect to any of the matters discussed in Questions 7 and 8? Would such a requirement create any unintended adverse consequences? For example, would a covered entity receiving the request want or need to set up a new administrative process to confirm the identity of the requester? Do the risks associated with disclosing PHI to health care providers not subject to HIPAA's privacy and security protections outweigh the benefit of sharing PHI among all of an individual's health care providers?

(10) Should a non-covered health care provider requesting PHI from a HIPAA covered entity provide a verbal or written assurance that the request is for an accepted purpose (*e.g.,* TPO) before a potential disclosure requirement applies to the covered entity receiving the request? If so, what type of assurance would provide the most protection to individuals without imposing undue burdens on covered entities? How much would it cost covered entities to comply with this requirement? Please provide specific cost estimates where available.

(11) Should OCR create exceptions or limitations to a requirement for covered entities to disclose PHI to other health care providers (or other covered entities) upon request? For example, should the requirement be limited to PHI in a designated record set? Should psychotherapy notes or other specific types of PHI (such as genetic information) be excluded from the disclosure requirement unless expressly authorized by the individual?

(12) What timeliness requirement should be imposed on covered entities to disclose PHI that another covered entity requests for TPO purposes, or a non-covered health care provider requests for treatment or payment purposes? Should all covered entities be subject to the same timeliness requirement? For instance, should covered providers be required to disclose PHI to other covered providers within 30 days of receiving a request? Should covered providers and health plans be required to disclose PHI to each other within 30 days of receiving a request? Is there a more appropriate timeframe in which covered entities should disclose PHI for TPO purposes? Should electronic records and records in other media forms (*e.g.,* paper) be subject to the same timeliness requirement? Should the same timeliness requirements apply to disclosures to non-covered health care providers when PHI is sought for the treatment or payment purposes of such health care providers?

(13) Should individuals have a right to prevent certain disclosures of PHI that otherwise would be required for disclosure? For example, should an individual be able to restrict or ''opt out'' of certain types of required disclosures, such as for health care operations? Should any conditions apply to limit an individual's ability to opt out of required disclosures? For example, should a requirement to disclose PHI for treatment purposes override an individual's request to restrict disclosures to which a covered entity previously agreed?

(14) How would a general requirement for covered health care providers (or all covered entities) to share PHI when requested by another covered health care provider (or other covered entity) interact with other laws, such as 42 CFR part 2 or state laws that restrict the sharing of information?

(15) Should any new requirement imposed on covered health care providers (or all covered entities) to share PHI when requested by another covered health care provider (or other covered entity) require the requesting covered entity to get the explicit affirmative authorization of the patient before initiating the request, or should a covered entity be allowed to make the request based on the entity's professional judgment as to the best interest of the patient, based on the good faith of the entity, or some other standard?

(16) What considerations should OCR take into account to ensure that a potential Privacy Rule requirement to disclose PHI is consistent with rulemaking by the Office of the National Coordinator for Health Information Technology (ONC) to prohibit ''information blocking,'' as defined by the 21st Century Cures Act? [17]

(17) Should OCR expand the exceptions to the Privacy Rule's minimum necessary standard? For instance, should population-based case management and care coordination activities, claims management, review of health care services for appropriateness of care, utilization reviews, or formulary development be excepted from the minimum necessary requirement? Would these exceptions promote care coordination and/or case management? If so, how? Are there additional exceptions to the minimum necessary standard that OCR should consider?

(18) Should OCR modify the Privacy Rule to clarify the scope of covered entities' ability to disclose PHI to social services agencies and community-based support programs where necessary to facilitate treatment and coordination of care with the provision of other services to the individual? For example, if a disabled individual needs housing near a specific health care provider to facilitate their health care needs, to what extent should the Privacy Rule permit a covered entity to disclose PHI to an agency that arranges for such housing? What limitations should apply to such disclosures? For example, should this permission apply only where the social service agency itself provides health care products or services? In order to make such disclosures to social service agencies (or other organizations providing such social services), should covered entities be required to enter into agreements with such entities that contain provisions similar to the provisions in business associate agreements?

(19) Should OCR expressly permit disclosures of PHI to multi-disciplinary/multi-agency teams tasked with ensuring that individuals in need in a particular jurisdiction can access the full spectrum of available health and social services? Should the permission be limited in some way to prevent unintended adverse consequences for individuals? For example, should covered entities be prevented from disclosing PHI under this permission to a multi-agency team that includes a law enforcement official, given the potential to place individuals at legal risk? Should a permission apply to multi-disciplinary teams that include law enforcement officials only if such teams are established through a drug court program? [18] Should such a multi-disciplinary team be required to enter into a business associate (or similar) agreement with the covered entity?

[16] *See* 45 CFR 164.506(c)(1)–(3).

[17] Sec 4004, Public Law 114–255, 130 Stat. 1033 (amending Subtitle C of title XXX of the Public Health Service Act by adding Sec. 3022(a)(3)).

[18] Information about drug courts is available at *https://www.nij.gov/topics/courts/drug-courts/Pages/welcome.aspx.*

What safeguards are essential to preserving individuals' privacy in this context?

(20) Would increased public outreach and education on existing provisions of the HIPAA Privacy Rule that permit uses and disclosures of PHI for care coordination and/or case management, without regulatory change, be sufficient to effectively facilitate these activities? If so, what form should such outreach and education take and to what audience(s) should it be directed?

(21) Are there provisions of the HIPAA Rules that work well, generally or in specific circumstances, to facilitate care coordination and/or case management? If so, please provide information about how such provisions facilitate care coordination and/or case management. In addition, could the aspects of these provisions that facilitate such activities be applied to provisions that are not working as well?

b. Promoting Parental and Caregiver Involvement and Addressing the Opioid Crisis and Serious Mental Illness

As discussed earlier, the Privacy Rule allows covered entities to disclose PHI to caregivers in certain circumstances, including certain emergency circumstances, and this permission has particular relevance today in relation to the opioid crisis and efforts to address serious mental illness (SMI).[19] Nevertheless, anecdotal evidence suggests that some covered entities are reluctant to inform and involve the loved ones of individuals facing such health crises for fear of violating HIPAA. This reluctance may hinder effective coordination of care and case management involving caregivers, including family members and friends. In an effort to encourage covered entities to share necessary information with caregivers and loved ones, especially when an individual is suffering from substance use disorder (including opioid use disorder) or SMI, OCR is considering a separate rulemaking that would seek to encourage covered entities to share PHI with family members, caregivers, and others in a position to avert threats of harm to health and safety, when necessary to promote the health and recovery of those struggling with substance use disorder, including opioid use disorder, and/or SMI.[20] OCR would like to consider amendments to the Privacy Rule that would allow OCR to address the opioid crisis as well as facilitate parental involvement in the treatment of their children.

Specifically, OCR requests comment on these issues, including the following:

(22) What changes can be made to the Privacy Rule to help address the opioid epidemic? What risks are associated with these changes? For example, is there concern that encouraging more sharing of PHI in these circumstances may discourage individuals from seeking needed health care services? Also is there concern that encouraging more sharing of PHI may interfere with individuals' ability to direct and manage their own care? How should OCR balance the risk and the benefit?

(23) How can OCR amend the HIPAA Rules to address serious mental illness? For example, are there changes that would facilitate treatment and care coordination for individuals with SMI, or ensure that family members and other caregivers can be involved in an individual's care? What are the perceived barriers to facilitating this treatment and care coordination? Would encouraging more sharing in the context of SMI create concerns similar to any concerns raised in relation to the previous question on the opioid epidemic? If so, how could such concerns be mitigated?

(24) Are there circumstances in which parents have been unable to gain access to their minor child's health information, especially where the child has substance use disorder (such as opioid use disorder) or mental health issues, because of HIPAA? Please specify, if known, how the inability to access a minor child's information was due to HIPAA, and not state or other law.

(25) Could changes to the Privacy Rule help ensure that parents are able to obtain the treatment information of their minor children, especially where the child has substance use disorder (including opioid use disorder) or mental health issues, or are existing permissions adequate? If the Privacy Rule is modified, what limitations on parental access should apply to respect any privacy interests of the minor child?

(a) Currently, the Privacy Rule generally defers to state law with respect to whether a parent or guardian is the personal representative of an unemancipated minor child and, thus, whether such parent or guardian could obtain PHI about the child as his/her personal representative; if someone other than the parent or guardian can or does provide consent for particular health care services, the parent or guardian is generally not the child's personal representative with respect to such health care services.[21] Should these standards be reconsidered generally, or specifically where the child has substance use disorder or mental health issues?

(b) Should any changes be made to specifically allow parents or spouses greater access to the treatment information of their children or spouses who have reached the age of majority? If the Privacy Rule is changed to encourage parental and spousal involvement, what limitations should apply to respect the privacy interests of the individual receiving treatment?

(c) Should changes be made to allow adult children to access the treatment records of their parents in certain circumstances, even where an adult child is not the parent's personal representative?[22] Or are existing permissions sufficient? For instance, should a child be able to access basic information about the condition of a parent who is being treated for early-onset dementia or inheritable diseases? If so, what limitations should apply to respect the privacy interests of a parent?

(26) The Privacy Rule currently defers to state or other applicable law to determine the authority of a person, such as a parent or spouse, to act as a personal representative of an individual in making decisions related to their health care.[23] How should OCR reconcile any changes to a personal representative's authority under HIPAA with state laws that define the scope of parental or spousal authority for state law purposes?

c. Accounting of Disclosures

The Privacy Rule requires covered entities to provide an individual, upon request, with an accounting of certain disclosures of the individual's PHI that were made by the covered entity or its business associate during the six years before the request. See 45 CFR 164.528. While the Privacy Rule currently excludes certain disclosures from the accounting requirement, including disclosures made for TPO purposes, *see* 45 CFR 164.528(a), section 13405(c) of the HITECH Act directs the Department to modify the Privacy Rule to require that an accounting of disclosures include disclosures made for TPO purposes through an electronic health record during the three years before the request.

In 2010, OCR issued a Request for Information (''2010 RFI'')[24] ''to help us

[19] *See, e.g.,* 45 CFR 164.510(b)(3), 45 CFR 164.512(j).

[20] See RIN: 0945–AA09, Fall 2018 Unified Agenda, Office of Information and Regulatory Affairs, Office of Management and Budget, *www.reginfo.gov.*

[21] *See* 45 CFR 164.502(g)(3).

[22] *See* 45 CFR 164.502(g).

[23] *See* 45 CFR 164.502(g).

[24] 75 FR 23214 (May 3, 2010). Available at *https://www.gpo.gov/fdsys/pkg/FR-2010-05-03/pdf/2010-10054.pdf.*

better understand the interests of individuals with respect to learning of such disclosures [for TPO], the administrative burden on covered entities and business associates of accounting for such disclosures, and other information that may inform the Department's rulemaking in this area.'' After reviewing public comments, OCR issued a Notice of Proposed Rulemaking (''2011 NPRM'') [25] proposing several modifications to the Privacy Rule to implement the HITECH Act requirement, improve the workability of the accounting of disclosures, and create a new right to an access report.

Based on public feedback on the RFI that many covered entities' systems could not distinguish between internal access (a ''use'' under the Privacy Rule) and external access (a ''disclosure'') for TPO, and that providing a full accounting of disclosures for TPO would be overly burdensome to regulated entities, OCR proposed, in addition, to provide individuals with a right to receive an ''access report.'' The access report would have shown who had accessed the information in an individual's electronic designated record set (which would include any access, not only access that represented a disclosure outside of the entity for TPO). Commenters on the NPRM overwhelmingly opposed the proposed individual right to obtain an ''access report.'' Many commenters expressed concern that their then-existing, commonly used EHR systems did not have the technical capability to produce the required access report and updates would be prohibitively costly for covered entities. In addition, some commenters stated that the content and format of the proposed access report would not provide meaningful, usable information to individuals. A virtual hearing conducted by a federal advisory committee in 2013 elicited similar concerns from the public and presenters at the hearing.[26]

OCR has not taken action to finalize the proposed accounting of disclosures rule since the comment period closed in 2011, and it now believes that the proposed access report requirement would create undue burden for covered entities without providing meaningful information to individuals. Thus, OCR intends to withdraw the NPRM, and requests public input on the questions below to help OCR to implement the HITECH Act requirement and ensure that individuals can obtain a meaningful accounting of disclosures that gives them confidence that their PHI is being disclosed appropriately as part of receiving coordinated care or otherwise, without erecting obstacles or disincentives to the adoption and use of interoperable electronic healthcare records, which is necessary for efficient care coordination, case management, and value-based healthcare.

OCR requests public input on these issues and specifically on following questions:

(27) How many requests for an accounting of disclosures do covered entities receive annually and from what percentage of total patients? Of these, how many requests specify a particular preferred electronic form or format, and to what extent do covered entities provide the accounting in the requested form or format?

(28) How much time do covered entities take to respond to an individual's request for an accounting of disclosures? How many worker-hours are needed to produce the accounting? What is the average number of days between receipt of a request and providing the accounting to the requesting individual? How would these estimated time periods change, if at all, if covered entities were to provide a full accounting of disclosures for TPO purposes? What is the basis for these revised estimates?

(29) If your covered entity does capture and maintain information about TPO accounting, even though it is not currently required by the Privacy Rule, what is the average number of TPO disclosures made by the entity for a given individual in a calendar year? How many such disclosures are made from EHRs?

(30) In what scenarios would a business associate make a disclosure of PHI for TPO through an EHR? What is the average number of such disclosures for a given individual in a calendar year, if known?

(31) Should the Department require covered entities to account for their business associates' disclosures for TPO, or should a covered entity be allowed to refer an individual to its business associate(s) to obtain this information? What benefits and burdens would covered entities and individuals experience under either of these options?

(32) For existing EHR systems:

(a) Is the system able to distinguish between ''uses'' and ''disclosures'' as those terms are defined under the Privacy Rule at 45 CFR 160.103? (Note that the term ''disclosure'' includes, but is not limited to, the sharing of information between a hospital and physicians who may have staff privileges but who are not members of its workforce).

(b) If the existing system only records access to information without identifying whether such access represents a use or disclosure, what information is recorded about each instance of access? How long is such information retained? What would be the burden for covered entities to retain the information for three years? Once collected, what additional costs or other resources would be required to maintain the data for each subsequent year? At what point would retention of the information be excessively burdensome? OCR requests specific examples and cost estimates, where available.

(c) If the system is able to distinguish between uses and disclosures of information, what details regarding each disclosure are automatically collected by the system (*i.e.,* collected without requiring any additional manual input by the person making the disclosure)? What information, if any, is manually entered by the person making the disclosure or accessing the information?

(d) If the system is able to distinguish between uses and disclosures of information, what data elements are automatically collected by the system for uses (*i.e.,* collected without requiring any additional manual input by the person making the disclosure)? What information, if any, is manually entered by the person making the use?

(e) If the system is able to distinguish between uses and disclosures of information, does it record a description of disclosures in a standardized manner (for example, does the system offer or require a user to select from a limited list of types of disclosures)? If yes, is the feature being utilized? What are the benefits and drawbacks?

(f) To what extent do covered entities maintain a single, centralized EHR system versus a decentralized system (*e.g.,* different departments maintain different EHR systems, and an accounting of disclosures for TPO would need to be tracked for each system)? To what extent are covered entities that currently use decentralized systems planning to migrate to centralized systems or vice versa? How is the industry mix of centralized and decentralized systems likely to change over the next five or ten years?

(g) Do existing EHR systems automatically generate an accounting of disclosures under the current Privacy Rule (*i.e.,* does the system account for disclosures other than to carry out TPO)? If so, what would be the additional burden to also account for

[25] 76 FR 31426 (May 31, 2011). Available at *https://www.gpo.gov/fdsys/pkg/FR-2011-05-31/pdf/2011-13297.pdf.*

[26] *https://www.healthit.gov/hitac/events/policy-privacy-security-tiger-team-accounting-disclosures-virtual-hearing.*

disclosures to carry out TPO? If not, to what extent do covered entities use a separate system or module to generate an accounting of disclosures, and does the system interface with the EHR system? OCR requests cost estimates, where available.

(33) If an EHR is not currently able to account for disclosures of an EHR to carry out TPO, what would be the burden, in time and financial costs, for covered entities and/or their vendors to implement such a feature?

(34) For covered entities already planning to adopt new EHRs, to what extent would a requirement to track TPO disclosures affect the cost of the new system?

(35) A covered entity's Notice of Privacy Practices must inform individuals of the right to obtain an accounting of disclosures. Is this notice sufficient to make patients aware of this right? If not, what actions by OCR could effectively raise awareness?

(36) Why do individuals make requests for an accounting of disclosures under the current rule? Why would individuals make requests for an accounting of TPO disclosures made through EHRs?

(37) What data elements should be provided in an accounting of TPO disclosures, and why? How important is it to individuals to know the *specific* purpose of a disclosure—*i.e.,* would it be sufficient to describe the purpose generally (*e.g.,* for ''for treatment,'' ''for payment,'' or ''for health care operations purposes''), or is more detail necessary for the accounting to be of value? To what extent are individuals familiar with the range of activities that constitute ''health care operations?'' On what basis do commenters make this assessment?

(38) How frequently do individuals who obtain an accounting of disclosures request additional information not currently required to be included in the accounting (*e.g.,* information about internal uses or about disclosures for TPO)? What additional information do they request, and do covered entities provide the additional information? Why or why not?

(39) If covered entities are unable to modify existing systems or processes to generate a full accounting of disclosures for TPO (*e.g.,* because modification would be prohibitively costly), should OCR instead require covered entities to conduct and document a diligent investigation into disclosures of PHI upon receiving an individual's request for an accounting of disclosures for TPO? If not, are there certain circumstances or allegations that should trigger such an investigation and documentation by a covered entity? How much time should a covered entity be allowed to conduct and provide the results of such an investigation?

(40) If OCR requires or permits covered entities to conduct an investigation into TPO disclosures in lieu of providing a standard accounting of such disclosures, what information should the entities be required to report to the individual about the findings of the investigation? For example, should OCR require covered entities to provide individuals with the names of persons who received TPO disclosures and the purpose of the disclosures?

(41) The HITECH Act section 13405(c) only requires the accounting of disclosures for TPO to include disclosures through an EHR. In its rulemaking, should OCR likewise limit the right to obtain an accounting of disclosures for TPO to PHI maintained in, or disclosed through, an EHR? Why or why not? What are the benefits and drawbacks of including TPO disclosures made through paper records or made by some other means such as orally? Would differential treatment between PHI maintained in other media and PHI maintained electronically in EHRs (where only EHR related accounting of disclosures would be required) disincentivize the adoption of, or the conversion to, EHRs?

(42) Please provide any other information that OCR should consider when developing a proposed rule on accounting for disclosures for TPO.

d. Notice of Privacy Practices

The Privacy Rule requires covered providers and health plans to develop a Notice of Privacy Practices (NPP) that describes individuals' heath information privacy rights and how their health information may be used and disclosed by the covered entity.[27] Covered entities are required to provide their NPPs to individuals, consistent with the specific requirements of the Privacy Rule, including prominent display on their websites. In addition, a covered health care provider that has a direct treatment relationship with the individual must clearly and prominently post the NPP in physical service delivery locations. Providers must also provide the NPP to individuals by the date of first service delivery, and to any individual upon request.

In addition, the Privacy Rule requires covered providers that have a direct treatment relationship with an individual to make a good faith effort to obtain a written acknowledgement of receipt of the provider's NPP. If providers are unable to obtain the written acknowledgement, they must document their good faith efforts and the reason for not obtaining an individual's acknowledgment, and the provider must maintain the documentation or sufficient proof to support compliance with the requirements for six years.[28] OCR established the requirement to make a good faith attempt to obtain a written acknowledgment in the August 14, 2002, final Privacy Rule modifications (67 FR 53182). That final rule strengthened the notice requirements, in part, to replace the previous requirement to obtain an individual's consent for uses and disclosures of PHI for treatment, payment, and health care operations, which would have created unnecessary barriers to the provision of health care and other routine and important health sector activities. The written acknowledgment process was intended to provide an opportunity for the individual to review the NPP, including the individual's privacy rights, to discuss any concerns related to the privacy of her or his PHI, and to request additional restrictions or confidentiality of communications.

The questions below seek public input on whether the signature and recordkeeping requirements should be eliminated to reduce burden on providers and to free up time and resources for providers to spend on treatment and care coordination. The questions also ask how the NPP requirements might be modified in other ways to alleviate covered entity burden without compromising transparency regarding providers' privacy practices or an individual's awareness of his or her rights.

(43) What is the burden, in economic terms, for covered health care providers that have a direct treatment relationship with an individual to make a good faith effort to obtain an individual's written acknowledgment of receipt of the provider's NPP? OCR requests estimates of labor hours and any other costs incurred, where available.

(44) For what percentage of individuals with whom a direct treatment provider has a relationship is such a covered health care provider unable to obtain an individual's written acknowledgment? What are the barriers to obtaining it?

(45) How often do individuals and covered entities mistake the signature or acknowledgment line that accompanies NPPs as contracts, waivers of rights, or required as a condition of receiving services? What conflicts have arisen

[27] 45 CFR 164.520.

[28] 45 CFR 164.520(c)(2)(ii) and (e).

because of these or other misunderstandings?

(46) What other state and federal laws, guidelines or standards require covered health care providers to obtain the patient's acknowledgement or signature on a document at their first visit? How many of those documents require patient signatures? What is the nature of those other documents that require signatures?

(47) How often are NPPs bundled with other documents at patient ''intake'' and with how many other pages of documents? How often are NPPs printed with non-NPP materials, either on the same page, or as a continuation of one integrated document, or as being physically attached to other documents? What is the nature of these non-NPP materials? How often, if at all, are covered health care providers required to have the patient sign updated versions of these forms (*e.g.,* annually, each visit, no subsequent updates required)? Are electronic signatures permitted for these forms? If so, does this make the process less burdensome?

(48) If NPP training is part of your general annual training, how much of this training cost do you estimate your organization spends to train covered entity staff on their obligations to seek and maintain documents related to the NPP acknowledgment requirements?

(49) What is the burden, in economic terms, for covered health care providers to maintain documentation of the acknowledgment or the good faith effort to obtain written acknowledgment and the reason why the acknowledgment was not obtained? What alternative methods might providers find useful to document that they provided the NPP? For example, to what extent would the use of a standard patient intake checklist reduce the burden?

(50) What use, if any, do covered health care providers make of the signed NPP forms, or documentation of good faith efforts at securing written acknowledgments, that the Privacy Rule requires providers to maintain?

(51) What benefits or adverse consequences may result if OCR removes the requirement for a covered health care provider that has a direct treatment relationship with an individual to make a good faith effort to obtain an individual's written acknowledgment of the receipt of the provider's NPP? Please specify whether identified benefits or adverse consequences would accrue to individuals or covered providers.

(52) Are there modifications to the content and provision of NPP requirements that would lessen the burden of compliance for covered entities while preserving transparency about covered entities' privacy practices and individuals' awareness of privacy rights? Please identify specific benefits and burdens to the covered entity and individual, and offer suggested modifications.

(53) With the assistance of consumer-oriented focus groups, OCR has developed several model NPPs, available at *https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/index.html,* that clearly identify, in a consumer-friendly manner, an individual's HIPAA rights and a covered entity's ability to use and disclose PHI.

(a) While covered entities are required to provide individuals an NPP, use of OCR's model NPPs is optional. Do covered entities use these model NPPs? Why or why not?

(b) OCR has received anecdotal evidence that individuals are not fully aware of their HIPAA rights. What are some ways that individuals can be better informed about their HIPAA rights and how to exercise those rights? For instance, should OCR create a safe harbor for covered entities that use the model NPPs by deeming entities that use model NPPs compliant with the NPP content requirements? Would a safe harbor create any unintended adverse consequences?

(c) Should more specific information be required to be included in NPPs than what is already required? If so, what specific information? For example, would a requirement of more detailed information on the right of patients to access their medical records (and related limitations of what can be charged for copies) be useful?

(d) Please identify other specific recommendations for improving the NPP text or dissemination requirements to ensure individuals are informed of their HIPAA rights.

e. Additional Ways To Remove Regulatory Obstacles and Reduce Regulatory Burdens To Facilitate Care Coordination and Promote Value-Base Health Care Transformation

As noted at the beginning of this RFI, OCR seeks public input on ways to modify the HIPAA Rules to remove regulatory obstacles and decrease regulatory burdens in order to facilitate efficient care coordination and/or case management and promote the transformation to value-based health care, while preserving the privacy and security of PHI. Specifically:

(54) In addition to the specific topics identified above, OCR welcomes additional recommendations for how the Department could amend the HIPAA Rules to further reduce burden and promote coordinated care.

(a) What provisions of the HIPAA Rules may present obstacles to, or place unnecessary burdens on, the ability of covered entities and/business associates to conduct care coordination and/or case management? What provisions of the HIPAA Rules may inhibit the transformation of the health care system to a value-based health care system?

(b) What modifications to the HIPAA Rules would facilitate efficient care coordination and/or case management, and/or promote the transformation to value-based health care?

(c) OCR also broadly requests information and perspectives from regulated entities and the public about covered entities' and business associates' technical capabilities, individuals' interests, and ways to achieve these goals.

This is a request for information only. Respondents are encouraged to provide complete but concise responses to the questions outlined above. OCR also requests that commenters indicate throughout their responses the questions to which they are responding. OCR notes that a response to every question is not required. This request for information is issued solely for information and planning purposes; it does not constitute a notice of proposed rulemaking.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. This request for information constitutes a general solicitation of comments. In accordance with the implementing regulations of the Paperwork Reduction Act (PRA) at 5 CFR 1320.3(h)(4), information subject to the PRA does not generally include ''facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration of the comment.'' Consequently, this document need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Dated: December 10, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–27162 Filed 12–12–18; 11:15 am]

BILLING CODE 4153–01–P

expression of different proteins from whole cell lysates exposed to different endocrine disrupting chemical (EDC) treatments. Specifically, Respondent:

• Digitally altered the original image to darken the western blot panel for COX IV expression in Figure 4b in *Nature Communications* 2017 and represented the blot as the expression of:

—pNF-kB p65 Figure 4b in *Nature Communications* 2017
—NF-kB p65 Figure 4b in *Nature Communications* 2017
—p50 Figure 4b in *Nature Communications* 2017
—p105 Figure 4b in *Nature Communications* 2017
—p100 Figure 4b *Nature Communications* 2017

• Digitally altered the original image by superimposing a darker band over the original bands in lanes 2 and 4 of the western blot panel for COX IV expression in whole cell lysates exposed to different endocrine disrupting chemical (EDC) treatments in Figure 4b in *Nature Communications* 2017 and represented the falsified blot in Figure 6a in *Nature Communications* 2017 as expression of:

— P-p65 Figure 6a in *Nature Communications* 2017
— p50 Figure 6a in *Nature Communications* 2017
— p105 Figure 6a in *Nature Communications* 2017
— p52 Figure 6a in *Nature Communications* 2017

• Reused and relabeled the blot from Figure 3d in *Cell Stem Cell* 22:698–712, 2018 to falsely represent BiP expression under different experimental conditions in Figure 3d in *Nature Communications* 2017.

As a result of its inquiry, CSMC recommended that *Nature Communications* 2017 be retracted.

Dr. Rajamani entered into a Voluntary Settlement Agreement (Agreement) and voluntarily agreed:

(1) To have her research supervised for a period of one (1) year beginning on November 27, 2018; Respondent agrees that prior to submission of an application for U.S. Public Health Service (PHS) support for a research project on which Respondent's participation is proposed and prior to Respondent's participation in any capacity on PHS-supported research, Respondent shall ensure that a plan for supervision of Respondent's duties is submitted to ORI for approval; the supervision plan must be designed to ensure the scientific integrity of Respondent's research contribution; Respondent agrees that she shall not participate in any PHS-supported research until such a supervision plan is submitted to and approved by ORI; Respondent agrees to maintain responsibility for compliance with the agreed upon supervision plan;

(2) that for a period of one (1) year beginning on November 27, 2018, any institution employing her shall submit, in conjunction with each application for PHS funds, or report, manuscript, or abstract involving PHS-supported research in which Respondent is involved, a certification to ORI that the data provided by Respondent are based on actual experiments or are otherwise legitimately derived and that the data, procedures, and methodology are accurately reported in the application, report, manuscript, or abstract;

(3) that if no supervisory plan is provided to ORI, Respondent will provide certification to ORI at the conclusion of the supervision period that she has not engaged in, applied for, or had her name included on any application, proposal, or other request for PHS funds without prior notification to ORI;

(4) to exclude herself from serving in any advisory capacity to PHS including, but not limited to, service on any PHS advisory committee, board, and/or peer review committee, or as a consultant for a period of one (1) year beginning on November 27, 2018; and

(5) that as a condition of the Agreement, Respondent will request that *Nature Communications* 8(219):1–15, 2017 be retracted.

Wanda K. Jones,

Interim Director, Office of Research Integrity.

[FR Doc. 2018–27874 Filed 12–21–18; 8:45 am]

BILLING CODE 4150–31–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Organization, Functions, and Delegations of Authority; Part G; Indian Health Service

Part G, of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (HHS), as amended at 70 FR 24087, May 6, 2005, as amended at 75 FR 38112, July 1, 2010, and most recently as amended at 79 FR 65671, November 5, 2014, is hereby amended to reflect a reorganization of the Indian Health Service (IHS) Headquarters (HQ).

The IHS proposes a reorganization at IHS HQ to strengthen operations and oversight responsibilities to ensure quality health care by establishing an Office of Quality.

Delete the functional statements for the IHS HQ Office of the Director, Office of Clinical and Preventive Services, and Office of Management Services, and replace with the following revised statements, which includes a new Office of Quality:

Chapter GA—Office of the Director

Section GA–10, Indian Health Service—Organization

The IHS is an Operating Division within the Department of Health and Human Services (HHS) and is under the leadership and direction of a Director who is directly responsible to the Secretary of Health and Human Services. The IHS Headquarters is proposing to reorganize the following major components: Office of the Director (GA), Office of Clinical and Preventive Services (GAF), Office of Management Services (GAL), and the Office of Quality (OQ).

Section GA–20, Indian Health Service—Functions

Office of the Director (OD) (GA)

Provides overall direction and leadership for the IHS: (1) Establishes goals and objectives for the IHS consistent with the mission of the IHS and ensures agency performance is managed through goals/objectives, achievements, and/or improved outcomes; (2) provides for the full participation of Indian tribes in the programs and services provided by the Federal Government; (3) develops health care policy; (4) ensures the delivery of quality comprehensive health services; (5) advocates for the health needs and concerns of American Indians/Alaska Natives (AI/AN); (6) promotes the IHS programs at the local, state, national, and international levels; (7) develops and demonstrates alternative methods and techniques of health services management and delivery with maximum participation by Indian tribes and Indian organizations; (8) supports the development of individual and tribal capacities to participate in Indian health programs through means and modalities that they deem appropriate to their needs and circumstances; (9) the IHS will carry out the responsibilities of the United States to Indian tribes and individual Indians; (10) affords Indian people an opportunity to enter a career in the IHS by applying Indian preference; (11) ensures full application of the principles of Equal Employment Opportunity laws and the Civil Rights Act in managing the human resources of

the IHS; and (12) participates in cross-cutting issues and processes, including but not limited to, emergency preparedness/security, quality assurance, internal controls, recruitment, budget formulation, self-determination issues, and resolution of audit findings as may be needed and appropriate.

Congressional and Legislative Affairs Staff (CLAS) (GA1)

(1) Serves as the principal advisor to the IHS Director on all legislative and congressional relations matters; (2) advises the IHS Director and other IHS officials on the need for changes in legislation and manages the development of IHS legislative initiatives; (3) serves as the IHS liaison office for congressional and legislative affairs with Congressional offices, the HHS, the Office of Management and Budget (OMB), the White House, and other federal agencies; (4) tracks all major legislative proposals in the Congress that would impact Indian health; (5) ensures that the IHS Director and appropriate IHS and HHS officials are briefed on the potential impact of proposed legislation; (6) develops legislative strategy for key policy and legislative initiatives; (7) provides technical assistance and advice relative to the effect that initiatives/implementation would have on the IHS; (9) provides support and collaborates with the Office of Finance and Accounting relative to IHS appropriations efforts; (10) directs the development of IHS briefing materials for congressional hearings, testimony, and bill reports; (11) analyzes legislation for necessary action within the IHS; (12) develops appropriate legislative implementation plans; (13) serves as the IHS liaison office to the Government Accountability Office (GAO) and Office of Inspector General (OIG); (14) except for personnel matters, coordinates the development, clearance, and transmittal of IHS responses and follow-up to reports issued by the OIG, the GAO, and other federal internal and external authorities; and (15) coordinates with IHS HQ and Area Offices as appropriate to provide leadership, advocacy, and technical support to respond to requests from the public, including tribal governments, tribal organizations, and Indian community organizations regarding IHS legislative issues.

Executive Secretariat Staff (ESS) (GA2)

(1) Manages the processing of executive correspondence and related information to the IHS Director from tribes and tribal governments, tribal organizations, and Urban Indian organizations, federal departments and agencies, Congress and congressional staff offices, attorneys, patients, schools, universities, employees, grantees, contractors, and the general public; (2) reviews and monitors correspondence received by the IHS Director and assigns reply or follow-up action to appropriate IHS HQ program offices and IHS Area Offices; (3) ensures the quality (responsiveness, clarity, and substance) of IHS-generated correspondence prepared for the IHS Director's signature by coordinating the review of integrity and policy issues, and performing standard edits and revisions; (4) reviews and coordinates clearance of decision documents for the IHS Director's approval to ensure successful operations and policy-making within the agency; (5) assists IHS officials as they prepare documents for the HHS Secretary's review, decision, and/or signature; (6) serves as the agency's liaison with the HHS Office of the Secretary's Executive Secretariat on IHS program, policy, and special matters; (7) performs special writing assignments for the IHS Director; (8) maintains official records of the IHS Director's correspondence and conducts topic research of files, as needed; (9) oversees an electronic document handling system to assist in managing the timely processing of internal and external executive correspondence; (10) conducts training to promote conformance by IHS HQ and Area staff to the IHS Executive Correspondence Guidelines; (11) tracks reports required by Congress; and (12) manages the IHS review of non-IHS regulatory documents that impact the delivery of health services to Indians.

Diversity Management and Equal Employment Opportunity Staff (DMEEOS) (GA3)

(1) Administers the IHS equal employment opportunity, civil rights, and affirmative action and Alternative Dispute Resolution programs, in accordance with applicable laws, regulations, and HHS policies; (2) plans and oversees the implementation of IHS affirmative employment and special emphasis programs; (3) reviews data and advises IHS managers of possible discriminatory trends; (4) ensures immediate implementation of required actions on complaints of alleged sexual harassment or discrimination; (5) decides on accepting, for investigation, or dismissing discrimination complaints and evaluates accepted complaints for procedural sufficiency and investigates and resolves complaints; (6) evaluates accepted formal complaints of discrimination for procedural sufficiency and adjudicates and resolves complaints; and (7) develops/administers equal employment opportunity education and training programs for IHS managers, supervisors, counselors, and employees.

Public Affairs Staff (PAS) (GA4)

(1) Serves as the principal advisor for strategic planning on communications, media relations, and public affairs policy formulation and implementation; (2) ensures IHS policy is consistent with directives from the HHS Assistant Secretary for Public Affairs; (3) provides leadership and advocacy to establish and implement policy for internal and external dissemination of agency information intended for public release or employee and stakeholder information; (4) serves as the central office for technical guidance and assistance to IHS staff for the development of public affairs and media communication; (5) coordinates public affairs activities with other public and private sector organizations; (6) coordinates the clearance of IHS public relations activities, campaigns, and communications materials; (7) represents the IHS in discussions regarding policy and public affairs initiatives/implementation; (8) provides technical assistance and advice relative to the effect public affairs initiatives/implementation would have on the IHS; (9) collaborates with the Division of Regulatory and Policy Coordination, for review and response to media requests received under the Freedom of Information Act (FOIA) or the Privacy Act, and ensures the security of IHS documents used in such responses that contain sensitive and/or confidential information; and (10) serves as the IHS liaison office for press and public affairs activities with HHS, IHS Area Offices, media and other external organizations and representatives.

Office of Clinical and Preventive Services (OCPS) (GAF)

(1) Advises the IHS Director and Chief Medical Officer on clinical, preventive, and public health programs for the IHS, Area Offices, and Service Units; (2) serves as the primary source of national advocacy, policy development, budget development and allocation for these programs; (3) provides leadership in articulating the clinical, preventive, and public health needs of AI/AN, including consultation and technical support to clinical and public health programs and coordination with the Office of Quality to ensure quality standards are met for all clinical, preventive and public health programs; (4) develops, manages, and administers program functions that include, but are not limited to, oral

health, medicine, telehealth, alcohol and substance use prevention and treatment, mental health, suicide prevention, domestic and sexual violence, behavioral health integration, Youth Regional Treatment Centers, dental services, forensic nursing services, medical services, Health Promotion/Disease Prevention, pharmacy and pharmaceutical acquisition, community health representatives (CHRs), emergency medical services, health records, disabilities, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), maternal health, child health, clinical nursing, public health nursing, men's health, women's health, nutrition and dietetics, elder care, cancer prevention and treatment; and chronic diseases such as diabetes, asthma, hypertension, and obesity; (5) leads and coordinates tribal consultation and urban Indian confer sessions for clinical and preventive health topics, funding, and other priority areas; (6) investigates service delivery and community prevention evidence-based and best practice models for dissemination to community service locations; (7) expands the availability of resources available for AI/AN health by working with public and private entities as well as federal agencies within and outside the HHS; (8) coordinates development of staffing requirements for new or replacement health care facilities and approves Congressional budget requests for staffing, in collaboration with the Office of Environmental Health and Engineering; (9) provides clinical oversight and direction for the health facilities planning process; (10) develops and coordinates various grant programs; (11) provides the national focus for recruitment and retention of health professionals and coordinates with the scholarship and loan repayment programs; (12) works with the Purchased/Referred Care (PRC) program on PRC denial appeals to the IHS Director and in determining PRC medical priorities; (13) works with the Office of Human Resources in managing the clinical aspects of the IHS workers' compensation claims; (14) monitors approximately one-half of the IHS's Government Performance and Results Act (GPRA) indicators, overseeing indicator development, data collection, and reporting results; (15) responds to tribal, Departmental, and Congressional inquiries; and (16) participates in cross-cutting issues and processes, including but not limited to, emergency preparedness/security, quality assurance, internal controls, recruitment, budget formulation, self-determination issues, and resolution of audit findings as may be needed and appropriate.

Division of Behavioral Health (DBH) (GAFA)

(1) Manages, develops, and coordinates comprehensive clinical, preventive, and community-based programs for mental health, social work, and alcohol and substance abuse focused on: Prevention, treatment, training, technical assistance, evaluation, quality improvement, data collection, trauma informed care, Native youth programming, recovery services, suicide prevention, tele-behavioral health, behavioral health integration, Youth Regional Treatment Centers; (2) provides, develops, and implements IHS guidelines, standards, policies, and procedures for professional and program standards related to behavioral health services, including maintenance of existing or development of new relevant chapters in the Indian Health Manual; (3) monitors, measures, and evaluates the quality of behavioral health programs to improve the effectiveness and efficacy of behavioral health programs including the development of behavioral health budget materials for resource management, program data collection, behavioral health-related GPRA measures, administrative system integrity and accountability; (4) coordinates behavioral health professional staff recruitment and training needs by serving as a subject matter expert for the American Indians into Psychology, scholarship, and loan repayment assignments to meet Area Office, Service Unit, and tribal health professional human resource needs; (5) develops and monitors behavioral health contracts and grants with IHS programs and other entities, in collaboration with the Division of Acquisition Policy and the Division of Grants Management; (6) develops and disseminates IHS behavioral health program information and materials to IHS facilities and to tribes and Urban Indian organizations including the dissemination of culturally appropriate and traditional best practices in behavioral health; (7) leads and coordinates the National Tribal Advisory Committee on Behavioral Health; (8) partners with tribes and urban Indian organizations on the evaluation of health outcomes of clinical and community behavioral health services; (9) develops, coordinates, and maintains public and private professional partnerships with philanthropies, universities, community-based, and faith-based organizations to promote training, resources, and technical assistance to expand, leverage, increase access to, and coordinate behavioral health resources and services outside of the typical health care setting; (10) manages the operation of direct behavioral health services provided through the Tele-Behavioral Health Center of Excellence; (11) provides continuing education for behavioral health providers, nurses, pharmacists, physicians, and other health care providers and paraprofessionals on current and pressing behavioral health clinical issues; and (12) provides financial resources and programmatic oversight for complying with the Americans With Disabilities Act through programs such as the Indian Children's Program that focus on autism spectrum disorders, fetal alcohol spectrum disorders, and other neurobiological disorders.

Division of Clinical and Community Services (DCCS) (GAFB)

(1) Manages, develops, and coordinates comprehensive clinical, preventive, and community-based programs using a public health approach focused on: Medicine, pharmacy and pharmaceutical acquisition, emergency medical services, CHRs, men's health, maternal and child health, cancer prevention, elder health, hepatitis C prevention and surveillance, medicine, HIV/AIDS, health records, health education, health promotion, and disease prevention; (2) develops objectives, priorities, and methodologies to conduct and evaluate clinical, preventive, and community-based programs; (3) coordinates the analysis and implementation of approaches for recognizing and supporting traditional medicine and cultural practices in the health of all AI/AN; (4) serves as the IHS HQ liaison for the IHS Chief Clinical Consultants; (5) serves as the agency's liaison and coordinating role for the American College of Obstetrics & Gynecology and Association of American Indian Physicians contracts; (6) manages the Veterans Affairs Pharmaceutical Prime Vendor Contract and IHS National Core Formulary; (7) manages the pharmacy residency program; (8) develops program budget materials for resource management, program data collection, clinical and community health-related GPRA measures, administrative system integrity and accountability; (9) applies identified profession and program standards for clinical, preventive, and community health services, including relevant chapters in the Indian Health Manual; (10) disseminates culturally appropriate clinical and community

health best practices, including traditional medicine and cultural healing and disseminates this information among clinical, medical, and community health program directors, division staff, Area staff, and other agencies and institutions; and (11) manages virtual and in-person training for CHRs to ensure that basic training requirements are met for new CHRs, refresher training is available, and continuing education is provided regularly.

Division of Nursing Services (DNS) (GAFC)

(1) Plans, develops, coordinates, evaluates, manages and advocates for administrative, clinical, and public health nursing services focused on acute care, ambulatory care, breastfeeding, prevention, forensic nursing, elder care, infectious disease control and care, immunizations, and adolescent and prenatal care in AI/AN communities; (2) develops objectives, priorities, and methodologies for the conduct and evaluation of clinical, preventive, and public health nursing programs; (3) provides, develops, and implements IHS guidelines, standards, policies, and procedures related to nursing, including relevant chapters in the Indian Health Manual; (4) provides nursing staff with advanced education opportunities in the field of nursing in exchange for payback service obligations; (5) provides funding for nursing programs where junior level commissioned officers with IHS and tribal programs gain experience in nursing; (6) provides specialized training opportunities for specialized nursing experience in critical nursing shortage areas such as obstetrics, intensive care, and the operating room; (7) coordinates professional nursing staff recruitment and training needs, and loan repayment and scholarship recipient assignments and development to meet Area Office, Service Unit, and tribal health professional human resource needs; (8) develops program budget materials for resource management, program data collection, administrative system integrity and accountability; and (9) coordinates nursing quality improvement and other nurse-led initiatives on behalf of the agency, such as Relationship-Based Care and Baby-Friendly Hospitals.

Division of Oral Health (DOH) (GAFD)

(1) Develops broad-based objectives, priorities, and methodologies to evaluate dental health programs; (2) monitors personnel orders for appointments and transfers; (3) processes special pay and retention bonus contracts; (4) disseminates information to IHS, tribal, and urban (I/T/U) dental programs on issues of importance, emerging technologies, standards of care, clinical best or promising practices; (5) provides an annual budget narrative and funding justification; (6) responds to Department, tribal, and other inquiries as required; (7) develops long-term training opportunities to help fill critical dental specialty needs; (8) maintains a continuing dental education program to relay oral health standards of care, educate I/T/U dental staff, and retain a high quality oral health workforce; (9) provides recruitment information, including available positions, for I/T/U dental programs; (10) oversees an externship program to expose dental students to I/T/U dental programs; (11) works with IHS Loan Repayment, Human Resources, and Commissioned Corps to promote loan repayment, special pays, etc., to help recruit a competent, qualified oral health workforce; (12) utilizes existing workforce models, including alternative dental workforce models, to provide maximum, effective, and quality oral health care to AI/AN; (13) monitors clinical productivity, efficiency, and effectiveness of dental programs; (14) establishes standards for staffing ratios, productivity, and efficiency of dental programs; (15) maintains a centralized database of dental productivity and efficiency data; (16) develops and incorporates public health clinical standards of care and publishes clinical guidelines to support I/T/U programs; (17) promotes quality improvement through continuing education of providers on clinical best practices, incorporation of various quality models, and continuous evaluation of program quality, efficiency, and effectiveness; (18) communicates with internal and external stakeholders to provide information on oral health; (19) fosters collaborations with non-dental partners to improve the oral health of AI/AN; (20) serves as a liaison for oral health issues with other federal agencies; (21) develops resource opportunities to promote disease prevention programs; (22) evaluates programs on community-based services and oral health promotion/disease prevention; (23) promotes quality assurance/improvement principles in improving the delivery of oral health services in programs; (24) oversees clinical and preventive support centers that aid in management of oral health promotion/disease prevention programs; (25) monitors the prevalence and burden of dental disease in AI/AN; (26) educates internal and external stakeholders on disease prevalence and disparities and develops strategies for improvement; and (27) supports clinical research and demonstration projects designed to identify and promote evidence-based best practices.

Division of Diabetes Treatment and Prevention (DDTP) (GAFE)

(1) Plans, manages, coordinates, and evaluates a comprehensive clinical and community program focusing on type 2 diabetes in AI/AN communities and other related chronic conditions; (2) plans, manages, develops, coordinates, and evaluates the Congressionally-mandated Special Diabetes Program for Indians (SDPI), a large grant program focused on the prevention and treatment of diabetes; (3) coordinates requirements for and monitors program performance related to contracts and grants with IHS, tribal, Urban Indian organizations and other entities; (4) develops objectives, priorities and methodologies for the conduct of clinical and community diabetes programs; (5) monitors, evaluates, and provides consultation to clinical and community diabetes grant programs and other new initiatives; (6) provides leadership, professional guidance, and staff development to Area Diabetes Consultants and IHS, tribal, Urban diabetes program providers; (7) provides virtual and in-person trainings on diabetes clinical care, nutrition education, SDPI program management, and other topics; (8) develops and implements IHS standards of care and clinical guidelines, policies, and procedures for diabetes and diabetes-related conditions; (9) conducts an annual collection and assessment of clinical process and outcomes data for diabetes and diabetes-related conditions; (10) develops and disseminates diabetes-related information and materials to I/T/U facilities; (11) coordinates the Tribal Leaders Diabetes Committee; (12) provides annual estimates of diabetes prevalence; (13) provides national nutrition and tele-ophthalmology consultation, training, and programming; (14) coordinates and oversees the Healthy Lifestyles for Youth cooperative agreement which funds grants to provide the Together Raising Awareness for Indian Life obesity prevention program at Boys & Girls Clubs in Indian Country; and (15) is responsible for preparing budgetary data, analysis and program evaluations for budget presentations and congressional hearings.

Office of Management Services (OMS) (GAL)

(1) Advises the IHS Director on all aspects of the management of grants, acquisitions, records management, personal property, supply, and the regulations program and provides agency-wide guidance and support for these programs; (2) formulates, administers, and coordinates the review and analysis of IHS-wide policies, delegations of authority, and organizations and functions development; (3) develops and oversees the implementation of policies, procedures and delegations of authority for IHS grants management activities, including grants added to self-governance compacts; (4) ensures that IHS policies and practices for the administrative functions identified above are consistent with applicable regulations, directives and guidance from higher echelons in the HHS and other federal oversight agencies; (5) advises the IHS Director on regulatory issues related to the IHS; (6) provides overall coordination and leadership for policies, services, including the continuity of operations plans, deployment, and public health infrastructure for the IHS HQ emergency preparedness plans consistent with those of the Department of Homeland Security and the HHS, addressing the IHS mission critical elements of emergency plans; (7) provides leadership and direction of activities for continuous improvement of management accountability and administrative systems for effective and efficient program support services IHS-wide; (8) ensures the accountability and integrity of grants and acquisition management, records management, personal property utilization and disposition of IHS resources; (9) assures that the IHS OMS services, policies, procedures, and practices support IHS Indian Self-Determination Act policies; (10) oversees and coordinates the annual development and submission of the agency's federal Activities Inventory Reform Act report to the HHS; and (11) participates in cross-cutting issues and processes, including but not limited to, emergency preparedness/security, quality assurance, internal controls, recruitment, budget formulation, self-determination issues, and resolution of audit findings as may be needed and appropriate.

Division of Asset Management (DAM) (GALA)

(1) Plans, develops, and administers the IHS personal property and supply management program in conformance with federal personal property management laws, regulations, policies, procedures, practices, and standards; (2) interprets regulations and provides advice on execution and coordination of personal property and supply management policies and programs; (3) administers management systems and methods for planning, utilizing, and reporting on personal property and supply programs, including the precious metals recovery program and IHS personal property and supply accountability and control systems; (4) provides guidance and serves as principal administrative authority for IHS on federal personal property and supply management laws, regulations, policies, procedures, practices, and standards; (5) conducts surveys and studies involving evaluation and analysis of the personal property and supply management activities IHS-wide; (6) maintains liaison with the HHS and the General Services Administration (GSA) on personal property and supply management issues and programs affecting the IHS; (7) plans, develops and administers the IHS Fleet Management Program; (8) prepares reports on IHS personal property and supply management activities; and (9) administers the local HQ personal property management program to include receiving, tagging, storage and disposal in addition to conducting the annual inventory for all HQ locations.

Division of Administrative and Emergency Services (DAES) (GALB)

(1) Administers physical security, facility management, space management services, parking management, including the employee transit subsidy program, the IHS mail and commercial printing programs, and Homeland Security Presidential Directive 12 (HSPD–12) badge issuance for HQ; (2) coordinates with OIT to provide telecommunication services to HQ; (3) serves as liaison with HHS and the GSA on logistics issues affecting the IHS; (4) provides guidance and oversight to the IHS on the control and safeguard of classified national security information; (5) plans, develops and administers the IHS-wide HSPD–12 program to include providing leadership on the Physical Access Control Systems, and the Physical Security Program; (6) provides special transportation and security; (7) provides overall coordination and leadership for the IHS HQ emergency preparedness plans consistent with those of the Department of Homeland Security and the HHS, addressing the IHS mission critical elements of emergency plans; (8) provides leadership for the development of emergency preparedness plans, policies, and services, including the continuity of operations plans, deployment, and public health infrastructure; (9) coordinates IHS HQ with the IHS Area Offices activities and available resources of other government and non-government programs for essential services related to homeland security and emergency preparedness; (10) coordinates periodic national emergency preparedness exercises with the HHS and Area Offices; (11) maintains and administers the HQ emergency preparedness equipment including the office-site and alternative locations; (12) advocates for the emergency preparedness needs and concerns of AI/AN and promotes these program activities at the local, state, national, and international levels; (13) serves as an information gathering and dissemination point for local and national emergency preparedness information including situational awareness; (14) distributes key information to IHS locations on a routine and as-needed basis including federal agencies/partners; (15) provides leadership and guidance for the IHS Forms Management Program; and (16) provides leadership and coordination in the planning, development, operation, oversight, and evaluation of special office support projects for office relocations, and inter-and intra-agency activities.

Division of Acquisition Policy (DAP) (GALC)

(1) Develops, recommends, and oversees the implementation of policies, procedures and delegations of authority for the acquisition management activities in the IHS, consistent with applicable regulations, directives, and guidance from higher echelons in the HHS and federal oversight agencies; (2) advises the OMS Director, Deputy Director for Management Operations, and other senior staff of proposed legislation, regulations, and directives that affect contracting in the IHS; (3) provides leadership for compliance reviews of all IHS acquisition operations and oversees completion of necessary corrective actions; (4) administers the agency conference management policy; (5) manages for the agency, the HHS acquisition training and certification program; (6) supports and maintains the IHS Contract Information System and controls entry of data into the HHS Contract Information System; (7) serves as the IHS contact point for contract protests and the HHS contact for contract-related issues; (8) reviews and makes recommendations for approval/disapproval of contract-related

documents such as: Pre- and post-award documents, unauthorized commitments, procurement planning documents, Justification for Other Than Full and Open Competition waivers, deviations, and determinations and findings that require action by the agency Head of the Contracting Activity, or the Office of the Secretary; (9) processes unsolicited proposals for the IHS; (10) coordinates the IHS Small Business programs; (11) oversees compliance with the Buy Indian Act; and (12) manages the processing of Inter- and Intra-agency agreements as well as Memoranda of Understanding.

Division of Grants Management (DGM) (GALD)

(1) Directs grants management and operations for the IHS; (2) authorizes, awards and administers discretionary grants and cooperative agreements for IHS financial assistance programs; (3) provides guidance for the resolution of audit findings for grant programs; (4) manages for the agency, the HHS grants training and certification program; (5) continuously assesses grants operations; (6) oversees implementation of corrective action plans for those entity recipients (grantees) receiving IHS discretionary grant support; (7) reviews and makes recommendations for improvements in grantee and potential grantee management systems; (8) serves as the IHS liaison to the HHS and the public for discretionary grants and cooperative agreements authorized by the IHS; (9) maintains the Catalog of Federal Domestic Assistance for IHS financial assistance programs; (10) provides guidance and limited, technical, grants-related training and assistance for IHS staff, grantees, and applicants; (11) coordinates payment to scholarship recipients; (12) serves as liaison to the Centers for Excellence (grant award system) and controls data entry into the grant award system; and (13) maintains the official, electronic grant files for funded grants.

Division of Regulatory and Policy Coordination (DRPC) (GALE)

(1) Manages the IHS' overall regulations program and responsibilities, including determining the need for and developing plans for changes in regulations, developing or assuring the development of needed regulations, and maintaining the various regulatory planning processes; (2) serves as IHS liaison with the Office of the Federal Register (FR) on matters relating to the submission and clearance of documents for publication in the FR; (3) assures proper agency clearance and processing of FR documents; (4) informs management and program officials of regulatory activities of other federal agencies; (5) advises the OMS Director on such matters as regulations, related policy issues, and administrative support issues; (6) manages the retrieval and transmittal of information in response to requests received under the FOIA, Privacy Act, the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, in collaboration with the Public Affairs Staff; (7) ensures the security of sensitive and/or confidential information when responding to FOIA, Privacy Act, HIPAA, and HITECH Act issues; (8) advises the IHS Director regarding requests for IHS employees to serve as expert witnesses when IHS is not a party to the suit; (9) provides leadership and guidance for the IHS Records Management Program; (10) develops and recommends policies and procedures for the protection and disposition of IHS records and oversees the evaluation of records management activities in the IHS; (11) develops and implements a management control system for evaluation of records management functions IHS-wide; (12) maintains and updates various regulatory agendas; (13) manages, administers, implements and monitors the IHS's Paperwork Reduction Act and OMB information collection/activities; (14) provides guidance and technical assistance to IHS regarding information collection requirements and procedures for obtaining OMB approvals and extensions for IHS information collections; (15) coordinates the implementation and the application of Privacy Act, HIPAA, and HITECH Act requirements, including but not limited to HIPAA and HITECH Act compliance; (16) formulates, administers, and supports IHS-wide policies, delegations of authority, and organizations and functions development; (17) provides leadership, on behalf of the IHS Director, to functional area managers at IHS HQ in developing, modifying, and overseeing the implementation of IHS policies and procedures; (18) provides analysis, advisory, and assistance services to IHS managers and staff for the development, clearance, and filing of IHS directives and delegations of authority; and (19) serves as principal advisor and source for technical assistance for establishment or modification of organizational infrastructures, functions, and Standard Administrative Code configurations.

Office of Quality (OQ) (GAP)

(1) Advises the IHS Director on all aspects of assuring quality health care and develops and implements a strategic quality framework, integrating feedback and inputs from various levels of the organization and Tribal/Urban Indian organization partners; (2) oversees accreditation readiness activities and compliance with accreditation requirements for all IHS Direct Service facilities, to include periodic mock surveys and formal accreditation surveys; (3) conducts training and informational activities that promote skills development in quality improvement, quality assurance, and performance improvement; (4) routinely assesses and reports on patient satisfaction and experience using standardized survey instruments and processes, and facilitates improvement activities based on survey results; (5) coordinates and organizes participation of IHS facilities and staff in interagency quality improvement activities; (6) develops and monitors quality improvement and assurance metrics for health care delivery processes and outcomes, and advises other IHS Offices on quality improvement methods to improve support and outcomes of IHS administrative functions and processes; (7) develops programs to assess, address, and continuously improve systems and processes to improve health care quality, promote sustained compliance with relevant federal regulations and accreditation and professional standards, reduce and improve patient wait times and patient experience of care in all related health care settings; (8) consults on and provides guidance for standardization of health care delivery policies and protocols; (9) develops programs which promote patient safety management and reporting systems and processes, sentinel event investigations/root cause analysis, and clinical risk management; (10) supports credentialing of licensed independent practitioners via standardized methods and a uniform system; (11) supports patient-centered care processes, engagement of patients as partners in care, and patient activation through self-management support and involvement in service delivery improvements; (12) oversees and coordinates across IHS to establish and communicate IHS's Enterprise Risk Management (ERM) vision, culture, strategy, and framework; (13) oversees and coordinates the agency's efforts to establish and maintain proper internal controls and ensures that requirements are met under OMB Circular A–123; (14) facilitates enterprise-wide, integrated

and comprehensive assessments across IHS's risk portfolio including leading the development of the agency's risk profile and guiding management's prioritization of risks across the agency; and (15) participates in cross-cutting issues and processes, including but not limited to, emergency preparedness/security, quality assurance, recruitment, budget formulation, self-determination issues, and resolution of audit findings as may be needed and appropriate.

Division of Quality Assurance (DQA) (GAPA)

(1) Develops and implements programs to promote sustained compliance with relevant federal regulations and accreditation and professional standards: Manages and coordinates mock surveys, promotes accreditation services coordination, provides accreditation resource management, provides survey corrective action plan development assistance and coordination, manages accreditation and certification survey reports, promotes multidisciplinary integration of survey readiness support activities, supports and promotes patient-centered care including Patient and Family Engagement, and promotes unification of Area Quality Managers and Service Unit Quality Assurance and Performance Improvement Officers; and (2) develops and implements programs to manage credentialing standards and policy, acquires and maintains centralized credentialing software system, promotes unification of credentialing officers/prime source verification officers, and promotes standardized training and support resources for credentialing officers.

Division of Patient Safety and Clinical Risk Management (DPSCRM) (GAPB)

(1) Develops and implements programs to promote patient safety including: Promoting a culture of safety, providing education, training and application, establishing and monitoring systems and metrics related to adverse events, establishing policy and guidelines to reduce adverse events, reducing all types of hospital acquired conditions through technological innovation, attention to detail, and implementation of high reliability science, and reduce avoidable hospital readmissions through enhanced transition-of-care planning and coordination, communication with primary care, and management of community-based resource delivery; (2) develops and implements programs to employ strategies that reduce the possibility of a specific loss, systematically gathers and utilizes data, implements proactive and reactive components to prevent losses and mitigates impact of losses, implements strategies to reduce the risk of harm to patients, liability exposure of health care providers, and financial loss to the IHS; and (3) develops and implements programs to perform incident identification and reporting, identifies and addresses potential tort claims, sequestering medical records, and investigation of medical adverse events, reviews patient grievances concerning quality of care, performs sentinel event/root cause analysis review and documentation, analyzes methods for dismissal of patients from care, reviews outside requests for medical records, responds to inquiries from governmental agencies, media, and advocacy groups, promotes compliance with regulatory, accreditation, and contractual agreements, examining issues related to determination of standards of care, represents IHS when claims are presented for review by the Malpractice Claims Review Panel chartered by the HHS, maintains case files and a malpractice claims database, provides case summaries, peer review, outcome information, and feedback of risk management recommendations, disseminates information about the review process, responds to outside organizations requesting tort claim-involvement histories on former employees, assists providers with Malpractice Claims Review Panel, and submits payment reports to the National Practitioner Data Bank.

Division of Innovation and Improvement (DII) (GAPC)

(1) Develops and implements programs to increase quality improvement capacity in the Indian health system including training health care staff and support team members in the Model for Improvement to rapidly test small scale changes at the local level for improvement in clinical processes to improve patient outcomes, experience of care, and resource utilization, builds capability in all staff to support improvement and ensure that patients, families, providers and care team members are involved in quality improvement activities, establishes and monitors metrics to evaluate improvement efforts and outcomes and ensures all staff members understand the metrics for success, optimizes use of health information technology and data to continuously improve performance, quality and service (Resource and Patient Management System and iCare), and improves patient and staff satisfaction with health care service delivery; (2) leads change management for practice transformation to embrace new models of care delivery and to enhance efficiency of the care delivery process, develops and implements programs to promote the implementation of the patient-centered medical home model of care including: Increase patient empanelment to facilitate care management and population health, promotes continuous and team-based healing relationships in which roles are well defined and tasks are distributed among multidisciplinary care team members to reflect the skills, abilities and credentials of the individual team members, fosters patient-centered interactions through expanded patient roles in decision making, health-related behaviors and self-management, reduces barriers to accessing care through more efficient service delivery processes, alternative care delivery methods, expanded access to the care team, and appointment scheduling flexibility; boosts care coordination through community resource linkages, integrating specialty care referral and coordination processes, assisting with referral-related processes, and assuring completion of all elements of care; and (3) develops and implements programs to promote a competent health care management staff to include coordinating training and support resources for standardized position descriptions and competencies for management staff, standardizing management tools and resources, provides leadership development and skill-building, and facilitates change management to support quality assurance and quality improvement.

Division of Enterprise Risk Management and Internal Controls (DERMIC) (GAPD)

(1) Coordinates with key HQ Offices to ensure cross-cutting agency strategic planning, ERM, and management of internal controls across IHS; (2) ensures IHS' portfolio of enterprise risks are appropriately and effectively managed by identifying accountable individual risk owners; (3) advises on risk management and provides expertise, advice, and assistance to the IHS Director, Office Directors, Area Directors and other key staff at both HQ and Area levels on ERM matters; (4) develops goals and objectives for the ERM program, integrates them with broader IHS-wide strategic goals/objectives, and tracks progress toward achieving them; (5) evaluates and monitors systems of internal control across IHS and uses the assessments of the internal control program as an integral part of ERM to effectively manage risks across IHS; and (6) coordinates the agency's ERM program and administers the agency's

internal control program in compliance with the Federal Managers' Financial Integrity Act, OMB Circular No. A–123, and other applicable requirements.

Section GA–30, Indian Health Service—Delegations of Authority

All delegations of authority and re-delegations of authority made to IHS officials that were in effect immediately prior to this reorganization, and that are consistent with this reorganization, shall continue in effect pending further re-delegation.

Alex M. Azar II,

Secretary.

[FR Doc. 2018–27793 Filed 12–21–18; 11:15 am]

BILLING CODE 4165–17–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG–2010–1066]

Recreational Boating Safety Projects, Programs, and Activities Funded Under Provisions of the Fixing America's Surface Transportation Act; Fiscal Year 2018

ACTION: Notice.

SUMMARY: The Coast Guard is publishing this notice to satisfy a requirement of the Fixing America's Surface Transportation Act that a detailed accounting of the projects, programs, and activities funded under the national recreational boating safety program provision of the Act be published annually in the **Federal Register**. This notice specifies the funding amounts the Coast Guard has committed, obligated, or expended during fiscal year 2018, as of September 30, 2018.

FOR FURTHER INFORMATION CONTACT: For questions on this notice please contact Mr. Jeff Ludwig, U.S. Coast Guard, Regulations Development Manager, (202) 372–1061.

SUPPLEMENTARY INFORMATION:

Background and Purpose

Since 1998, Congress has passed a series of laws providing funding for projects, programs, and activities funded under the national recreational boating safety program, which is administered by the U.S. Coast Guard. For a detailed description of the legislative history, please see the Recreational Boating Safety Projects, Programs, and Activities Funded Under Provisions of the Fixing America's Surface Transportation Act; Fiscal Year 2017 Notice published in the **Federal Register** on November 24, 2017 (82 FR 17671).

These funds are available to the Secretary from the Sport Fish Restoration and Boating Trust Fund (Trust Fund) established under 26 U.S.C. 9504(a) for payment of Coast Guard expenses for personnel and activities directly related to coordinating and carrying out the national recreational boating safety program. Amounts made available under this subsection remain available during the two succeeding fiscal years. Any amount that is unexpended or unobligated at the end of the 3-year period during which it is available, shall be withdrawn by the Secretary and allocated to the States in addition to any other amounts available for allocation in the fiscal year in which they are withdrawn or the following fiscal year.

Use of these funds requires compliance with standard Federal contracting rules with associated lead and processing times resulting in a lag time between available funds and spending. The total amount of funding transferred to the Coast Guard from the Trust Fund, and committed, obligated, and/or expended during fiscal year 2018 for each project is shown below.

Specific Accounting of Funds

The total amount of funding transferred to the Coast Guard from the Sport Fish Restoration and Boating Trust Fund and committed, obligated, and/or expended during fiscal year 2018 for each project is shown in the chart below.

Project	Description	Cost
46 U.S.C. 43 Compliance: Inspection Program/Boat Testing Program.	Provided for continuance of the national recreational boat compliance inspection program, which began in January 2001.	$1,801,974
46 U.S.C. 43 Compliance: Staff Salaries and Travel.	Provided for personnel to oversee manufacturer compliance with 46 U.S.C. 43 requirements.	538,685
Administrative Overhead	Office supplies	63,640
Boating Accident Report Database (BARD) Web System.	Provided for maintaining the BARD Web System, which enables reporting authorities in the 50 States, five U.S. Territories, and the District of Columbia to submit their accident reports electronically over a secure internet connection.	327,195
Contract Personnel Support	Provided contract personnel to conduct boating safety-related research and analysis.	653,167
Boating Accident News Clipping Services	Provided for the collection of news stories of recreational boating accidents for more real time accident information and to identify accidents that may involve regulatory non-compliances or safety defects.	25,000
National Boating Safety Advisory Council	Provided for member travel and meeting costs for the 96th & 97th National Boating Safety Advisory Council meetings.	52,496
Grant Management Training	Provided to facilitate staff training on new grant management requirements	121,770
Recreational Boating Safety Program Travel.	Provided for travel by employees of the Boating Safety Division to gather background and planning information for new recreational boating safety initiatives.	182,164
Reimbursable Salaries	Provided for 18 personnel directly related to coordinating and carrying out the national recreational boating safety program.	2,429,557

Of the $7.984 million made available to the Coast Guard in fiscal year 2018, $2,696,985 has been committed, obligated, or expended and an additional $3,498,663 of prior fiscal year funds have been committed, obligated, or expended, as of September 30, 2018. The remainder of the FY17 and FY18 funds made available to the Coast Guard (approximately $5,329,880) may be retained for the allowable period for the National Recreational Boating Survey, other projects, or transferred into the pool of money available for allocation through the State grant program.

Authority

This notice is issued pursuant to 5 U.S.C. 552 and 46 U.S.C. 13107(c)(4).

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Review of Legislative and Policy Issues in 2018

Quarterly Board Meeting
Hosted by: Suquamish Tribe
January 22, 2019

2018 Legislative Requests

- Indian Health Service
  - Exempt IHS from Sequestration (p. 1)
  - Require IHS to provide detailed breakdown of IHS funding nationally and to areas (p. 1, RES)
  - Mandatory funding for IHS (p. 1)
  - Advance Appropriations for IHS (p. 1-2)
  - Equity in Health Care Facility Funding (p 2, RES)
  - Permanently Reauthorize the Special Diabetes Program for Indians (p. 2, RES)
  - Support transfer of IHS Appropriations from jurisdiction of Interior, Environment & Related Appropriations to Labor, Health and Human Services, Education and Related Appropriations (p. 5)

2018 Legislative Requests

- ACA/IHCIA and Medicaid
  - Preserve the Indian Health Care Improvement Act and Indian-Specific Protections in the ACA (p. 6, RES)
  - Preserve Medicaid/CHIP & 100% FMAP (p. 8)
  - Equal Access for AI/AN under Medicaid (RES only)
- Veterans
  - Preserve VA reimbursement agreements, reimbursements at OMB encounter rate, allow an exemption for tribes from value-based structure and ensure tribal consultation
  - Support for Veteran's Tribal Advisory Committee (TAC) (RES only)

2018 DOI/IHS Appropriations Requests

- Fully Fund the Indian Health Service at $32 billion (p. 1, RES)
- Fund Small Ambulatory Care Facilities (p. 3)
- Fund Regional Referral Specialty Care Center for planning and design at $3.4 million (p. 3, BF)
- Fund Dental Health Aide Therapy/Community Health Aide Nationalization (p. 4, BF, RES)
- Market pay Increases for providers (p. 4, BF)
- Fully Fund the Indian Health Care Improvement Act (p. 6, BF)
  - Provider Recruitment and Training Programs (p. 4)
  - Long Term Care (p. 6)
  - Behavioral Health and Substance Abuse (p. 6)
- Fund HCV Treatment (p. 10 , BF, RES)
- Increase funding for Sanitation Facilities & M&I programs (p. 11, BF)
- Increase funding for IHS Scholarship Program (RES only)

2018 HHS Appropriations Requests

- Fund HCV Prevention and Treatment (HHS)
  - Fund Secretary's Minority AIDS Initiative Fund (p. 10)
- Public Health & Environment (CDC)
  - Fund tribes directly for tribal public health infrastructure (p. 10)
  - Authorize and fund a public health emergency fund through Secretary of HHS (p. 10)
  - Increase funding for asthma treatment programs (p. 11)
  - Fund training and remediation for housing contamination (p. 11)
- Fund Native American Center of Excellence (HRSA) (RES only)

2018 HHS Appropriations Requests Cont'd

- Behavioral Health and Substance Abuse (SAMHSA)
  - Increase funding to implement the National Tribal Behavioral Health Agenda (p. 6, BF)
  - Ensure that all tribes have access to State Targeted Response Funding and other SAMHSA funding to address opioid crisis with consideration of reduced administrative burden to ensure there are no barriers for tribes and tribal organizations to access these funds (RES only)
  - Provide support for prevention (BF)
  - Expand telebehaviorial health platform (BF)

2018 Policy Requests-IHS

Indian Health Service – IT/EHR System Replacement (pp. 4-5)

- Provide tribal consultation in each IHS Area throughout process
- Provide training, and technical assistance
- Focus on the benefits to patient care
- Consider the various EHR systems that tribes are using
- Provide additional training and technical support, especially for smaller tribal health clinics.
- Provide a more user-friendly format for health care providers to highlight certain patient information and reporting for data collection.
- Make operability more of a focus

2018 Policy Requests-IHS Cont'd

Indian Health Service – DHAT/CHAP Nationalization (pp. 4-5)

- Amend IHCIA to remove state authorization requirement
- Support the Training and Utilization of DHATs in Tribal communities. (RES)
- Expand CHAP in the Portland and California IHS Areas (RES)
- Support the development of regional certification boards with federal baseline standards (RES)
- Increase funding for CHAPs in order to expand and implement the program nationally (appropriations)
- Provide more resources for behavioral health and dental aides
- Allow tribes to authorize/license/certify CHAP providers that at a minimum meet Alaska CHAP Standards.

2018 Policy Requests-CMS

Centers for Medicare and Medicaid Services (CMS)-Medicaid Initiatives (pp. 7-8)

- Monitor and Enforce Tribal Consultation
- Include IHS in discussions with tribes, HHS/CMS, and state when waivers are being considered that will impact the Indian health system.
- Provide more information to IHS/tribes on Value Based Payment (VBP) models
- Allow tribes an exemption from VBP models and preserve fee-for-service payment structure within states.

2018 Policy Requests-CMS Cont'd

CMS-Medicaid HCV Treatment (p. 10)

– State Medicaid Agencies must make HCV treatment a clinical priority and ensure access to medications to all (p. 10, RES)

Policy Requests-Veterans 2018

Veteran's Administration (pp. 8-9)

- Conduct Area tribal roundtables on the VA reimbursement agreements prior to the end of the existing renewal agreements.
- Improve care coordination for AI/AN Veterans.
- Reimburse tribal PRC dollars for specialist care to AI/AN veterans.
- improve eligibility and service eligibility determinations.
- Expand direct care services for care provided to all veterans regardless if they are eligible for IHS funding or not.

Questions?

Northwest Portland Area Indian Health Board

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2018 Legislative and Policy Issues

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization that represents 43 federally-recognized Tribes in Idaho, Oregon and Washington on health care issues.

Indian Health Service

Fully Fund the Indian Health Service / Exempt IHS From Sequestration

Indian Health Service (IHS) is significantly underfunded compared to other federal health agencies. For example, in 2015, IHS expended only $3,136 per AI/AN patient, while the national average spending per user was $8,517 -- an astonishing 63 percent difference. IHS funding is in fulfillment of the federal government's trust responsibility assumed through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 U.S.C. § 13) legislatively affirmed this trust responsibility. For AI/ANs, the federal budget is not just a fiscal document, but also a moral and ethical commitment that reflects the extent to which the United States honors its promises of justice, health, and prosperity to AI/AN people. Health funding for Indian Country has been hurt by sequestration and government shutdown in the past. In FY 2013, sequestration cuts devastated Tribal communities throughout the United States. In a health care delivery system that has been chronically underfunded for decades, this was disastrous for clinics across Indian Country.

Recommendations:

- Congress must fully fund the IHS at $32 billion annually as fulfillment of the federal trust responsibility. (NPAIHB/CRIHB Joint Res No. 17-04-08)
- Congress must permanently, fully exempt the IHS from sequestration. (NPAIHB/CRIHB Joint Res No. 17-04-08)
- Congress must require the IHS to provide a detailed breakdown of how spending is allocated at the national and Area level to Congress and Tribes each year. (NPAIHB/CRIHB Joint Res. 17-04-08)
- Congress must make IHS funding mandatory, no longer subject to the constraints of the annual discretionary appropriations process. (NPAIHB/CRIHB Joint Res 17-04-08)

Advance Appropriations for IHS

Since FY 1998 there has been only one year (FY 2006) when IHS appropriations have been provided at the beginning of the fiscal year. Late funding results in administrative challenges related to budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts. This affects access to care and the quality of health care provided. Providing sufficient, timely, and predictable funding is needed to ensure the federal government meets its obligation to provide health care for AI/AN people. Healthcare services directly administered by the federal government, such as the Department of Veterans Affairs, are funded by advance appropriations to minimize the impact of late and, at times, inadequate budgets. The decision of Congress to enact advance appropriations for the VA medical program provides a compelling argument for the effectiveness of advance funding a federally-administered health program; which could easily be applied to the IHS. Beyond the efficiency inherent

to advance appropriations, providing timely and predictable funding helps to ensure the federal government's trust responsibility is carried out.

Recommendation: Provide advance appropriations for the Indian Health Service.

Permanently Reauthorize the Special Diabetes Program for Indians

Congress established the Special Diabetes Program for Indians (SDPI) in the Balanced Budget Act of 1997 to provide for the prevention and treatment services to address the growing problem of diabetes in Indian Country. Congress recently extended the Act through September 30, 2017; however they should permanently extend the Act. The SDPI provides a comprehensive source of funding to address diabetes issues in Tribal communities that successfully provide diabetes prevention and treatment services for AI/ANs and have resulted in short-term, intermediate, and long-term positive outcomes.

Recommendation: Congress must reauthorize SDPI at $200 million per year with medical inflation rate increases annually or, in the alternative, reauthorization of SDPI for 2018 to 2024 at $150 million per year in 2018 with medical inflation rate increases annually thereafter. (NPAIHB Res No 17-03-08)

Equity in Health Care Facility Funding

The IHCIA requires the Health and Human Services (HHS) Secretary to submit a report to Congress that describes the comprehensive, national, ranked list of all health care facilities' needs for the Indian Health Service (IHS), Indian Tribes, and Tribal Organizations carrying out health programs under the IHCIA, initially by March 23, 2011, and thereafter update the report every five years.[1] The IHCIA also requires the IHS to maintain a health care facility priority system which is to be developed in consultation with Indian Tribes and Tribal Organizations and serve as the basis for the HHS Secretary to submit the above referenced report to Congress.[2] The initial report submitted to Congress estimated facilities needs and costs based on unfunded projects in the existing Health Care Facilities Construction Priority List (Priority List), in addition to those projects identified in Area Health Services and Facilities Master Plans (Masters Plans) developed in FY 2005 with their costs estimated by using the health care facility priority system. CRIHB, NPAIHB, and many other Tribes and Tribal Organizations do not feel that the report submitted to Congress was adequate to identify a national comprehensive list of facilities needs in light of the fact that the Priority List has been locked since approximately 1991 and Tribes and Tribal Organizations have not had an equitable opportunity to compete for funding in order to be placed on the list. The 2005 Area Master Planning process included inconsistent planning criteria (and the necessary resources to complete thorough and comparable master plans) across the entire IHS system, and neither of these two processes incorporated new authorities for health services or facility types authorized in the 2010 amendments to the IHCIA. The 2016 IHS/Tribal Health Care Facilities' Needs Assessment Report to Congress stated that the current Priority List will not be complete until 2041 and at the current rate of construction appropriations and the replacement timeline, a new 2016 facility would not be replaced for 400 years. Many Tribes and Tribal Organizations have had to assume substantial debt to build or renovate clinics for Indian people to receive IHS-funded health care.

Recommendations:

- Instruct the Government Accountability Office to review and issue a report on the IHS Facilities Construction Priority System, including historical and current funding distribution inequities. (NPAIHB/CRIHB Joint Res No. 17-04-12)

[1] 25 USC § 1631(c)(2)(A)(ii)(I).
[2] See "Report to Congress on Estimated Need For Tribal and Indian Health Service Health Care Facilities," submitted by the Indian Health Service, circa March 2011.

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

Fund Regional Referral Specialty Care Centers

Portland Area Tribes have been very innovative in developing alternatives for facilities construction. The Portland Area Tribes completed a Pilot Study to evaluate the feasibility of regional referral centers in the IHS system. The Pilot Study concluded that the demand for Regional Specialty Referral Centers, when strategically placed, to offer specialty care, diagnostics, and ambulatory surgery care are economically feasible. The Study further recommends that a demonstration project be completed in the IHS. The current IHS Health Care Facility Priority system does not provide a mechanism for funding specialty referral centers. The Portland Area Facilities Advisory Committee recommends that the first specialty referral center be constructed as a demonstration project under the authorities in the Indian Health Care Improvement Act. The facility is anticipated to provide services such as medical and surgical specialty care, specialty dental care, audiology, physical and occupational therapy as well as advanced imaging, and outpatient surgery. It is anticipated that this facility could provide services for approximately 50,000 users within the regional service area as well as an additional 20,000 in telemedicine consults.

Recommendation: Congressional appropriations committees must include $3.4 million for planning and design of a Regional Referral Specialty Care Center demonstration project in the Portland Area.

Fund Small Ambulatory Care Facilities

Portland Area Tribes annually request that small ambulatory facilities have a source of funds to support the new facility construction needs of smaller tribes who cannot compete in the current new facilities construction priority system. The current priority list was developed in 1991 and tribes are locked out of accessing badly needed construction dollars unless their facility is one of the facilities on the current list. The Portland Area Tribes continue to oppose any new facilities construction projects until the IHS completes its revision of the Health Facilities Construction Priority System.

Portland Area Tribes have long encouraged alternative methods to acquire new facilities. These alternative methods of acquiring health facilities must be supported in an effort to meet the demand for primary care. There is such an enormous need that depending exclusively upon IHS appropriations for all health facility requirements is not realistic. The IHS and Tribes have developed strategies (Joint Venture and Small Ambulatory Funding) that will greatly increase the number of new ambulatory health facilities constructed, but some IHS funding is required for this strategy of leveraging financing to work. In addition, staffing packages should be available to any new facility, regardless of how construction was funded.

The Indian Health Care Improvement Act (Section 305) authorized a grant program for the construction, expansion, and modernization of small ambulatory care facilities. This program assists tribes to secure quality health care in isolated rural areas. In the Northwest this could mean replacing old, worn out trailers that serve as the health clinics in Tribal communities. Small modern clinic facilities assist tribes to attract health care professionals, provide a health focus for the community, and, where tribes are agreeable and resources available, provide health care services to underserved non-Indian individuals in the community. This program has an excellent record of achievement that should be rewarded with increased appropriations.

Recommendation: Congress must continue to provide annual funding for small ambulatory facilities to support new facilities construction.

Workforce Development

Both IHS and tribally operated facilities have difficulty with recruitment and retention of qualified medical providers. Due to lack of funding, many recruiter positions have been abolished and those responsibilities have transferred to full time staff, making it difficult to devote meaningful time to these activities. Tribes are concerned that the expansion of Medicaid and Medicare, as well as, new funding authorities for Veterans Administration, has created more competition for the same amount of providers.

Recommendations:

- Expand Title 38 authorities for market pay for all provider positions including physician assistants to ensure that Indian Health Service and tribal facilities can be competitive in the current job market.
- Congress must fund IHCIA sections 112, 132 as well as 134, which would also provide additional resources to address recruitment as well as training programs to increase AI representation in provider positions.

Dental Health Aide Therapist Program and Community Health Aide Program Nationalization

The dental care workforce can be expanded safely, effectively and quickly to address these deplorable oral health disparities through dental health aide therapists (DHATs). DHATs are part of a dentist-led team. They educate patients about oral health and prevention, perform dental evaluations, give fluoride treatments, place sealants, clean teeth, place fillings, and perform simple extractions. Like nurse practitioners and physician assistants in the field of medicine, dental therapists expand the reach of dentists and free them to perform advanced treatments. DHATs who come from and return to their communities bring immeasurable strengths. They have excellent technical skills and the cultural understanding, and personal connections to their communities. DHATs will help provide access and quality oral health care to AI/AN people who need it badly.

Our organization has a DHAT initiative program that has been instrumental in paving the way for DHATs in the lower 48. The Swinomish Tribe, a tribe in our area, had the first tribally operated DHAT program in the lower 48 and more are being planned in Washington since the state legislature passed a law allowing DHATs to practice on tribal land. And in Oregon, pilot project legislation has authorized two tribal DHAT sites and one urban site.

Relatedly, our area has been a strong voice for nationalization of the Community Health Aid Program (CHAP). We expect the next IHS Director to have a strong voice in advocating for nationalization of CHAP and to actively support DHATs in the lower 48.

Recommendations:

- Amend IHCIA to remove state authorization requirement for DHATs.
- Expand the Dental Health Aide Therapists (DHAT) program to allow sites to provide more preventative and routine care by allowing DHATs to perform exams and basic services.
- Support the Training and Utilization of DHATs in Tribal communities. (NPAIHB/CRIHB Joint Res No .17-04-10)
- Expand CHAP in the Portland and California IHS Areas and support the development of regional certification boards with federal baseline standards for consistency of services provided by any CHAP program. (NPAIHB/CRIHB Joint Res No. 17-04-09)
- Increase funding for Community Health Aide Programs (CHAPs) in order to expand and implement the program nationally under IHCIA section 111. (Portland Area Tribes Budget Recommendation)
- Provide more resources for behavioral health and dental aides, in order to leverage individuals who already live in a community that can build trust between providers and patients, while also

ensuring that services are available and delivered as close to the patient as possible. (Portland Area Tribes Budget Recommendation)

- Recognize tribal sovereignty and allow tribes to authorize/license/certify CHAP providers that at a minimum meet Alaska CHAP standards.

Information Technology & Electronic Health Record Replacement

Since 1984, the IHS has relied on RPMS as the health information solution. The RPMS is a government-developed health information system comprised of over 80 integrated software applications. The RPMS hardware, software, network, and database allows both large and small health facilities to work independently as well as within the larger network of the Indian Health system. The Veterans Administration's (VA) will move to a new health record system, which will leave the Indian Health Service's current Registration and Patient Management System (RPMS) without system support. RPMS has a similar infrastructure and clinical applications to VistA. The VA has selected to single source contract with Cerner as to be on the same platform as Department of Defense (DOD). Portland Area Tribes recognize there will be a need for substantial investment in IT infrastructure and software in order to transition to an alternate system.

Recommendations:

- IHS must provide tribal consultation in each IHS Area throughout process in efforts to modernize or replace RPMS.
- IHS must provide ample transition period, training, and technical assistance to tribes once IHS makes a decision on whether to improve RPMS or contract with a new EHR system.
- The RPMS improvements or the new EHR system must focus on the benefits to patient care that improve the involvement and utilization of providers in the health IT system.
- IHS must take into consideration the various EHR systems that tribes utilize instead of RPMS.
- IHS must provide additional training and technical support, especially for smaller tribal health clinics.
- IHS must provide a more user-friendly format for health care providers to highlight certain patient information and reporting for data collection purposes.
- IHS must make operability more of a focus in the modernization of the RPMS or a new EHR system, so that the system is more streamlined and aligned with other EHR systems.

Support transfer of IHS Appropriations from jurisdiction of Interior, Environment & Related Appropriations to Labor, Health and Human Services, Education and Related Appropriations

Move the IHS budget from the Interior Appropriations Sub-Committee to the Labor, Health and Human Services, and Education (LHE) Appropriations Sub-Committee. The LHE Committee handles health care related bills, and therefore understands the problems associated with health care delivery, such as medical inflationary rates. The Interior Appropriations Subcommittee is responsible for national parks, reclamation projects, mining activities, fish and wildlife, and other natural resource programs. It is reasoned that the IHS appropriation would benefit by being in the same pool of health expenditures that programs like Medicare, Medicaid, SCHIP, and other health programs appropriated out of the LHE Appropriations Subcommittee. The Labor-HHS-Education subcommittees have almost always been allocated appropriation increases that match or exceed health inflation indexes. While the Interior Appropriation Subcommittee allocations reflect natural resource program inflation rates, which generally fall below health inflation.

Recommendation: Move the IHS budget from the Interior Appropriations Sub-Committee to the Labor, Health and Human Services, and Education (LHE) Appropriations Sub-Committee.

IHCIA

Fully Fund IHCIA

The Affordable Care Act (ACA) included amendments to, and a permanent reauthorization of, the Indian Health Care Improvement Act (IHCIA). Both the ACA and IHCIA include many authorities that are beneficial for IHS, Tribal, and Urban (I/T/U) Indian health programs. Two areas with significant need are long term care and behavioral health:

Fund Long Term Care (LTC) and Assess LTC Needs

The IHS does not fund long-term care, which is why there are few long-term care services in Indian communities. There are only 15 known tribal nursing homes in the nation. Northwest Tribes support the study of the long-term care needs of AI/AN people. Tribes need more case management funding and funding to allow Tribes to provide advice on long-term care needs to their elders. Medicare and Medicaid programs could become important sources of funding for long term and home and community based care for elders with support from CMS. The IHS should receive a line-item appropriation to study long-term care programs in Tribal communities. Elder issues and Long Term Care (LTC) are a growing concern for Tribes across the country.

Recommendation: Fund long term care services, authorized under IHCIA, for AI/AN people and provide a line-item appropriation to IHS to study long-term care needs and programs for AI/AN people.

Increase Funding for Behavioral Health & Substance Abuse

AI/AN people have many socioeconomic factors that contribute to poor behavioral health outcomes such as high rates of poverty, unemployment and lower rates of education. They are 1.7 times more likely to die of suicide than all U.S. races. Suicide is also the second leading cause of death for AI/AN teens and young adults. According to national data on drug and alcohol use, AI/AN have the highest rates of substance dependence or abuse of all ethnic groups at 14.9% compared to 8.4% for whites.

Recommendations:

- Increase funding to implement National Tribal Behavioral Health Agenda to improve the behavioral health of American Indians and Alaska Natives.
- Fully IHCIA sections 702, 704, 705, 709, 710, 711,712, 714, 715, 723 & 724 for increases to Behavioral health funding to provide inpatient treatment, training for mental health Techs, expansion of tele-mental health as well as demonstration grants.

Preserve the Indian Health Care Improvement Act and Indian-Specific Provisions in the Patient Protection and Affordable Care Act

Any proposed future legislation repealing the Patient Protection and Affordable Care Act (ACA) must preserve the Indian Health Care Improvement Act (IHCIA). IHCIA, permanently reauthorized under the ACA, has improved the Indian health care system in several ways. It improved workforce development and recruitment of health professionals, it provided new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs, and has created opportunities to improve access and financing of health care services for American Indian and Alaska

Natives (AI/ANs). For example, the law has allowed the Indian Health Service (IHS) to carry out long term-care related services and be reimbursed for services such as home and community based services. IHCIA has also helped modernize the delivery of health services provided by IHS.

The ACA has provided an incredible opportunity for increased health coverage for the tribal citizens in our area through Marketplace plans and many tribes have implemented premium sponsorship programs for their tribal citizens. The increased access for AI/AN people to health care services through the Marketplaces and increased revenue at our IHS/tribal facilities has been significant and tribes cannot afford to lose these services for their tribal citizens or revenue to their clinics.

In addition, there are several Indian-specific provisions in the ACA that are critical to the Indian health system that are in jeopardy with an ACA repeal. Section 2901(b) ensures that IHS, Tribal and urban Indian programs (I/T/Us) are the payers of last resort; Section 2901 (c) simplifies eligibility determinations for AI/AN enrolling in CHIP when seeking services from Indian providers; Section 2902 authorizes I/T/Us reimbursement for Medicare Part B services; and Title IX, Section 9021 ensures that health benefits provided by a Tribe to Tribal Members are not counted as taxable income.

Recommendations: Urge Congress to ensure that the IHCIA and Indian-specific provisions in any health care reform legislation are preserved so the Indian health system can continue to operate under a framework appropriate for 21st century healthcare delivery that honors the United States' trust responsibility to provide healthcare to AI/ANs. (NPAIHB Res No. 17-03-01)

Medicaid/CHIP

Medicaid Initiatives

Section 1115 of the Social Security Act (SSA) allows a state to apply to the Centers for Medicare and Medicaid Services (CMS) for a waiver of Medicaid requirements of the SSA for experimental, pilot, or demonstration projects. States can use section 1115 waivers to test health care services that promote the objectives of Medicaid and Children's Health Insurance Program (CHIP). These waivers can influence policy-making and alter the delivery of health care services provided to AI/ANs. In addition, states can also apply for a Section 1915(b) waiver to provide services through managed care delivery systems or otherwise limit choice of providers; or apply for a Section 1915(c) home and community-based services waiver to provide long-term care services in home and community settings rather than institutional settings; or get certain ACA Marketplace provisions waived under a 1332 waivers. Oregon and Washington have 1115 waivers in place, while Washington has structured this waiver to completely transform its Medicaid system. Idaho is currently working on a combined 1115 and 1332 waiver application which will partially expand Medicaid for a very limited segment of the population.

As part of these initiatives, all three of our states are moving towards value based payment (VBP) models. VBP models are part of CMS's quality strategy to reform how health care is delivered and paid for. These models reward health care providers with incentive payments for the quality of care they provide to patients rather than the quantity of care to patients. These models are meant to replace, or move away from, fee-for service. Tribes and urban Indian health programs (UIHPs) are concerned about these models and have requested that states retain the fee-for-service system. These models also require collection of common performance measures for health outcomes that IHS/tribal EHR systems may not have the capacity to collect; or that could be met with GPRA data.

Another ongoing concern in our area is that Medicaid regulations prohibit funding from being expended at I/T/U health facilities classified as Institutions for Mental Diseases (IMD) for patients between 21-65 years old. Current law also excludes Medicaid payments to facilities exceeding 16 beds and limits the

access to care for many. Given the severe underfunding of I/T/U programs, the IMD limitations are too restrictive and have prevented AI/AN patients from accessing greatly needed behavioral health services.

Recommendations:

- CMS must monitor and enforce state tribal consultation requirements on Medicaid Transformation initiatives, waivers, SPAs and other policy changes.
- IHS needs to be involved in discussions with tribes, HHS/CMS, and state when waivers are being considered that will impact the Indian health system or that transform the Medicaid system.
- IHS/tribes need more information on VBP models, including metrics, expected outcomes, incentives, penalties, and what data will be collected and how it will be used, and if there will be adequate funding for the programs that are interested in participating in these models.
- Allow tribes an exemption from value-based payment structures and preserve fee for service payment structure within states.

Medicaid Funding/Preserve 100% FMAP

The Medicaid program, provides critical health coverage for AI/AN people and has also become a very important source of financing for health care for Indian health programs in our area and across Indian country. Because the IHS budget has not received adequate increases to maintain current services, Medicaid has provided additional revenue for Indian health providers. Most of the IHS budget increases are directed toward staffing new facilities and minimally finance inflation and population growth for the Indian health programs. The increased coverage and revenue associated with Medicaid expansion has had a very positive effect on Northwest Tribal health programs. Northwest tribes have advocated that AI/AN who have been part of the expanded population continue to be covered in any health reform efforts.

It is essential in any health care reform efforts that the federal trust responsibility for Indian health care be honored, and 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS and tribal facility is preserved. Many of the health care proposals that have been discussed in the past are designed to stop or reduce federal spending on the Medicaid program, yet still recognize that certain limited and unique federal funding streams will have to be maintained. The tribes in our area are opposed to block grants, but if they were to move forward in legislation then we have requested a carve out for AI/AN to hold the federal government to its trust responsibility. The 100 percent FMAP provision for services received through an IHS or tribal facility must be preserved.

Recommendations:

- In any Medicaid reform efforts, honor the federal trust responsibility for Indian health care and preserve 100% FMAP for services received through the Indian health system (NPAIHB/CRIHB Joint Res No. 17-04-04).
- Any plan to change the manner in which State Medicaid costs are reimbursed by the federal government must include a carve out for services provided to AI/ANs so that the federal government's trust responsibility is not shifted to the States (NPAIHB/CRIHB Joint Res No. 17-04-04).
- Ensure state implementation of 100% FMAP to the benefit of tribes.

Veterans

Continue VA Reimbursement Agreements

Indian Country has long recognized the growing concerns and frustrations of AI/AN veterans in obtaining health services from the IHS and Veterans Administration (VA). Currently, the VA has 16

reimbursement agreements in the Northwest (1 in ID, 6 in OR, and 9 in WA) with Tribal health programs (THPs) and the program is growing so there is a need to improve the relationship between the VA and THPs as well as the experience of the veteran. Not all tribes have equal capability to get their veteran tribal members access to VA health benefits. The VA held a tribal consultation in Washington D.C. in September 2016; a roundtable in Phoenix, AZ. In July 2017; and is rescheduling a roundtable in Alaska (was scheduled for August 2017).

The VA is seeking tribal input on a new payment structure. VA has suggested a value-based rate structure instead of the all-inclusive rate payment methodology, which could decrease payments reimbursed to Tribes for health care services rendered to AI/AN veterans. The OMB all-inclusive rate is recent, established annually and based on cost reports from Tribal hospitals and IHS. It was set when Tribal facilities received authorization to bill Medicare and Medicaid services.

Recommendations:

- Legislation must preserve VA reimbursement agreements, reimbursement at OMB encounter rate, and allow an exemption for tribes from a value-based payment structure and ensure tribal consultation.
- VA leadership must conduct Area tribal roundtables this year with tribal leaders, tribal health directors, and tribal clinic directors on the VA reimbursement agreements prior to the end of the existing renewal agreements.
- VA must improve care coordination for AI/AN Veterans. It is a barrier to constantly refer AI/AN Veteran patients back to the VA because it is time consuming and, ultimately delays services.
- VA should reimburse tribal PRC dollars for specialist care to AI/AN veterans. The current process often leads to the tribe utilizing PRC dollars to pay for the specialist care of the AI/AN veteran. However, tribes do not get reimbursed for care coordination because of the restriction of reimbursement to direct care.
- VA must improve eligibility and service eligibility determinations. There is a need to streamline training so that eligibility requirements and benefits can be made quickly available.
- VA must expand direct care services for care provided to all veterans regardless if they are eligible for IHS funding or not. Tribes in the Northwest serve a significant number of non-native patients. There needs to be improvements in how to identify the veterans and make them eligible. When you a have a veteran in a rural community they are going to go to the facility that they know they will receive care and that they won't have to spend time and money, the VA system can be a barrier to this process.

Cross-Agency

HCV Funding

The NPAIHB seeks to carry out the NPAIHB/CRIHB joint resolution #17-04-11 to eliminate Hepatitis C among AI/AN people by "providing access to HCV treatment without restrictions" which was also enacted by ATNI and NCAI. AI/ANs are disproportionately affected by Hepatitis C virus and have both the highest rate of acute HCV (Hepatitis C) infection and the highest HCV-related mortality rate of any US racial/ethnic group. The AI/AN HCV-related mortality rate in Idaho, Oregon and Washington is over three times that of non-Hispanic whites and this disparity has persisted over time, demonstrating the need for enhanced and expanded access to HCV curative therapies. Lack of drug access to costly new medications (that reduce liver-related deaths, prevalence of hepatocellular carcinoma and

decompensated cirrhosis and liver transplants) is the single most important barrier to a scale-up of HCV treatment and liver disease prevention. These HCV drugs are not on the IHS formulary, so clinicians must spend considerable time mounting often unsuccessful attempts to get third-party payers such as private insurers, Medicaid, and patient-assistance programs to pay for them.

CMS issued a Medicaid Drug Rebate Program Notice for State Technical Contacts, Release No. 172, dated November 5, 2015, which states that "limitations should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments for beneficiaries with chronic HCV infections. States should, therefore, examine their drug benefits to ensure that limitations do not unreasonably restrict coverage of effective treatment using the new HCV drugs. Clinical guidelines for testing, managing, and treating HCV put forth by the American Association for the Study of Liver Diseases (AASLD), the Infectious Diseases Society of America (IDSA), and the International Antiviral Society-USA (IAS-USA) can be found at http://www.hcvguidelines.org/full-report-view. These guidelines state that treatment is recommended for all patients with chronic HCV infection, except those with a short life expectancy that cannot be remediated by HCV therapy, liver transplantation, or another directed therapy. Idaho and Oregon continue to impose discriminatory restrictions which contradict CMS and clinical guidance.

Recommendations:

- Congress must appropriate funding for HHS Secretary's Minority AIDS Initiative Fund (SMAIF) of $54 million or include appropriation of $3.6 million for the Indian Health Service for HIV/HCV prevention, treatment, outreach and education.
- Congress must appropriate funding to the Indian Health Service to Assure Access to Hepatitis C Medications for all AI/AN people with HCV as part of the initiative to Eliminate HCV among AI/ANs in parity with the U.S. Department of Veterans Affairs. (NPAIHB Res No. 18-02-02)
- Department of Health and Human Services, and its agencies, including but not limited to the Centers for Medicare and Medicaid Services (CMS) and Indian Health Service (IHS), must make HCV treatment a clinical priority and ensure access to medications to all persons with medical need as determined per AASLD, IDSA or IAS-USA guidelines. (NPAIHB Res No. 18-02-02)
- State Medicaid Agencies must make HCV treatment a clinical priority and ensure access to medications to all persons with medical need as determined per American Association for the Study of Liver Diseases (AASLD) guidelines. (NPAIHB Res No. 18-02-03)

Support Tribal Public Health Infrastructure

While Tribal health programs have public health and medical care infrastructure; it is often underfunded and may lack the capacity to respond effectively to health, natural, and manmade disasters. Too often population density is often a primary consideration in the allocation of emergency preparedness resources, it is important to recognize that public health emergencies and disasters can and do occur on Indian reservations and in rural areas in proximity to Tribes, and that the impact of these emergencies can be felt on all Americans regardless of geography. One need only consider the far reaching impacts of natural disasters, agricultural blight, and infectious diseases to realize the interconnectedness of our reservation, rural and urban citizens.

Recommendations:

- Congress must provide funding and resources directly to tribes for tribal public health infrastructure.
- Portland Area Tribes request the authorization of a Public Health Emergency Fund established through the Secretary of Health and Human Services.

Environment & Health Effects

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

Recommendations:

- Targeted funding to increase asthma treatment programs including education and remediation of the environmental triggers associated with poor asthma control.
- More funding needs to be devoted to training and remediation for those tribes that are dealing with housing contamination.
- Increased funding in the Sanitation Facilities program will also address training as well as provide evaluation and maintenance of current water systems to help mitigate or treat contamination from heavy metals such as lead and other harmful substances.

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NARCH and Prevention Research Center Program Updates

Tom Becker, Medical Epidemiologist

Game Plan

- Provide a short update on the history of our NW NARCH (Native American Research Centers for Health)
- Relate summary information from various projects, past and present
- Provide update on the Prevention Research Center (PRC), a collaboration among the Board, several member tribes, and OHSU

Short NARCH History

- Relatively new federal program that required collaborations among tribes and academic programs
- Initial planning for the NIH and Indian HS-funded program began 16 years ago
- The Board was awarded funding in the first round, and has received funding for every round for which we have applied ($15 million)

NARCH First Round

- Toddler obesity and tooth decay prevention
- Child safety seat use
- Scholarship program
- Use of internet for diabetes self management
- Other components of that application were not funded (7 submitted)

Subsequent Components of NARCH

- NARCH 3 Scholarship program
- NARCH 4 Summer Research Training Institute
- NARCH 5 Monitoring Abuse of Drugs
- NARCH 5 Supplement: HIV prevention
- NARCH 6, 7 Continued scholarships and Summer Institute

- NARCH 8 Dental follow up study of 'tweens'
- NARCH 9 includes: Improving asthma management in tribal children, and Cancer Prevention and Control fellowship program for tribal trainees
- NARCH 10 includes: Graduate fellowship program for tribal students in biomedical or social science research (Summer Institute was not renewed)

2018 Accomplishments

- Continued support of prior fellows—many new graduates
- Identified several new fellows
- Added Board-based scholars
- Hosted summer institute with 84 participants
- Implemented NARCH 9 and 10 grants
- Hired Asthma Project Director (Celeste) and Coordinator (Mattie)

Coming up in 2019

- Continue fellow/scholar support (Grazia Cunningham)
- Conduct follow up of summer institute trainees and graduate trainees (Grazia Cunningham)
- Continue asthma (Mattie Tomeo-Palmanteer and Celeste Davis) and Cancer (Ashley Thomas) projects
- Prepare new NARCH grant for round 11 when funding announcement comes out
- Attend and present at conferences on Indian health and on public health

NARCH Team

Current NARCH staff and valued helpers

- Mattie Tomeo-Palmanteer
- Celeste Davis
- Ashley Thomas
- Grazia Ori Cunningham
- Tam Lutz
- Nicole Smith
- Candice Jimenez
- Kerri Lopez

- Jacqueline Left Hand Bull
- Victoria Warren-Mears
- Eugene Mostofi
- Tara Fox
- Tom Weiser
- Teshia Solomon
- Linda Burhansstipanov
- Nancy Scott
- Board of advisors

Prevention Research Center (PRC)

- Funding from CDC to OHSU, to partner with the Board and member tribes in health projects
- Main topics: preservation of sight and hearing via community-based research projects, avoidance of risky decisions by tribal youth
- Additional activities: regular seminar series on Indian health, classes in epidemiology of health conditions in tribal people, assisting with Board projects, provided funding for expansion of HPV vaccine

Future of the PRC

- In our last year of funding in current cycle
- We were not eligible to apply for renewal
- We will seek the Delegates' support for exploring additional funding sources (like NIH)
- We have a viable research idea that has met with enthusiastic response from local tribal people –related to fall prevention in older American Indians

Key Participants in PRC

- Caitlin Donald
- Michelle Singer
- Bill Lambert
- Brittany Morgan
- Jodi Lapidus
- Stephanie Craig-Rushing
- Jackie Shannon
- Raina Croff

- Thanks much...please contact me if questions at tbecker@npaihb.org
- Mattie Tomeo-Palmanteer will update you on the Asthma (NARCH 9) Project and seek volunteer tribal sites
- Graham Harker is also here to answer questions about falls and new balance-related technology

"Enhancing Control of Childhood Asthma in AI/AN Communities

- The Asthma project is funded by the U.S. Department of Health and Human Services, National Institutes of Health and is sponsored by the Northwest Portland Area Indian Health Board in partnership with the Indian Health Service.

https://www.youtube.com/watch?v=PzfLDi-sL3w

Purpose

- We want to learn how to help AI/AN children and their caregivers be successful in managing asthma triggers, medications, and decreasing hospitalization visits

Project Aims

- Provide clinic-based education by pharmacy emphasizing self-management and coordinated with home environment management
- Provide training materials and recommended practices for dissemination and implementation of childhood asthma control programs in additional Pacific NW Tribes and/or Urban Indian Health Clinics
- Support Tribal and Urban Indian Health Clinic's ability to sustain their pediatric asthma control program through organizational and institutional resources

Benefits

- Benefits: the goal of this research is to improve asthma management for AI/AN children and their quality of life
- Tribes and participants will help create better asthma education for AI/AN children
- Participants and their parent and/or caregiver will receive asthma education
- Patients and their parent and/or caregiver will receive in-home visits in order to conduct an environmental health assessment
- Participants will receive vacuum cleaners with High Efficiency Particulate Air (HEPA) filters, mattress & pillow covers, and green cleaning supplies

Risks

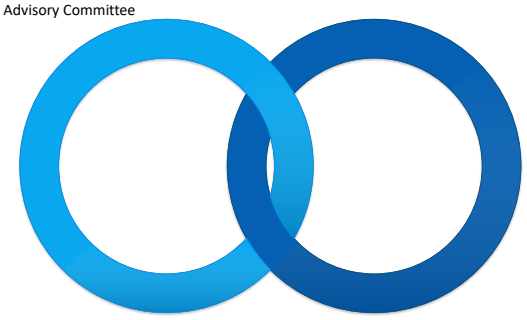
- Risks are minimal. However, we will be collecting personal information and asthma related data from children and adolescent participants IHS electronic health record
- Participants who choose to enroll will be assigned with a random participant identification number to de-identify data obtained from three questionnaires

Progress

- December 17, 2019 The Portland Area Institutional Review Board granted approval
- The Yakama Indian Health Service Clinic is enrolling patients to participate in the project.
- Supplies to complete environmental home visits are now in the process of being ordered after receiving recommendations from the Indian Health Service, Environmental Protection Agency and Housing and Urban Development
- We are seeking additional volunteer NW tribes and/or Urban Indian Health Centers that serve AI/AN to join our research project expansion efforts.

Please contact Mattie if you are interested in obtaining more information in person during QBM or via email asthma@npaihb.org

We are thankful for our project collaborators including Lieutenant Commanders Ryan Pett and Shawn Blackshear, Yakama Service Unit CEO Jay Sampson, Yakama Service Unit Providers, Yakama Nation HEW Committee, and the Community Advisory Committee



Additional Resources

- https://www.healthandenvironment.org/our-work/publications/a-story-of-health
- https://www.thecommunityguide.org/topic/asthma
- https://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma/living-with-asthma/creating-asthma-friendly-environments/asthma-at-home.html

Questions?

NPAIHB Tribal Opioid Response – *Taking care of each other*

Jessica Leston, Tsimshian
Colbie Caughlan
Heidi Lovejoy

Overview

What is a Tribal Opioid Response?

What is the community telling us?

How are we responding?

What is a Tribal Opioid Response?

"Honestly, at this time, we are not certain."

"Housing is a problem in our community especially for people with substance use issues and poor rental and legal history. A good plan moving forward would be to implement a pathway to affordable/subsidized/transitional housing for those in treatment."

"Low rate of new opiate prescriptions for pain to reduce risks related to unintentionally starting new addictions, CD support through the tribe…"

"Successful participation in our MAT program and the community embracing a Harm Reduction way!"

"Our plan would include lots of education/prevention to the tribal community in terms they could understand. We desperately need follow up services/housing for clients to return to. We need community buy in to provide a healthier drug free atmosphere."

What is a Tribal Opioid Response?

"An outline of strategies to be implemented in pursuit of the tribe's ultimate goals to: 1) Prevent opioid misuse and abuse 2) Identify and treat opioid use disorder 3) reduce morbidity and mortality from opioids."

"Having access to treatment services up to and including OTP (Opiate Treatment Program) and MAT (Medication Assisted Treatment)"

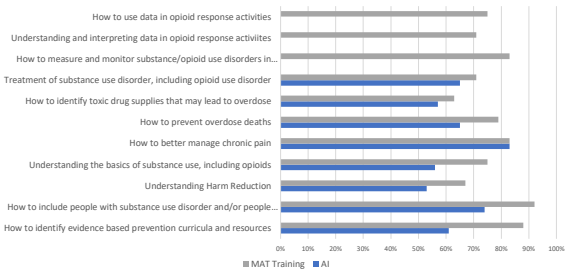
"The whole community receives quality services"

"Community Awareness-Harm reduction Primary Care support -Medical Assistance SUD-BH counseling Community Support - Peer Counselors Overdose prevention – Narcan"

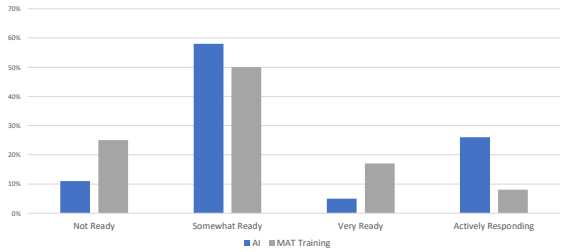
"Prevention! And, perhaps, a Chemical Dependency Professional."

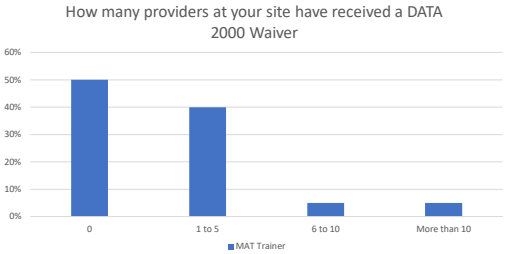
"Treatment of the whole person, mind, body, spirit. Understanding this is a disease, that a person should not be shamed about it but supported to heal."

What support do you need to address opioid and substance use in your community?



Who would you describe your Tribe's readiness for a comprehensive opioid response?





The Right to Health

- Health is a Human Right
- Access to essential medications is a Human Right
- Access to Rights is a Human Right
- People who use drugs are People first, and foremost
- Universal, People-friendly systems are the most equitable ones
- Cost is reality, Price is choice
- No elimination without decriminalization
- *Advocacy is repeating the same truth, over and over again.*

My life has been an on going Struggle. Before Suboxone. I was using drugs to survive, And it Ruined my life, Drugs took my family from me, my home, my license. Ext.. And then I was introduced to Suboxone. And it changed my life! I now can pass drug test And I no longer have to create a high I can live a normal life. Happy and free from addiction. And I am getting my kids back they will be home for good next month. I can now hold down a job. Without Suboxone I would still be lost. I hope this proves to you all how much this program has changed my life.

Harm Reduction Conference - Roundtable

- What are your ideas for policies that can support harm reduction at the national and Tribal levels?
- What are your suggestions for improving ham reduction skills and capacity?
- What are two things you would like to see done to advance harm reduction nationally and in Indian Country?

National Policy Suggestions - Involving our people in policy change

Funding
- Mandatory HCV treatment funding to Tribes
- **Reconciliation – restorative justice**
- Funding for trainings for behavioral health providers
- Mandatory HCV education funding to Tribes
- **Improve resources/policies for telemedicine and mobile services**

Legal
- **Decriminalizing maternal substance use laws**
- **Support sovereignty**
- **Decriminalization**
- National legalization of safe injection facilities

Allocation of existing resources
- **Federal support to buy syringes**
- Use of federal funds to purchase needles
- Change reimbursement policies for medication-assisted treatments (MAT) and remove limits to prescribe them

Indigenizing Programs
- **Programs run by Tribes – not federal government**
- Decolonize funding access – federal government needs to take more chances on programs that don't fit narrow requirements
- **Prioritizing indigenous-driven and culturally focused projects**
- **Tribes make their own policies as sovereign nations**
- End genocide – systems that intersect through colonization, capitalism, criminalization of drug users, destruction of environment

Tribal Policy Suggestions - Nothing about us without us approach

Programming
- **Development and distribution of indigenous-focused harm reduction**
- HIV/HCV education and materials
- **Tribal level data**

Legal
- Fewer requirements to start harm reduction programs
- **Decriminalize use of substance on reservations**
- Decriminalize maternal substance use
- **Syringe exchange could be made easier**
- Change laws for syringe programs

Leadership considerations
- **Getting Tribal leaders engaged in grassroots issues**
- **Mandate harm reduction policies**
- **Move away from abstinence only**
- **Issues are not just opioids**
- **Move away from abstinence**

Suggestions for Skills/Capacities Development - Understand what harm reduction truly is

Clinical education

- Healthcare providers working in native communities need training in harm reduction and substance use treatment
- **Practitioner and all health care workers training in harm reduction**

Collaboration

- **Buy-in from the community**
- **Respect for those with lived experiences**
- Navigating and creatively utilizing funding streams

Systems education

- **Policies and practices to destigmatize substance use**
- Rid of shame-based for people less successful – move away from abstinence only
- **Accept something different – people are living lives with harm reduction**
- **Trauma-informed care**
- **Advocacy, education, culturally sensitive harm reduction**

Things we would like to see changed -

Education

- **Space beyond abstinence conversation** – teaching regarding impacts of colonization and substance use
- Train the trainers by and for indigenous harm reduction champions as well as other folks working in communities
- **More education/knowledge sharing**
- **Education about harm reduction**

Legal

- Reform drug laws with attention to rural realities
- Drug-related banishment must end (perpetuates isolation)
- **Discuss decriminalization**

Stigma change

- **Non-judgmental care and holistic approaches** – acknowledging that folks live full lives while using substances
- Acceptance for harm reduction
- Reduce stigma

Culture

- **An indigenous harm reduction network – to share, support, and organize**
- Bringing ceremony to folks who are excluded due to substance use – low barrier cultural activities
- Developing culturally responsive trainings for all providers

Access

- **Opiate options for our people – suboxone access**
- **Narcan availability and behavioral health services**
- Universal access to buprenorphine and IHS and Tribal run facilities beyond borders
- Connections among physicians working with indigenous communities to network and share
- **24 hour access to drop-in services (safe consumption, safer injection supplies, naloxone, etc.)**
- **Syringe service programs (SSPs) and universal screening everywhere**
- **Connect with existing services to share knowledge and get services to isolated communities**

How are we responding?

"We choose to go to the Moon! We choose to go to the Moon in this decade and do the other things, not because they are easy, but because they are hard; because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one we intend to win, and the others, too."

NPAIHB Opioid Projects

- Tribal Opioid Response (TOR) – SAMHSA
  - Consortium of 22 Tribes (35 Total)
  - *Capacity Building*
- Strategic Planning (CDC)
  - Regional and National Work
  - Comprehensive
- Opioid Overdose Data and Surveillance (CDC)
  - Improve accuracy and access to data on drug and opioid overdoses for Northwest Tribes
- Indian Country Substance Use Disorder ECHO clinic (SAMHSA + OMH)
  - Integrating Medications for Addictions Treatment in Primary Care
  - *Clinical Focus*

NPAIHB Tribal Opioid Response Consortium

The overarching goal of the NPAIHB TOR Consortium is to develop a comprehensive and strategic approach to assist Tribes in developing capacity to address the complex factors associated with a comprehensive opioid response. This includes:

- Developing a framework for a NW Opioid Response strategic plan,
- Increasing awareness of opioid use disorder,
- Preventing opioid use disorder,
- Increasing access to treatment and recovery services and overdose reversal capacity
- Reducing the health consequences of opioid use disorder in tribal communities.

Indian Country Strategy Process

The overarching aim of this project will address *regional* and *national* level strategy planning for addressing opioid overdose by using the SOAR (Strengths, Opportunities, Aspirations and Results) framework. Goals include:

- Increased awareness about regional and national opioid response in AI/AN communities.
- Developed understanding of the strengths and opportunities related to the Opioid Response in Indian Country.
- Increased tribal capacity to deliver Opioid Response services in Indian Country.
- Innovated and disseminated Regional and National Strategy to address Opioid Use in Indian Country.

Opioid Overdose Data and Surveillance

The overarching goal of the project is to improve drug & opioid surveillance among Northwest tribes and improve tribal access to drug/opioid data.

Goals include:

- Create advisory group to assess tribal opioid data needs
- Address AI/AN racial misclassification in state data systems
- Use corrected data to create accurate opioid reports for Northwest AI/AN
- Provide a substance use/opioid epidemiology workshop and other opioid data technical assistance for tribes
- Work with states to improve collection of race, tribal affiliation, and overdose cause of death information
- Explore gaining access to additional opioid/overdose data systems

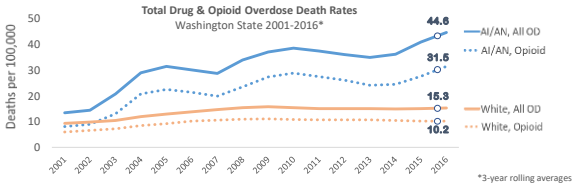
Opioid Overdose Data and Surveillance

Opioid and overdose data challenges:

- Racial misclassification
  - Many AI/AN are not classified as AI/AN in state data systems
    = **underrepresentation** of burden on AI/AN
- Limited access to behavioral health/treatment data
  - Takes time to develop data-sharing agreements
- Difficulty obtaining tribe-level data
  - Can only provide regional data
- Inconsistency in overdose cause of death reporting
  - What drug(s) actually involved?

Among American Indian/Alaska Natives in Washington

- Overdose death rates increased 20% in the last 5 years
- AI/AN had 3 times the death rate of whites in 2014-2016
- 40-54 year olds have the most overdose deaths
- 70% of drug overdoses involved opioids



Indian Country Substance Use Disorder ECHO

The overarching aim of the Indian Country SUD ECHO is to prevent opioid use disorder, increase access to treatment and recovery services and overdose reversal capacity (focusing on MAT services for persons with an opioid use disorder), and reduce the health consequences of opioid use disorder in tribal communities using evidence-based interventions.

- In-person trainings with DATA Waiver
- Telehealth sessions
- Options for telemedicine options

Limited Uptake of Buprenorphine

Only one third of addiction treatment programs offer medications for treatment of OUD[1]

43% of U.S. counties have no waivered buprenorphine prescriber[2]

Many waivered providers don't prescribe

Barriers to adoption include:[3]

Lack of belief in agonist treatment
Lack of time for new patients
Belief that reimbursement rates insufficient

1 Knudsen HK, J Addict Med 2011; 2 Stein BD, Milbank Quarterly 2015; 3 Huhn AS, JSAT 2017

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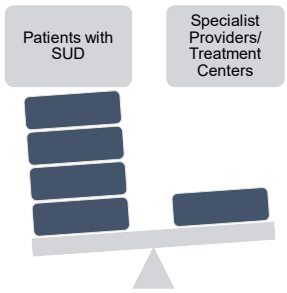
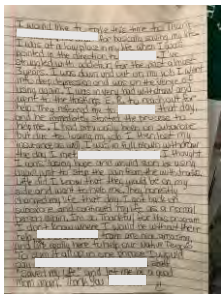




Best Practice – Indian Country ECHO

Project ECHO
Northwest Portland Area Indian Health Board (NPAIHB)
Indian Leadership for Indian Health

Indian Country Opioid Project ECHO Curriculum Design and Learning Objectives

Each teleECHO clinic will offer learners the opportunity to benefit from didactics presented by experts in the field supported by references and will contain at least three main learning objectives. The didactic curriculum will be inter-professional in scope and will provide:

- Current practice guidelines pertaining to opioid use disorders, addiction and MAT management
- Foundations of opioid use disorders to provide a baseline understanding of the topic, and will include epidemiology, diagnosis, and treatment/management approaches
- Topics based on organizational, local and national trends in Indian Country, new findings in peer-reviewed medical literature, as well as participant feedback of interest

DATA 2000 Waiver Training + ECHO Onboarding

Upcoming Trainings:

Grand Ronde, OR – Feb 28th
Pendleton, OR – March 5-6th
Green Bay, WI – May 1-2nd

Possible Trainings:

Tulsa, OK – May 10th or 17th
MT – June?
Rapid City, SD – Fall 2019?

A Practical Application of CHAs and BHAs for SUD Treatment

Sue Steward, CHAP Director
Northwest Portland Area Indian Health Board
Suquamish Casino & Hotel
January 22, 2019

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Goals

- Comparison of Community Health Worker types
- CHAs and BHAs role in SUD treatment

Community Health Worker

- Community health worker are members of a community who are chosen by tribes to provide basic health and medical care to their community capable of providing preventive, promotional and rehabilitation care to these communities. Other names for this type of health care provider include village health worker, community health representative, community health promoter, health coach and lay health advisor.

Statistics

- **Median salary:** $45,360 USD (2017)
- **Median hourly rate:** $21.81 USD (2017)
- **Work experience in related occupation:** None
- **Openings:** 118,500 (2016)

www.bls.gov/oes/current/oes211094

CHR v. CHA

•**Legislative Authority**- CHAP is authorized under 25 USC § 1616 a-d while the CHR Program is authorized under IHCIA PL. 100-713.

•**Funding Sources**- The Alaska CHAP is funded through the hospital and health clinics (H&HC) line item in the IHS budget and CHRs are funded through a specific CHR line item.

•**Scopes of Work**- While the "community health" portion of the names are similar, the scope of work for a Community Health Aide and Community Health Representative are vastly different. CHAs are mid-level primary medical providers who can provide basic medical attention and can connect a patient to clinical care. CHRs provide health promotion, prevention, and outreach to community members.

CHAP Compensation Average

- CHA/T $29,250 to $37,050
- CHA I certified $33,150 to $40,950
- CHA II certified $37,050 to $44,850
- CHA III certified $40,950 to $48,750
- CHA IV certified $44,850 to $52,650
- CHP Certified $48,750 to $68,250

BHA Average Salary Range

- BHA $29,250 to $37,050
- BHA I/II certified $33,150 to $40,950
- BHA III/IV/P certified $37,050 to $48,750

SUD Treatment BHAs Role

- BHA/P's
  - Provide traditional healing/spiritual healing holistic care
  - Provide health education
  - Provide Patient Support and Advocacy
  - Arrange Transportation
  - Make Home Visits

SUD Treatment CHAs Role

- CHA/Ps
  - Provide health education
  - Provide patient support and advocacy
  - Make home visits
  - Provide history, vitals, exam, labs, treatment and care coordination.

CHAs and BHAs Role

CHA/P Role

- Check in
- Vitals
- History
- Labs
- Exam
- Treatment
- Follow up/Care Corodination
- Order medication

BHA/P Role

- Set up VTC
- Observe labs
- Village based counselor
- Patient advocate
- Patient liaison

Sustainability

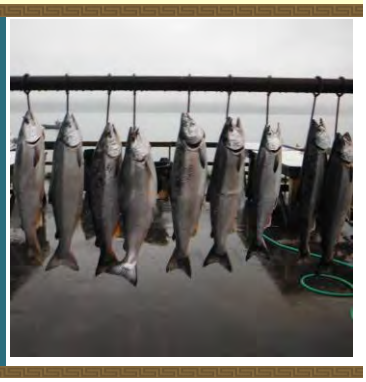
Three critical issues are linked to the sustainability of community health aide programs (CHAP):

- Evaluation
- Financing
- Credentialing/ Certification

Dr. Cooper and Glenn Schiff, Pharm D - Port Graham, AK

Questions?

Thank you and Safe Travels



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Indian Leadership for Indian Health

BHA/P Talking Points for Leaders

What is BHA/P?

- A Behavioral Health Aide/Practitioner (BHA/P) is a culturally informed, community and/or residential based, behavioral services Tribal Health Provider (THP);
- Behavioral Health THP's are educated in traditional healing/spiritual healing as mentored by tribal respected practitioners providing holistic care for their community;
- Care includes behavioral health prevention, intervention, aftercare and postvention services to elders, youth, families and individuals;
- Treatment includes screening, case management, community education, substance abuse assessment and treatment, rehabilitative services, and quality assurance for case reviews;
- Connects mental health and SUD services;
- BHA/P care and services wrap around the patient in unison with the other two disciplines of CHAP THP (DHA/T and CHA/P) to provide holistic care.

How do you become a BHA/P?

- Interested parties need to apply at their local Tribe;
- Must be a high school graduate or have a GED;
- Must pass a 10M TABE test;
- Prior behavioral health experience is helpful.

Education & Career Track:

- Most education is online, in real-time virtual class rooms and independent study environments with occasional face to face sessions that may last one to two weeks;
- Online class can be accessed anywhere that internet connectivity is available;
- Education is delivered in a manner that supports the American Indian/Alaska Native learner in a way that is appropriate for them;
- The BHA/P can be working in the community, providing patient care at their current scope while continuing their education to BHP, BSW or MSW;
- An MOA with a tribal college will help drive that educational and degree seeking path.

Funding:

- Tribes currently receive no re-occurring program funding;
- Current efforts are supported through MTF & ACH grants;
- To achieve sustainability, SPA's will need to include encounter rates for THP's of all disciplines;

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Impact:

- Access to on time, culturally appropriate, gold standard care is increased for beneficiaries;
- When a BHA/P works in a clinic with other Behavioral Health Providers, the attrition rate for all provider's decreases;
- The program includes local elders to inform the BHA about ceremony, traditions and history while supporting them with individual and community activities;
- Local tribal based practices can be woven into the curricula and electronic Behavioral Health Aide Manual (eBHAM) to benefit all Pacific Northwest Tribes;
- The IHS policy needs amended to include tribal and Indian urban health care clinics.

Human Trafficking:
The Pivotal Role of Healthcare

Jeri Moomaw, Executive Director of
Innovations Human Trafficking Collaborative

January 22nd 2019

NPAIHB
Indian Leadership for Indian Health

Approach to Trafficking

- Criminal Justice
- Public health

Public Health Approach to Violence Prevention

Identify the Problem	Risk/Protective Factors	Prevention Strategies	Implementation
Trafficking	What's causing trafficking? What are the risk and protective factors?	How can trafficking be prevented by considering social and economic determinants involved?	How can we implement identified interventions and determine their effectiveness?
Step 1	Step 2	Step 3	Step 4

What do we mean by human trafficking*?*

Human trafficking is a crime involving the exploitation of someone for the purpose of compelled labor or a commercial sex act through the use of force, fraud, or coercion. Where a person younger than 18 is induced to perform a commercial sex act, it is a crime regardless of whether there is any force, fraud, or coercion.

—The Trafficking Victims Protection Act

Trafficking Victims Protection Act of 2000 (TVPA)

ACTION BY MEANS FOR PURPOSE

Victims of Trafficking and Violence Protection Act of 2000 (TVPA), Pub. L. No.106-386, 8 U.S.C. §1101, §7101, 114 STAT 1464 (2000)

Action

- Recruiting
- Harboring (or housing)
- Transporting
- Providing
- Obtaining

In the case of sex trafficking

- Patronizing
- Soliciting
- Advertising

Means

Force—Physical assault, sexual assault, physical confinement, or isolation

Fraud—False promises about work and living conditions, false pretenses for interpersonal relationships, use of fraudulent travel documents, fraudulent employment offers, withholding wages

Coercion—Threats of serious harm or psychological manipulation such as holding someone at gunpoint, threating the life and safety of a person or their family and friends, withholding legal documents, debt bondage

Sex Trafficking of Minors

Minors induced into commercial sex are trafficking victims regardless of whether force, fraud, or coercion have been used.

Purpose

Forced Labor

Commercial Sexual Exploitation

Labor traffickers often make false promises of a high-paying job, exciting education or travel opportunities to lure people into horrendous working conditions. Yet, victims find that the reality of their jobs proves to be far different than promised and must frequently work long hours for little to no pay.

https://polarisproject.org/labor-trafficking

Labor Trafficking

Hidden in Plain Sight

- Domestic labor
- Agriculture
- Landscaping
- Day labor sites
- Panhandling/Begging
- Garment factories
- Meat-packing plants
- Door-to-door sales
- Nail salons
- Massage parlors
- Chain and fast-food restaurants
- Bars
- Fishing Industry

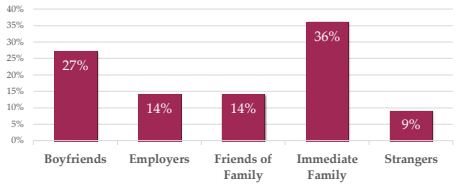
10

Sex and Labor Trafficking **May Co-Occur** Although state and federal law divides human trafficking into the **categories of sex trafficking or labor trafficking, in many cases a survivor has experienced both forms of exploitation**. When working with victims, it is important to ask about potential sex and labor exploitation to identify the full range of services they may need.

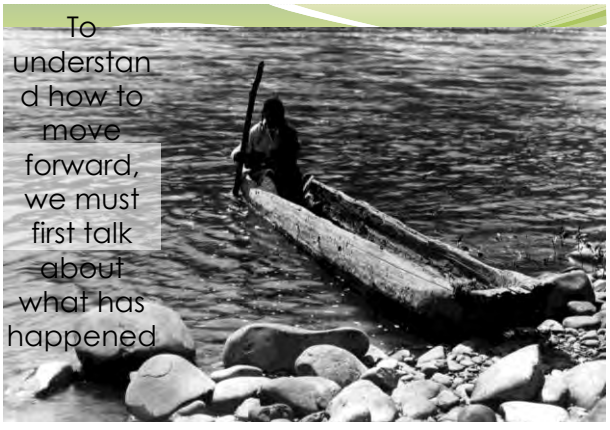
Sex Trafficking—*Hidden in Plain Sight*

- Prostitution
- Pornography
- Strip clubs
- Commercial/Residential Brothels
- Illicit massage parlors
- Escort services
- Truck stops

Relationships Between Trafficker and Trafficked Individual



Covenant House New York and Fordham University's Applied Developmental Psychology Department. Homelessness, survival sex, and human trafficking as experienced by the youth of Covenant House New York. May 2013. https://traffickingresourcecenter.org.



Traditional View of Women and Children

- No words for rape or prostitution
- Violence against women was a capital offense
- Women were viewed as sacred
- Children were seen as a gift from the Creator

American Indian / Alaska Native Statistics

Native American women experience domestic violence at a rate that is 50% higher than the national average.

U.S. Department of Justice Violence Against American Indian and Alaska Natives and the Criminal Justice Response: What is known. 2008:7

Native Americans are the most raped, assaulted, stalked, and murdered of all ethnicities.

U.S. Department of Justice Violence Against American Indian and Alaska Natives and the Criminal Justice Response: What is known. 2008:7

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"Perfect Population"

"If you're a trafficker looking for the perfect population of people to violate, Native [American] women would be a prime target. You have poverty. You have a people who have been traumatized. And you have a legal system that doesn't step in to stop it."

Source: Sarah Deer, attorney & author of "The Beginning and End of Rape: Confronting Sexual Violence in Native America."

17

Historical Trauma

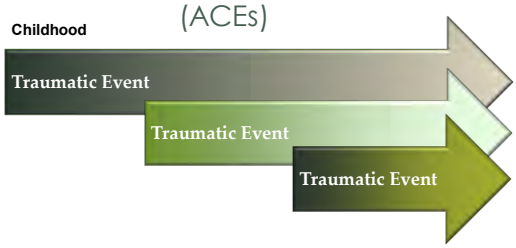
Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants.

Brave Heart, M.Y.H. (2003)

Results of Historical Trauma

- Defense mechanisms
- Developmental malfunctions
- Behavioral issues
- Depression
- Anger
- Isolation
- Violence
- Suicide
- Shame
- Substance use
- Anxiety

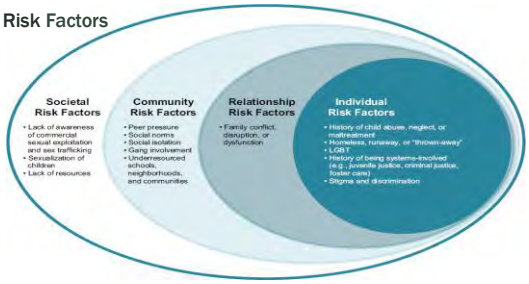
Adverse Childhood Experiences (ACEs)



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-Being Throughout the Lifespan

https://www.cdc.gov/violenceprevention/acestudy/about.html

Risk Factors



Signs of Trauma

Physical	Behavioral	Social/Environmental
• Frequent sexually transmitted infections • Multiple pregnancies/abortions • Dental issues • Bruising and burns • Signs of self-harm • Weight loss or malnourishment • Respiratory issues • Suicide attempts • Physical and sexual abuse	• Confusing or contradicting stories • Inability to focus • Unaware of current date, location, or time • Minimizes abuse • Extreme timidity • Aggressive or defensive • Heightened stress response • Withdrawn or depressed	• Frequent school absences/failing grades • Increase in substance use • Change in dress • Age-inappropriate romantic partner • Change in friends • Repeat runaway • Doesn't share information • Evidence of being controlled • Crowded living conditions • No address

Barriers That Prevent Identification

Patient/Client-Related

Provider-Related

Reasons Why Individuals May Not Self-Identify

- Lack of awareness of victimization
- Lack of understanding of victim and legal rights
- Fear of law enforcement or social services
- Fear that reporting could lead to being returned to an abusive home, jail, or foster care placement
- Distrust of provider or those in authority
- Feels hopeless and helpless
- Feels isolation, shame, or guilt
- Feels complicit in an illegal act
- Fear that traffickers will cause harm to self, family, or loved ones
- Trauma bonding with trafficker or other victims
- Dependence on trafficker for drugs or emotional support

Reasons Why Professionals May Not Identify

- Lacks knowledge about human trafficking
- Inadequate understanding of federal, state, local and tribal human trafficking laws
- Fears violating Health Insurance Portability and Accountability Act (HIPAA rules)
- Lacks trauma-informed care training
- Has preconceived notions of how an individual who has been trafficked will present
- Doesn't believe it is his or her role to get involved
- Mistrust of law enforcement
- Lacks access to neutral, professional interpreters
- "Checks off boxes" without seeing the full patient or client situation
- Thinks that asking will be time consuming or too complex
- Feels the patient/client is unresponsive or hostile to questioning or tells a rehearsed story
- Lacks information on good referral options
- Attributes behavior(s) to harmful cultural stereotypes
- Misidentifies the case

Mandated Reporting

- Human Trafficking
- Child Abuse or Neglect
- Domestic Violence
- Health Insurance Portability and Accountability Act (HIPAA)

When to Report?

During the screening process for any of these crimes, if you are a mandated reporter, you are required to report suspected abuse. Many federal laws have expanded mandatory reporting requirements related to human trafficking.

HHS Screening Tools

Screening tool to identify minors who are being trafficked

Screening tool for adults who may be trafficked

Creating a Safe Environment

Survivor-Centered Screening Techniques

- Create a setting conducive to a victim-centered, trauma-informed screening.
- Get informed consent prior to the screening.
- Inform the individual of the purpose of the screening and the screening process.
- Discuss confidentiality and mandatory reporting.

Trauma-Informed Screening

- Avoids asking a person who is potentially being trafficked to share detailed history of exploitation
- In-depth questioning may lead patients to become unresponsive, defensive, and distrusting
- Only solicit information needed to effectively treat and refer patients to services

What Do We Mean by "Trauma"?

"Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being."

Substance Abuse and Mental Health Services Administration
https://www.samhsa.gov/trauma-violence

Trauma-Informed Services

- Incorporate knowledge about trauma in all aspects of service delivery
- Minimize traumatization or re-traumatization
- Facilitate healing, connection, and empowerment

Trauma Informed Care

Honoring Culture and Tradition

- Modeling of traditional behavior
- Offering sage, sweet grass, or something to drink in a warm, caring environment
- Traditional healing, sacred medicines, ceremonies
- Welcome home ceremonies
- Wiping Away the Tears (Lakota)
- Naming ceremony
- Making relatives
- Connect to Elders

Building a Response to Trafficking in Native Communities

Collaborating Across the Public Health Sectors

Engaging Survivor Leaders

"A survivor-informed practice acknowledges the unique perspectives of survivors with relevant expertise based on knowledge of their trafficking experiences and challenges they have faced in their efforts to regain and rebuild their lives. A survivor-informed practice includes meaningful input from a diverse community of survivors at all stages of a program or project, including development, implementation, and evaluation."

Human Trafficking Leadership Academy, 2017

Promising Practices

Involving Elders/Leaders

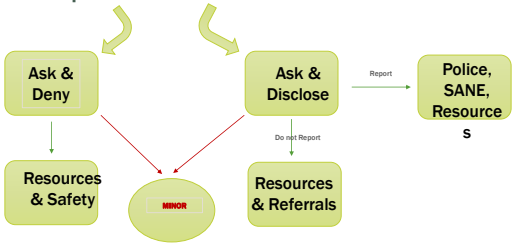
Protocol Components

Protocol development for human trafficking should include these elements:

1. Staff Training
2. Screening and Identification
3. Multidisciplinary Response
4. Mandated Reporting
5. Follow-up/Follow-through Procedures

HealTrafficking and Hope for Justice's Protocol Toolkit

Suspicion or Disclosure: Now what?



Prevention

1. Engage schools
   - Educate youth about healthy relationships
   - Strengthen cultural identity through traditional dance clubs, drum groups and craft classes
2. Address poverty
   - Establish programs that provide employment opportunities, especially for youth and women
   - Work toward economic equality
   - Provide access to higher education
3. Prevent and reduce ACEs
   - ACEs includes abuse, neglect, and household dysfunction; reducing the number of ACEs will reduce negative health outcomes, including trafficking
4. Awareness
   - Hold talking circles and support groups to raise awareness and provide safety and support

National Human Trafficking Hotline

NATIONAL HUMAN TRAFFICKING HOTLINE

1-888-373-7888

- Comprehensive service referrals for potential victims of human trafficking
- Tip reporting to trained law enforcement
- Data and trends on human trafficking in the United States
- **Text HELP to 233733 (BEFREE)** to get help for potential victims of human trafficking or to connect with local services.

https://www.watraffickinghelp.org/

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STRONGHEARTS
Native Helpline
1-844-7NATIVE | strongheartshelpline.org

Monday through Friday, from 9 a.m. to 5:30 p.m. CST.

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CONTACT US

www.innovationshtc.com

info@innovationshtc.org

360-705-8575

Shortage Designation Modernization Project: Auto-HPSAs

Dr. Janelle McCutchen (Anderson)
Chief, Shortage Designation Branch (SDB)
Division of Policy and Shortage Designation (DPSD)
Bureau of Health Workforce (BHW)
Health Resources and Services Administration (HRSA)

Health Resources and Services Administration (HRSA)

- Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically challenged
- HRSA does this through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities
- Every year, HRSA programs serve tens of millions of people, including people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

Shortage Designations* Help Target Resources**

Shortage Designation Option	National Health Service Corps (NHSC)	NURSE Corps	Health Center Program	IHS Loan Repayment Program	CMS HPSA Bonus Payment Program	CMS Rural Health Clinic Program	J-1 Visa Waiver
Primary Care							
Geographic HPSA	X	X		X	X	X	X
Population HPSA	X	X		X		X	X
Facility HPSA	X	X		X			X
Dental Care							
Geographic HPSA	X			X			
Population HPSA	X			X			
Facility HPSA	X			X			
Mental Health							
Geographic HPSA	X	X		X	X		X
Population HPSA	X	X		X			X
Facility HPSA	X	X		X			X
Medically Underserved Area (MUA)			X			X	X
Medically Underserved Population (MUP)			X				X
Exceptional MUP			X				X
State Governor's Certified Shortage Area						X	

*42 USC §254e(d)(1): "The Secretary shall determine health professional shortage areas in the States, publish a descriptive list of the areas, population groups, medical facilities, and other public facilities so designated, and at least annually review and, as necessary, revise such designations."

**List of programs is not exhaustive.

HRSA Health Workforce

The National Health Service Corps (NHSC)

THE NATIONAL HEALTH SERVICE CORPS (NHSC) builds healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care.

The NHSC is part of HRSA's Bureau of Health Workforce (BHW).

BHW improves the health of underserved populations by strengthening the health workforce and connecting skilled professionals to communities in need.

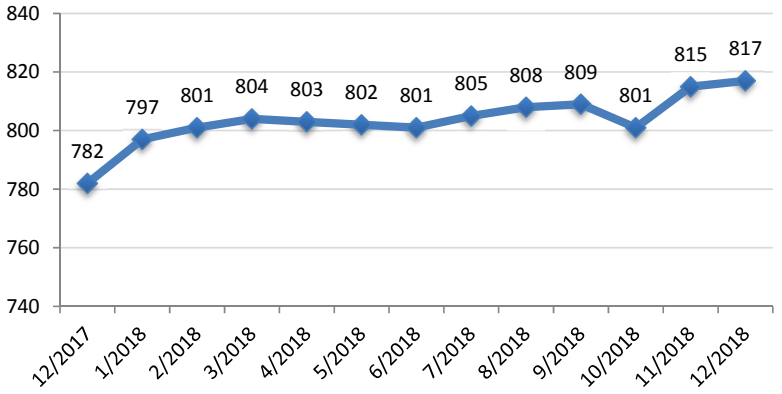
28% of **BHW** funding supports the **NHSC** and other programs that improve the distribution of health professionals to underserved areas.

Indian Health Programs[1]	Total Clinicians[2]	Sites Approved[3]	Total Sites[4]	HWC Opportunities[5]
December 2018	**564**	**4**	**817**	**362**

Field Strength

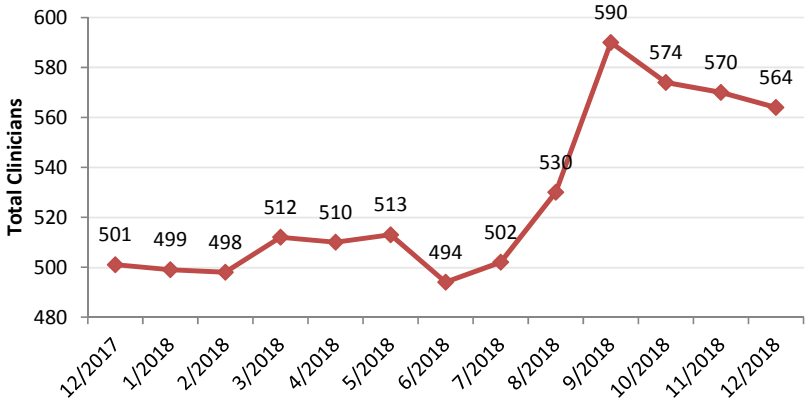
	Program			
Discipline	**NHSC LRP**	**NHSC SP**	**S2S LRP**	**Total**
Physician (MD/DO)	60	11	12	83
Psychiatry (MD/DO)	2	1	*0*	3
Certified Nurse Midwife	20	2	*0*	22
Dentist	89	15	7	111
Health Service Psychologist	21	*0*	*0*	21
Licensed Clinical Social Worker	38	*0*	*0*	38
Licensed Professional Counselor	79	*0*	*0*	79
Marriage and Family Therapist	17	*0*	*0*	17
Nurse Practitioner	107	5	*0*	112
Psychiatry (NP)	6	*0*	*0*	6
Physician Assistant	43	4	*0*	47
Psychiatry (PA)	2	*0*	*0*	2
Registered Dental Hygienist	23	*0*	*0*	23
Total	**507**	**38**	**19**	**564**

Active IHP Sites



Site Sub-Types	**Total**
Tribal/638 Health Facility	469
Dual Funded	169
Federal Indian Health Service	136
Urban Indian Health Program	43
Total	**817**

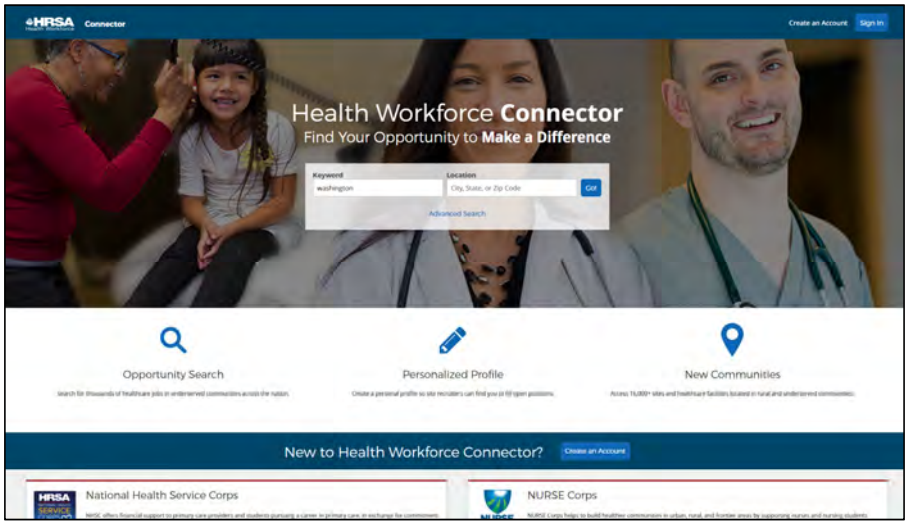
Clinicians at IHP Sites



Footnotes

[1] Represents Federal IHS Clinics, Tribally-run Health Clinics, Urban Indian Health Clinics, and Dual-funded Tribal Health Clinics.
[2] This reflects clinicians in service as of end of the month; the total will vary month to month, based on obligation end dates and new contracts. Final totals are reported at the end of the FY.
[3] Represents total number of sites approved or reactivated as IHP sites in the month of report.
[4] Represents cumulative number of Indian Health sites approved as NHSC service sites.
[5] HWC Opportunities as of the end of the month; positions not filled within 90 days are automatically removed, unless extended.

ITU approved sites in Idaho, Oregon and Washington as of 01/23/2019



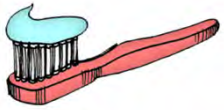
- Total of 83 approved NHSC sites
- Total of 61 NHSC participants at 33 of these sites
- Health Workforce Connector (43 of 83 sites have profiles)
  - Idaho: 6 sites, 1 opportunity
  - Oregon 15 sites, 2 opportunities
  - Washington: 22 sites, 3 opportunities

Types of HPSAs

A shortage of:

Primary Care

Mental Health



Dental Health

providers in a:

Geographic Area

Population Group

Facility

Ratio of Population to Providers

Which Providers Count?

Primary Care

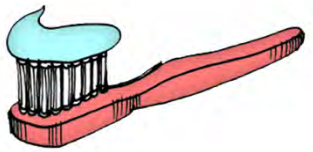
Includes Doctors of Medicine (MD) and Doctors of Osteopathy (DO) who provide services in the following specialties:

- Family Practice
- Internal Medicine
- Obstetrics and Gynecology
- Pediatrics

Mental Health

Includes:

- Psychiatrists, and may include other Core Mental Health (CMH) providers, such as:
- Clinical Psychologists
- Clinical Social Workers
- Psychiatric Nurse Specialists
- Marriage & Family Therapists



Dental Health

Includes:

- Dentists, and takes into account
- Dental Auxiliaries

Dental auxiliaries are defined as any non-dentist staff employed by the dentist to assist in the operation of the practice.

Note: Providers solely engaged in administration, research or training are excluded.

Automatically Designated Facility HPSAs

Using the statute and regulations, HRSA has deemed the following facility types as eligible for automatic HPSA designation:

- **Tribally-Run Clinics**
- **Urban Indian Organizations**
- **Dual-Funded Tribal Health Centers**
- **Federally-Run Indian Health Service Clinics**
- **Health Centers (funded under Sec. 330)**
- **Health Center Look-Alikes**
- **CMS-Certified Rural Health Clinics meeting NHSC site requirements**

Auto-HPSAs compared to other HPSAs

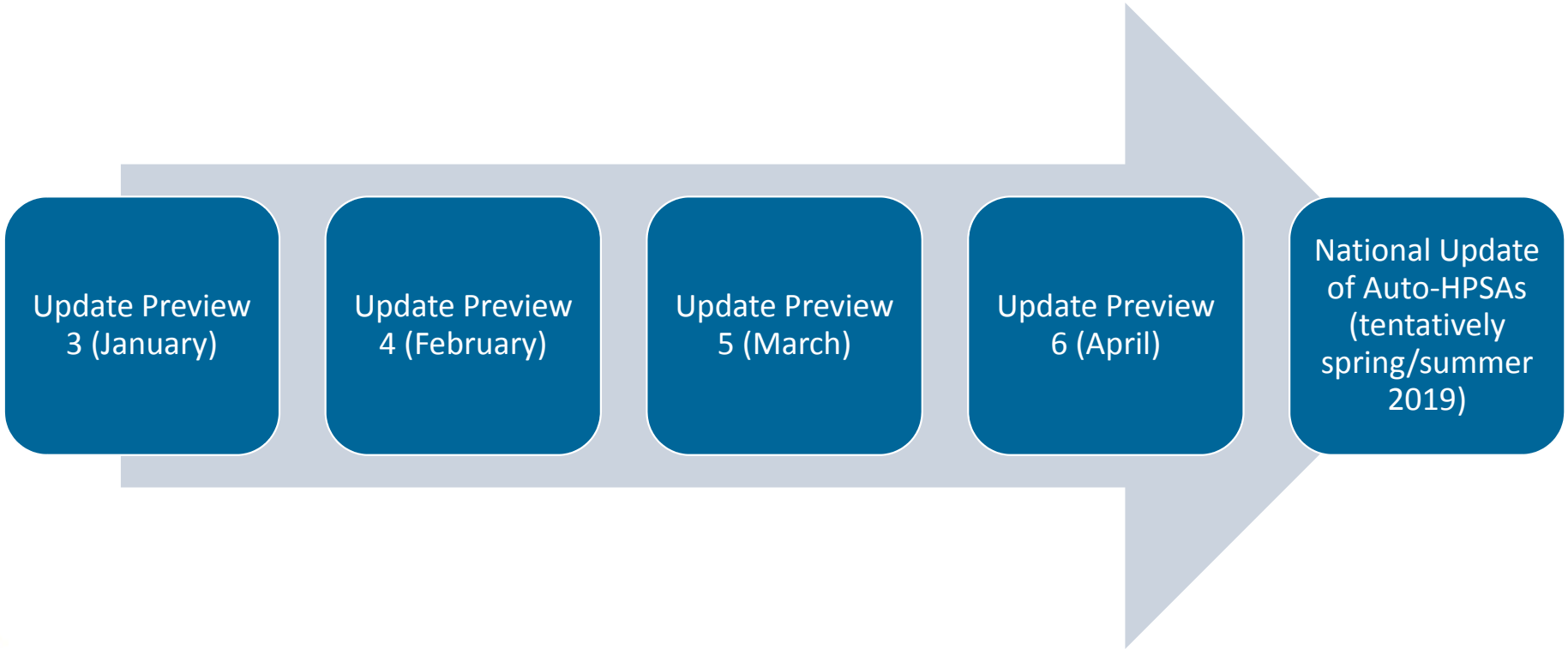
Similar but not the same

Other HPSAs	Automatic Facility (Auto-HPSAs)
• Designation & scoring done online • Criteria used to first designate as HPSA • Criteria used to determine HPSA score • Scores range from 0-25 (26 for dental) • Designations are required to be reviewed and updated as necessary annually • Score of “0” is rare	• Designation & scoring currently done ***manually*** • ***No application*** process necessary • Same criteria used to determine HPSA score as other HPSAs • Same scoring range used • HRSA has not historically required Auto-HPSA scores to be reviewed regularly; updates are requested by facility • Score of “0” ***more frequent*** and means low shortage or no data was available for scoring

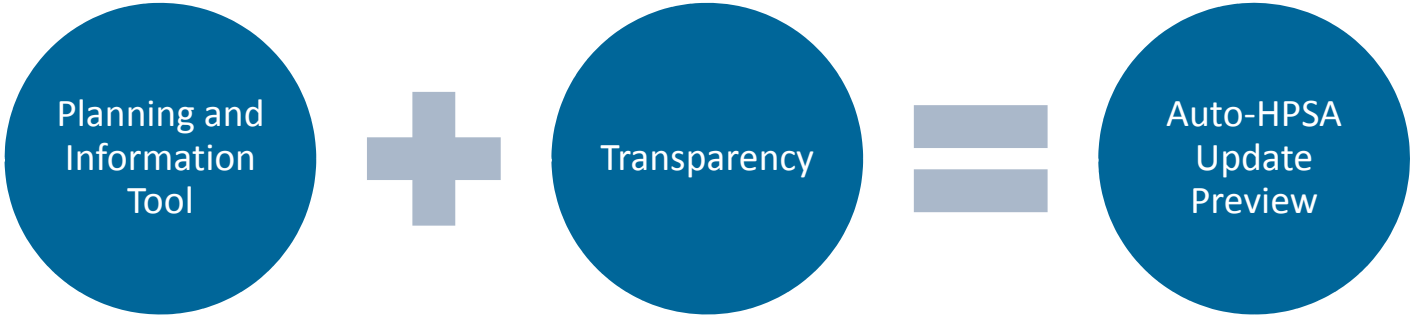
Shortage Designation Modernization Project

The Shortage Designation Modernization Project utilizes the existing HPSA scoring criteria. No changes to the criteria have been made.

National Update of Auto-HPSAs (tentative timeline)



Purpose of Auto-HPSA Update Previews



- Scores are subject to change; PCO provider data changes will likely result in score changes.
- Update preview scores are for information only. They are not published in the HRSA Data Warehouse.
- Update preview scores will not be used for NHSC LRP 2019 application cycle.
- No scores will change until the national update is implemented. *(Update is tentatively planned for spring/summer 2019. No earlier than April 2019.)*

HPSA Scoring Criteria

HPSA scores are based on a variety of criteria and range from 0 to 25 in the case of Primary Care and Mental Health, and 0 to 26 in the case of Dental Health.

Primary Care
0-25

Population-to-Provider Ratio Point Value *Double Weighted* + % of Population at 100% Federal Poverty Level Point Value + Infant Health Index Point Value (Based on IMR or LBW Rate) + Travel Time to Nearest Source of Care Point Values = HPSA Score (out of 25)

Mental Health
0-25

Population-to-Provider Ratio Point Value + % of Population at 100% Federal Poverty Level Point Value + Alcohol Abuse Prevalence Point Value + Substance Abuse Prevalence Point Value

+ Elderly Ratio Point Value + Youth Ratio Point Value + Travel Time to Nearest Source of Care Point Values = HPSA Score (out of 25)

Dental Health
0-26

Population-to-Provider Ratio Point Value *Double Weighted* + % of Population at 100% Federal Poverty Level Point Value *Double Weighted* + Water Fluoridation Status Point Value + Travel Time to Nearest Source of Care Point Values = HPSA Score (out of 26)

Population: Provider Ratio	Primary Care			Dental Health			Mental Health
HPSA Scoring Criteria	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
Population: Provider Ratio	5	x 2	**= 10**	5	x 2	**= 10**	**7**

Community Health Centers*

SERVICE AREA

- Defined by zip codes in which ***75% of a Auto-HPSA facility's patients reside*** to create a Zip Code Tabulation Area (ZCTA)-based service area. (*Source: UDS*)

DEFINITION

- Population defined ***as low income population at or below 200% FPL*** in the service area. (Source: *Census*)
- Providers defined as the count of eligible ***FTEs that serve Medicaid patients AND/OR provide services on a sliding fee scale*** in the service area. (Source: *SDMS*)

Rural Health Clinics**

SERVICE AREA

- Defined by census tracts intersecting with a ***30 or 40 minute travel polygon*** to create service area. (*Source: SDMS*)

DEFINITION

- Population defined ***as low income population at or below 200% FPL*** in the service area. (Source: *Census*)
- Providers defined as the count of eligible ***FTEs that serve Medicaid patients AND/OR provide services on a sliding fee scale*** in the service area. (Source: *SDMS*)

I/T/Us**

SERVICE AREA

- Defined by census tracts intersecting with a ***30 or 40 minute travel polygon*** to create service area. (*Source: SDMS*)

DEFINITION

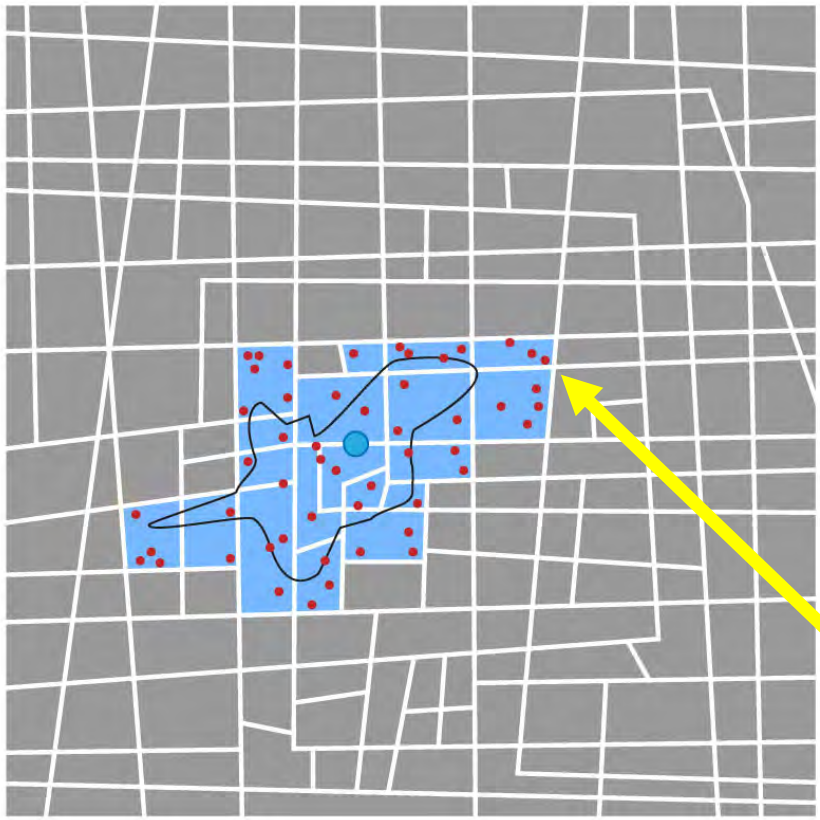
- Population defined as ***total population of American Indian and Alaska Native alone or in combination with one or more races (when available)*** in the service area. (Source: *Census*)
- Providers defined as the count of eligible ***FTEs that serve the American Indian and Alaska Native*** populations within the service area. (Source: *SDMS*)

***Scoring will be at the organizational level.**

***Following the National Update, RHCs and ITUs may provide facility-level data to be rescored.*

HRSA Health Workforce

Determining the Default Service Area



1. Site is geocoded
2. 30 or 40 min travel polygon is drawn around the site
3. Census tracts (CT) that overlap the travel polygon are identified and saved as the service area
4. All usable providers located in the CT service area are identified

NOTE: A provider used in the population to provider ratio can be more than 30 or 40 minutes away from the site.

*Default Service Area is used for RHCs, ITUs and FQHCs/LALs that have not reported UDS data.

Providers Used for Population to Provider Ratios

	A	B	C	D	E	F
1	**Auto-HPSA Update Preview 1: Providers Used for Population to Provider Ratio**					
2						
3	**Organization ID**	XXXX				
4	**Organization Name**	Auto-HPSA Name				
5						
6						
7						
8	**PC Designation ID**	**12XXXX**				
9	**Discipline**	**NPI**	**Last Name**	**First Name**		
10	PC	100XXXXXX	Golf	Alfa		
11	PC	200XXXXXX	Hotel	Bravo		
12						
13						
14	**MH Designation ID**	**34XXXX**				
15	**Discipline**	**NPI**	**Last Name**	**First Name**		
16	MH	300XXXXXX	India	Charlie		
17						
18						
19	**DT Designation ID**	**56XXXX**				
20	**Discipline**	**NPI**	**Last Name**	**First Name**		
21	DT	400XXXXXX	Juliett	Delta		
22	DT	500XXXXXX	Kilo	Echo		
23						
24						
25						

- Service Area Approach
  - Includes all eligible providers in your organization's service area
  - **Not just your organization**
  - If service area crosses state lines, providers may be from another state
  - A provider can be more than 30 or 40 minutes away from the site.
- If no eligible providers were identified, the Excel file will be blank

% of Population Below FPL

HPSA Scoring Criteria	Primary Care			Dental Health			Mental Health
	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
% of Population below FPL	5	x 1	**= 5**	5	x 2	**= 10**	**5**

Community Health Centers

SERVICE AREA

- Not used

DEFINITION

- The ***percent of population of patients served with known income*** at or below 100% FPL (*Source: UDS*)

Rural Health Clinics*

SERVICE AREA

- Defined by census tracts intersecting with a 30 or 40 minute travel polygon to create service area. (*Source: SDMS*)

DEFINITION

- Out of the ***population in the service area***, the count of individuals at or below 100% FPL ***divided by the total population for whom poverty is determined***. (*Source: Census*)

I/T/Us*

SERVICE AREA

- Defined by census tracts intersecting with a 30 or 40 minute travel polygon to create service area. (*Source: SDMS*)

DEFINITION

- Out of the ***population in the service area***, the count of individuals at or below 100% FPL ***divided by the total population for whom poverty is determined***. (*Source: Census*)

**Following the National Update, RHCs and ITUs may provide facility-level data to be rescored.*

Travel Distance/Time to Nearest Source of Care (NSC)	Primary Care			Dental Health			Mental Health
HPSA Scoring Criteria	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
Travel distance/time to nearest source of care (NSC)	5	x 1	**= 5**	5	x 1	**= 5**	**5**

Community Health Centers

DEFINITION

- The nearest ***provider that serves Medicaid patients AND provides services on a sliding fee scale*** who is not in an over utilized* area. *(Source: SDMS)*

Rural Health Clinics

DEFINITION

- The nearest ***provider that serves Medicaid patients AND provides services on a sliding fee scale*** who is not in an over utilized* area. *(Source: SDMS)*

I/T/Us

DEFINITION

- The nearest ***provider that serves American Indian/Alaska Native*** populations who is not in an over utilized* area. *(Source: SDMS)*

*To determine overutilization: a 30-40 minute travel polygon will be drawn around each provider based on private transportation to create an area from which the population and provider data will be pulled. (Source: *SDMS)*

A provider will be considered over-utilized if the population to provider ratio is greater than:

- **Primary Care:** 2,000:1
- **Dental Health:** 3,000:1
- **Mental Health**
  - Providers will be considered over-utilized if the population-to-provider ratio for psychiatrists ≥ 10,000:1 and the population-to-provider ratio for Core Mental Health providers is ≥ 3,000:1;
  - If there is no data on Core Mental Health providers other than psychiatrists or the Core Mental Health other than psychiatrists FTE = 0, providers will be considered over utilized if the population-to-provider ratio for psychiatrists is ≥ 20,000:1.x

Note: Following the national update, State Primary Care Offices will be able to change NSCs

Infant Mortality Rate or Low Birth Rate

HPSA Scoring Criteria	Primary Care			Dental Health			Mental Health
	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
Infant Mortality Rate *or* ***Low Birth Weight***	5	x 1	**= 5**				

Community Health Centers

DEFINITION

- **IMR:** Out of the total population, the count of infant deaths divided by the total number of infant births for the county/counties in which the Auto-HPSA 's service area intersects. Scaled by 1,000. *(Source: CDC)*
- **LBW:** Out of the total population, the count of low birth weight births divided by the total number of infant births for the county/counties in which the Auto-HPSA's service area intersects. Scaled by 100. *(Source: CDC)*

Rural Health Clinics

DEFINITION

- **IMR:** Out of the total population, the count of infant deaths divided by the total number of infant births for the county/counties in which the Auto-HPSA 's service area intersects. Scaled by 1,000. *(Source: CDC)*
- **LBW:** Out of the total population, the count of low birth weight births divided by the total number of infant births for the county/counties in which the Auto-HPSA's service area intersects. Scaled by 100. *(Source: CDC)*

I/T/Us

DEFINITION

- **IMR:** Out of the total population, the count of infant deaths divided by the total number of infant births for the county/counties in which the Auto-HPSA 's service area intersects. Scaled by 1,000. *(Source: CDC)*
- **LBW:** Out of the total population, the count of low birth weight births divided by the total number of infant births for the county/counties in which the Auto-HPSA's service area intersects. Scaled by 100. *(Source: CDC)*

Water Fluoridation

HPSA Scoring Criteria	Primary Care			Dental Health			Mental Health
	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
Water Fluoridation				1	x 1	**= 1**	

Community Health Centers

DEFINITION

- Score default to "0".

Rural Health Clinics

DEFINITION

- Score default to "0".

I/T/Us

DEFINITION

- Score default to "0".

Following the National Update tentatively scheduled for spring/summer 2019, all Auto-HPSA facilities may provide supplemental information for a point to be awarded, where warranted.

To receive a score of 1, must provide data showing that less than 50% of the population has access to fluoridated water

Ratio of Children & Ratio of Adults	Primary Care			Dental Health			Mental Health
HPSA Scoring Criteria	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
Ratio of children under 18 to adults 18-64							**3**
Ratio of adults 65 and older to adults 18-64							**3**

Community Health Centers

DEFINITION

- Out of the total unduplicated patient population, the count of individuals younger than 18, or 65 and older, divided by the count of adults age 18-64. *(Source: UDS)*

Rural Health Clinics*

DEFINITION

- The count of individuals younger than 18, or 65 and older, divided by the count of adults age 18-64. *(Source: Census)*

I/T/Us*

DEFINITION

- The count of individuals younger than 18, or 65 and older, divided by the count of adults age 18-64. *(Source: Census)*

**Following the National Update, RHCs and ITUs may provide facility-level data.*

Substance Misuse & Alcohol Misuse Rates	Primary Care			Dental Health			Mental Health
HPSA Scoring Criteria	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
Substance misuse rate							**1**
Alcohol misuse rate							**1**

Community Health Centers

DEFINITION

- Score default to “0”.

Rural Health Clinics

DEFINITION

- Score default to “0”.

I/T/Us

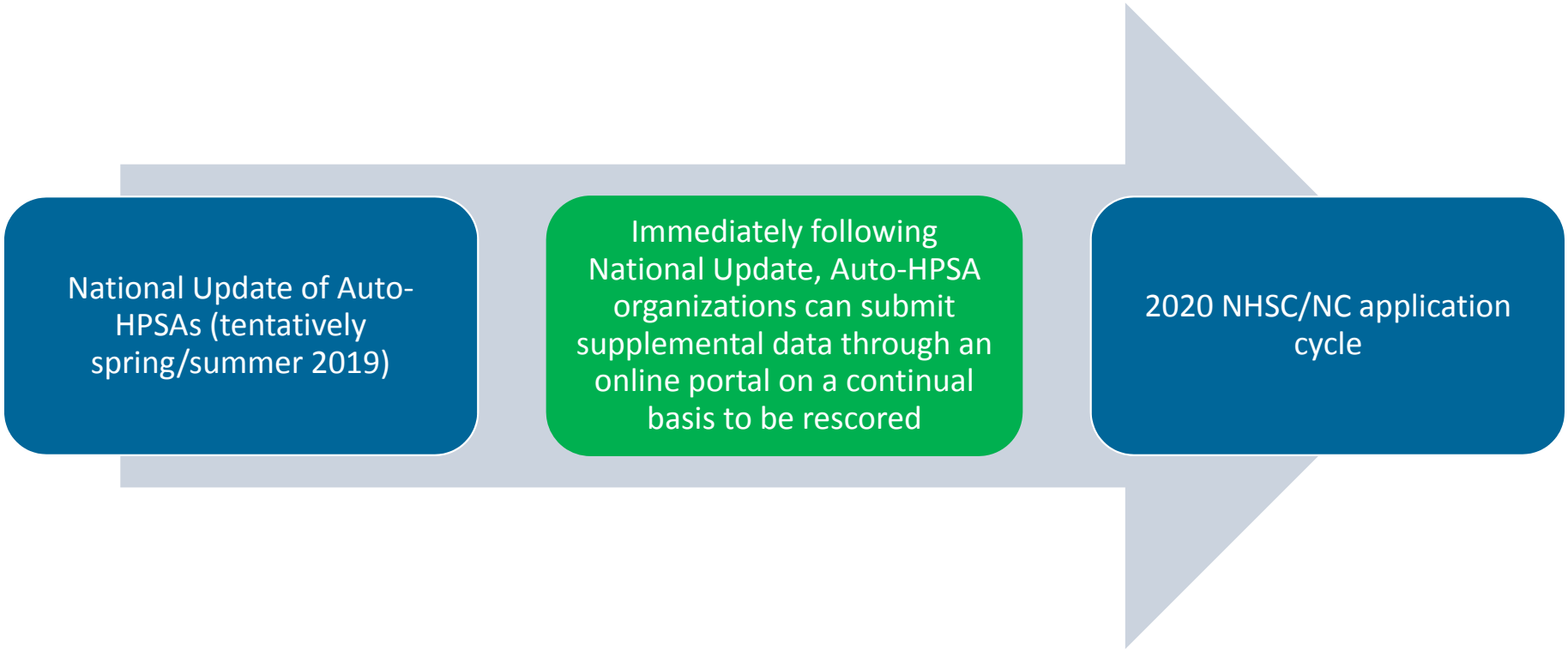
DEFINITION

- Score default to “0”.

Following the National Update tentatively scheduled for spring/summer 2019, all Auto-HPSA facilities may provide supplemental information for a point to be awarded, where warranted.

To receive a score of 1, must provide data showing that the alcohol misuse rate is in the worst quartile for the nation, region or state
To receive a score of 1, must provide data showing that the substance misuse rate is in the worst quartile for the nation, region or state

Following National Update of Auto-HPSAs



Supplemental Data: Following the National Update

ITUs

- **Zip codes in which 75% of the Auto-HPSA facility's patients reside**
- **The percent of population of patients served with known income at or below 100% FPL**
- **Out of the total unduplicated patient population, the count of individuals younger than 18, or 65 and older, divided by the count of adults age 18-64**
- Water Fluoridation
- Alcohol Misuse Rate
- Substance Misuse Rate

PCOs

- **Nearest Source of Care**
- Water Fluoridation
- Alcohol Misuse Rate
- Substance Misuse Rate

Facility-specific Data

- Reporting period: calendar year
  - January 1, 2017-December 31, 2017
  - January 1, 2018-December 31, 2018 (Preferable)
- The fluoridation, alcohol misuse and substance misuse data do not need to mirror the HRSA-created service area.
  - However, the information submitted should reflect the service area (i.e., be based on the organization's address and sites) and represent a minimum 12 month reporting period.

What You Can Do Now

- Focus on supplemental data collection
  - Particularly zip codes in which patients reside
  - The percent of population of patients served with known income at or below 100% FPL
- Connect with your State Primary Care Office
- Continue to review Auto-HPSA Update Previews upon receipt
- Make sure contact information is correct in the EHBs or BHW Portal/BMISS system
- Participate in upcoming technical assistance webinars to learn more about HPSA scoring and the supplemental data submission

To Whom to Direct Questions

- Project itself (purpose, timeline, etc.): SDMP@HRSA.gov
- Data shown on Update Preview Report: State PCO
- Provider data: State PCO
- Update preview scores: State PCO
- Supplemental data: State PCO
- Score or rescore* before the national update: SDB@HRSA.gov

*Tentative last day SDB will receive requests: April 1, 2019.

Connect with HRSA

To learn more about our agency, visit

www.HRSA.gov

Sign up for the HRSA *eNews*

FOLLOW US:

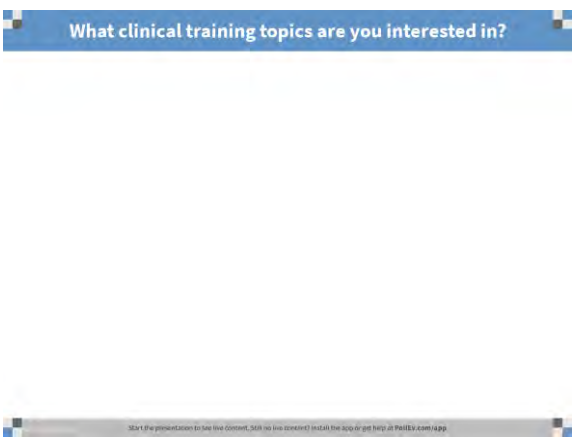
Clinical Training

Eric Vinson
ECHO Project
January 23, 2019
NPAIHB QBM

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Clinical Training and capacity building

- Are there any specific workforce shortages/capacity building that you/your tribes would like to see?



Types of trainings

- In-person or online
  - Lecture (didactic) w/o Q&A
    - Seminar, Conference, workshop
  - Group discussions
  - Case Presentations
  - Skills building (hands on)
  - One on one mentoring

CE Professions

- See a profession missing from what we currently offer? Let us know! What other types of CE would you like to see offered by NPAIHB?

Continuing Education professions

- Medical (CME): Accreditation Council for Continuing Medical Education
- Nursing (CNE): Accreditation Commission for Education in Nursing
- Social Work: Association of Social Work Boards
- Chemical Dependency: NAADAC, the Association for Addiction Professionals
- Health Education: National Commission for Health Education Credentialing
- Others: Depending on specialty (ex. Child Safety Seat)

TRAININGS OFFERED BY NPAIHB

Training Title: Health Data Literacy and Applications for Tribal Health

- **Topic:** Epidemiology 101, Sources of AI/AN Health Data, Introduction to GIS Mapping, Data Visualization, Finding and Using Data for Strategic Planning/Policy Development
- **Format:** Lecture w/ Q&A, Hands On Skill Building
- **Frequency:** At least once a year
- **Audience:** Tribal health staff (clinical and non-clinical), planners, grant writers, anyone who needs an introduction/refresher course for tribal epidemiology
- **Accreditation:** none
- **Funding:** CDC
- **Upcoming Dates:** TBD
- **Contact:** Sujata Joshi, MSPH sjoshi@npaihb.org

Training Title: EHR/RPMS

- **Topics:** Basic CAC, Advanced CAC, Advanced TIU, Reminders, Integrated Behavioral Health, Data Management, Advanced Reminders
- **Format:** Didactic lectures, hands-on, Q&A
  - Most courses available in computer training room at NPAIHB, also available remotely (log in from your home site).
- **Frequency:** Typically one class per month
  - (monitor https://www.ihs.gov/rpms/training/ and http://www.npaihb.org/events/ for schedule)
- **Audience:** CACs (Informaticists)
- **Accreditation:** N/A
- **Funding:** IHS
- **Upcoming Dates:** February for Basic CAC
- **Contact:** Katie Johnson, Pharm D kjohnson@npaihb.org

Training Title: Recorded EHR/RPMS Trainings

- RPMS Recordings Repository

- Including iCare, Behavioral Health, Radiology, Pharmacy, Lab, CAC, etc
- Nearly every RPMS package is covered

Training Title: Recorded EHR/RPMS Trainings

- NPAIHB YouTube Channel
  - Playlist of recordings aimed at providers new to using RPMS EHR
  - https://www.youtube.com/watch?v=v6ZecSIm2nY&list=PLzTTmEbo5e5FHNrDsqZM6JJ_5qz08-sNk
- IHS Recorded Training Repository
  - Large variety of topics on RPMS
  - Requires registration, but ANYONE can register https://ihscqpub.cosocloud.com/content/connect/c1/7/en/events/event/shared/1812032102/event_landing.html?sco-id=1812096787&_charset_=utf-8

Training Title: Diabetes ECHO series

- **Topic:** Diabetes
- **Format:** In-person and subsequent 1 hour virtual telehealth sessions include didactics, case presentations, and treatment recommendations for patients
- **Frequency:** Monthly
- **Audience:** All staff who work with patients with diabetes
- **Accreditation:** CME
- **Funding:** CDC
- **Upcoming Dates:** April – Sept 2019
- **Contact:** Kerri Lopez klopez@npaihb.org

Training Title: Western Tribal Diabetes Project DMS training

- **Topic:** Diabetes Management System – RPMS
- **Format:** Hands On training – Presentations
- **Frequency:** Quarterly
- **Audience:** CAC-RN-MA-Diabetes Coordinators-Data entry –PharmD
- **Accreditation:** N/A
- **Funding:** IHS
- **Upcoming Dates:** March 5-7, June 4-6, September 24-26, December 3-5, 2019
- **Contact:** Don Head, Erik Kakuska wtdp@npaihb.org

Training Title: Western Tribal Diabetes SDPI NW Gathering

- **Topic:** SDPI best practices, clinical component (MI, Tobacco Cessation, Childhood Obesity, Historical Trauma, Data) Round table topics: Traditional food, Physical Activity, Nutrition, Youth programs, healthy cooking, diabetes prevention and a SDPI poster board session
- **Format:** Lecture, hands on, interactive
- **Frequency:** Yearly
- **Audience:** CAC-RN-MA-Diabetes Coordinators-Data entry –PharmD
- **Accreditation:** CNE, RD
- **Funding:** IHS
- **Upcoming Dates:** May 2-3rd, 2019
- **Contact:** Don Head, Erik Kakuska wtdp@npaihb.org

Training Title: Western Tribal Diabetes NF gathering

- **Topic:** SDPI best data, clinical component (MI, Tobacco Cessation, Sugar sweeten beverage, Historical Trauma, AI/AN youth programs) Session topics: Physical Activity sessions: Chair Aerobics, native youth games, elders workouts, running/walking, strength/conditioning, boot camp, powwow yoga. A session on traditional food and healthy cooking.
- **Format:** hands on, interactive didactic lecture,
- **Frequency:** Yearly
- **Audience:** Diabetes Coordinators, Fitness Instructors, Nurses, Dietitians, MD's, PA's, MA's, CHR's, THD, and tribal leaders
- **Accreditation:** N/A
- **Funding:** IHS
- **Upcoming Dates:** June-August TBD, 2019
- **Contact:** WTDP staff wtdp@npaihb.org

Training Title: NW Tribal Tobacco Prevention Conference

- **Topic:** Tobacco Prevention
- **Format:** Didactic Lecture
- **Frequency:** Yearly
- **Audience:** MD/DO/NP/PA, RN, PharmD, MA, Health Ed, Admin
- **Accreditation:** N/A
- **Funding:** CDC
- **Upcoming Dates:** N/A
- **Contact:** Ryan Sealy rsealy@npaihb.org

Training Title: Prescribing NRT (Nicotine Replacement Therapy) 101 and treating commercial tobacco addiction as a chronic disease – Cervical Cancer Webinar

- **Topic:** Tobacco Cessation and Cervical Cancer
- **Format:** Didactic Lecture
- **Frequency:** N/A
- **Audience:** MD/DO/NP/PA, RN, PharmD, MA, Health Ed, Diabetes Coordinators, Admin
- **Accreditation:** CME, CNE, CPE
- **Funding:** CDC
- **Upcoming Dates:** N/A
- **Contact:** Antoinette Aguirre aaguirre@npaihb.org

Training Title: NTCCP Tobacco Cessation Trainings

- **Topic:** Tobacco Cessation / Clinical and Community Curriculum utilized: Second Wind, 5A's, Basic Tobacco Intervention Skills for AI/AN
- **Format:** Didactic Lecture, interactive curriculum teach back, on site tribal technical assistance
- **Frequency:** Bi-Annually
- **Audience:** MD/DO/NP/PA, RN, PharmD, MA, Health Ed, Admin
- **Accreditation:** N/A
- **Funding:** CDC
- **Upcoming Dates:** June 2019
- **Contact:** Antoinette Aguirre aaguirre@npaihb.org
  Rosa Frutos rfrutos@npaihb.org

Training Title: NTCCP Tribal Cancer Coalition Meetings

- **Topic:** PSE's, Cancer Screening, Women's Health, HPV, Colorectal Cancer, Tobacco Cessation, digital storytelling, survivorship, liver cancer, cancer data, traditional food, electronic health records, patient navigation, healthy life styles, etc.
- **Format:** Didactic Lecture, interactive curriculum, focus groups, on site tribal technical assistance
- **Frequency:** Yearly
- **Audience:** Tobacco Coordinators, Nurses, MD's, PA's, MA's, CHR's, Pharmacists
- **Accreditation:** N/A
- **Funding:** CDC
- **Upcoming Dates:** June 2019
- **Contact:** Antoinette Aguirre aaguirre@npaihb.org
  Rosa Frutos rfrutos@npaihb.org

Training Title: Tribal Clinician's Cancer Update

- **Topic:** Cancer Prevention, screening, treatment, survivorship,
- **Format:** Didactic Lecture, w/ Q&A
- **Frequency:** Yearly
- **Audience:** MD/DO/NP/PA, RN
- **Accreditation:** CME, CNE
- **Funding:** CDC
- **Upcoming Dates:** April 25, 2019
- **Contact:** Rosa Frutos rfrutos@npaihb.org

Training Title: Minimally Invasive Dentistry

- **Topic:** Dental
- **Format:** Hands on Skills
- **Frequency:** Yearly
- **Audience:** DDS, DMD, Dental Programs
- **Accreditation:** CDE
- **Funding:** Arcora Foundation
- **Upcoming Dates:** N/A
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Portland Area Dental Meeting

- **Topic:** various Dental
- **Format:** Didactic Lecture, w/ Q&A, interactive workgroups
- **Frequency:** Yearly
- **Audience:** DMD, DDS, Dental Hygiene, Dental Health Aid, Dental Assistant, Dental Program staff
- **Accreditation:** CDE
- **Funding:** IHS
- **Upcoming Dates:** May 14-16, 2019
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Elder Initiative Workgroup

- **Topic:** Dental
- **Format:** Didactic Lecture, w/ Q&A
- **Frequency:** Quarterly
- **Audience:** DDS, DMD, Dental Clinics
- **Accreditation:** CDE
- **Funding:** IHS and Arcora Foundation
- **Upcoming Dates:** various
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Baby Teeth Matter

- **Topic:** Dental
- **Format:** Didactic Lecture, w/ Q&A
- **Frequency:** quarterly in-person/online
- **Audience:** DDS, DMD, Dental clinics
- **Accreditation:** CDE
- **Funding:** IHS and Arcora Foundation
- **Upcoming Dates:** various
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Dental Site Visits

- **Topic:** Various dental
- **Format:** Didactic Lecture, w/ Q&A
- **Frequency:** as requested
- **Audience:** DMD, DDS, Dental Clinic
- **Accreditation:** CDE
- **Funding:** IHS
- **Upcoming Dates:** various
- **Contact:** Ticey Mason, MA tmason@npaihb.org

Training Title: Suicide Prevention Trainings

- **Topic:** ASIST – Applied Suicide Intervention Skills Training
  QPR – Question Persuade Refer
  safeTALK – Suicide Awareness For Everyone, Talk. Ask. Listen. Keepsafe.
- **Format:** Didactic Lecture, discussion, and role-plays
  ASIST is a 2-day training, QPR is 1.5-2hrs, safeTALK is 3hrs
- **Frequency:** As requested
- **Audience:** Everyone (over 16 for ASIST without parental consent)
- **Accreditation:** NASW (ASIST)
- **Funding:** IHS, SAMHSA
- **Upcoming Dates:** March 25-26 at Heritage University
- **Contact:** Colbie Caughlan, ccaughlan@npaihb.org, 503-416-3284

Training Title: Substance Use Disorder Training

- **Topic:** Integrating SUD services at your tribe or facility and medications for addictions treatment waiver
- **Format:** In-person, didactics, case presentations
- **Frequency:** Approximately Quarterly
- **Audience:** Clinicians and staff working in Indian Country
- **Accreditation:** CME, CNE
- **Funding:** SAMHSA, OMH
- **Upcoming Dates:** February 28, March 5-6, May 2
- **Contact:** David Stephens, RN, BSN dstephens@npaihb.org

Training Title: Substance Use Disorder ECHO

- **Topics:** Substance use and use disorders
- **Format:** 1 hour virtual telehealth sessions include didactics, case presentations, and treatment recommendations for patients
- **Frequency:** 2x/month
- **Audience:** Clinicians and staff working in Indian Country
- **Accreditation:** CME, CNE
- **Funding:** SAMHSA, OMH
- **Upcoming Dates:** First and third Thursday of every month @11am PST
- **Contact:** David Stephens, RN, BSN dstephens@npaihb.org

Training Title: Hepatitis C Training

- **Topic:** Screening, Treatment and Management of Patients w/ HCV
- **Format:** In-person, didactics, case presentations
- **Frequency:** Approximately Quarterly
- **Audience:** Clinicians and staff working in Indian Country
- **Accreditation:** CME, CNE
- **Funding:** IHS
- **Upcoming Dates:** Jan 31-Feb 1, May 1
- **Contact:** David Stephens, RN, BSN dstephens@npaihb.org

Training Title: Hepatitis C ECHO

- **Topics:** Screening, Treatment and Management of Patients w/ HCV
- **Format:** 1 hour virtual telehealth sessions include didactics, case presentations, and treatment recommendations for patients
- **Frequency:** 6x/month
- **Audience:** Clinicians and staff working in Indian Country
- **Accreditation:** CME, CNE, CPE
- **Funding:** IHS
- **Upcoming Dates:** Jan 23, Feb 6, Feb 12, Feb 14, Feb 20, Feb 27
- **Contact:** David Stephens, RN, BSN dstephens@npaihb.org

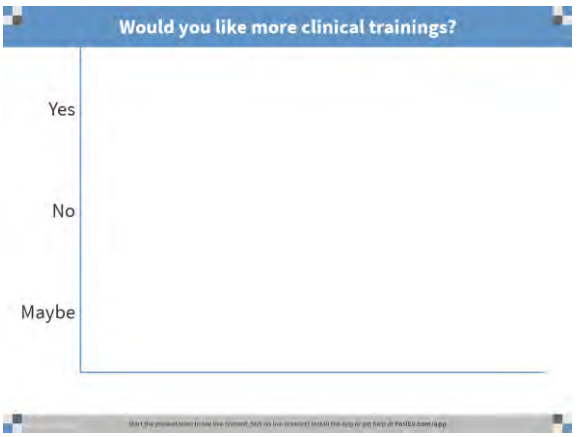
Training other organizations offer

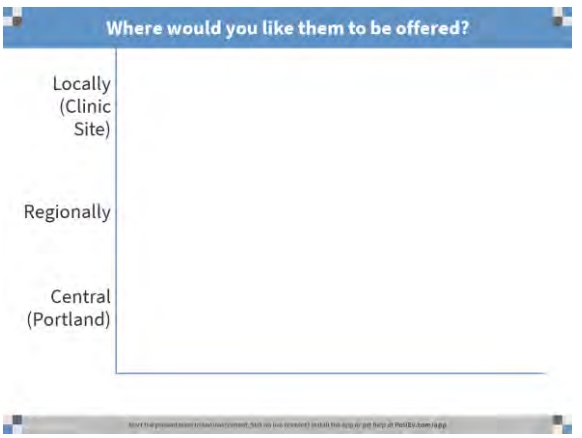
- UNM ECHO
  - IHS sponsored: Hep C, Chronic Pain
  - Many other topics: Cardiology, AIDS, Dementia, Palliative Care, etc
  - echo.unm.edu/initiatives/indian-health-services/
- UCSF Warmline
  - HIV/AIDS Management, Hepatitis C Treatment, Substance Use/Medication Assisted Treatment, PEP, PrEP
  - https://nccc.ucsf.edu/

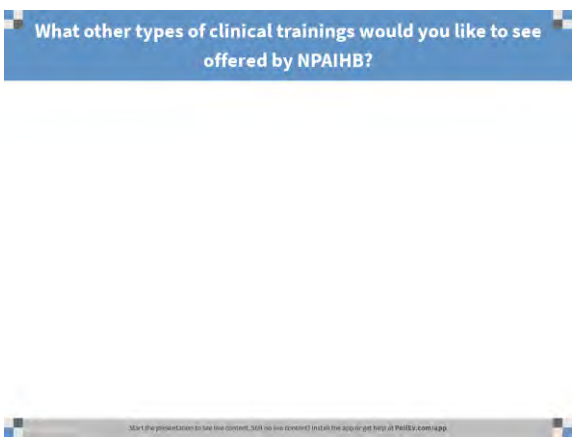
Other organizations

- Trauma Informed Oregon
  - OHSU and the Oregon Pediatric Society (OPS)
  - https://traumainformedoregon.org
- Vital Talk
  - Clinician communication skills for serious illness. Nonprofit founded at UW
  - www.vitaltalk.org
- Peer Wellness Specialist
  - Training for Peer Support Specialists
  - https://www.mhaoforegon.org/trainingandevents/

- See something missing from our list of trainings? Let us know!


Would you like more clinical trainings?
Yes
No
Maybe


Where would you like them to be offered?
Locally (Clinic Site)
Regionally
Central (Portland)


What other types of clinical trainings would you like to see offered by NPAIHB?

Contact Information

ECHO Project
Jessica Leston, MPH (Tsimshian), Clinical Programs Director
David Stephens, BSN, RN, ECHO Clinical Director
Eric Vinson (Cherokee) Project Manager

Phone: 503-416-3295
Email: evinson@npaihb.org

CHAP Board Advisory Work Group

NPAIHB QBM

Suquamish Casino & Hotel

January 22, 2019

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Work Group Purpose

- Purpose:
- To inform and support the strategic direction and development of a Portland Area CHAP Federal Certification Board in accordance with IHS policy (yet to be finalized) as referenced in IHCIA title 25 section 1616L that provides DHAT's, BHA/P's and CHA/P's aka Tribal Health Providers (THP) individual certification as well as review and certification of training centers, curricula, continuing education and manuals that dictate patient care.

Membership

CHAP Board Advisory Work Group

Jim Steinruck	WA	Tulalip Health
Andrew Shogren, Chair	WA	Suquamish Tribe
Lori Hartelius	WA	Stillaguamish Tribe
John Stephens	WA	Swinomish Indian Tribal Community
Cheryl Rasar	WA	Swinomish Indian Tribal Community
Rachel Hogan	WA	Swinomish Indian Tribal Community
Cheryl Sanders	WA	Lummi Nation
Regina Miller	WA	Lummi Nation
Veronica Smith	WA	Lummi Nation
Maureen Kinley	WA	Lummi Nation
Tara Olsen	WA	Lummi Nation
Vicki Lowe	WA	American Indian Health Commission
Cindy Gamble	WA	American Indian Health Commission
Candice Wilson	WA	NorthSound ACH
Kay Culbertson, Secretary	WA	Cowlitz Tribe
Cassandra Sellards Reck	WA	Cowlitz Tribe
Libby Cope (IHS), Co-Chair	WA	Makah Tribe
Matthew Whitacre	WA	Lower Elwha
Marilyn Scott	WA	Upper Skagit Tribe
Andy Joseph Jr	WA	Colville Tribes
Barbara Juarez	WA	Northwest Washington Indian Health Board
Wilbert James	WA	Sauk Suiattle
Aren Sparck	WA	Seattle Indian Health Board
Sharon Stanphill	OR	Cow Creek Tribe
Kelle Little	OR	Coquille Indian Tribe
Lisa Guzman	OR	Umatilla (Yellow Hawk)
Jon McConville	ID	Nimiipuu
Chantel Eastman	ID	Nez Perce
Carolyn Craig	AK	Alaska Native Tribal Health Consortium
Crystal Stordahl	AK	Tanana Chiefs Conference
Christina Peters	-	NPAIHB
Sue Steward	-	NPAIHB
Cheryl Sixkiller (IHS)	-	PAO-IHS
Tess Abrahamson-Richardson	-	NPAIHB consultant
Geoffrey D. Strommer		HOBBS STRAUS DEAN & WALKER, LLP
Stacia K. Roels		HOBBS STRAUS DEAN & WALKER, LLP

Project Funding

$548,228

- Washington tribes provided a percentage of their Medicaid Transformation Funds as detailed in Resolution 18-03-09 for CHAP Area Certification Board project start up.

CHAP TAG

Circular 18-01

- To provide subject matter expertise, program information, innovative solutions, and advice to the I.H.S. to establish a National CHAP.

IHS

- Meetings
  - August 17 in Seattle
    - Version IV
  - October 10 at HQ
    - Version V
- The good news is that the I.H.S. draft now includes tribal participation and has language including ACCB's. Honest conversation was held about what responsibilities a National CB could reasonably execute.

CHAP TAG

- 11/5/18 CHAP TAG requested that IHS provide an updated policy for discussion. IHS agreed to submit that by the next Friday and reschedule teleconference. That did not happen.
- 12/20/18 Version VI of draft policy was sent out to CHAP TAG with letter that it would be announced at the January 3, 2019 Tribal Leaders and Urban teleconference and a DTLL would be forth coming.
- 12/21/18 Partial Government shut down.
- 1/3/19 No announcement at Tribal and Urban Leaders Teleconference.
- 1/4/19 A letter was prepared by CHAP TAG and sent to IHS under signature of chairperson Dr. Segay's signature expressing CHAP TAGs concern that they did not approve the current draft being sent out for tribal consultation.

Analysis of AK Standards & Procedures

- Our focus is on those sections that relate to DHATs;
- We have completed review and legal analysis of the first 5 chapters;
- Our next face to face meeting is Thursday Noon to 4 PM to review the remainder of the AK S&P for DHATs needing certification to practice in June.

Analysis of AK Standards & Procedures

- June 2019 we celebrate the return of 7 graduating DHATs
  - (1) Coeur d'Alene (Idaho)
  - (1) NARA (Oregon)
  - (1) Colville (Washington)
  - (2) Lummi (Washington)
  - (2) Swinomish (Washington)

Analysis of AK Standards & Procedures

- The Alaska standards and procedures were develop for Alaskans by Alaskans after many years of CHA training and education.

Plan B

- The partial shut down of the U.S. Government may delay the release of an IHS Interim CHAP Policy;
- Temporary Solutions
  - Swinomish Licensing
  - Alaska CHAP Certification Board

Costs

- A Portland Area feasibility study will need to be completed, but we know this about the AK CB costs;
  - Current certification is about 600;
  - This amounts to about 150K annually;
  - Certification costs $500.00 q 2 years

Draft PACCB Resolution

Copies of the draft are located in packets.

- We are targeting April QBM to introduce a Resolution to create and seat Portland Area Federal Certification Board

Next Steps

- Finalize the draft Resolution;
- Submit it to the Policy Committee;
- Suggest membership

Questions?

CHAP Board Advisory Work Group meets here on Thursday after QBM

Safe Travels

DRAFT- COMMUNITY HEALTH AIDE PROGRAM POLICY

Sec.

1. INTRODUCTION

A. Purpose. To implement, outline, and define the National Community Health Aide Program (CHAP) to include health aides that function as part of a team of healthcare providers focused on providing effective, efficient, and patient centered care.

B. Background. The CHAP was established to train community health aides and practitioners, and maintain a system of certifying community health aides that have completed training and are competent to provide health care, health promotion and disease prevention services in rural Alaska. The CHAP was authorized by Congress to promote the achievement of the health status objectives in the Indian Health Care Improvement Act (IHCIA) in rural Alaska. These objectives are broad in scope and address virtually every aspect of health care, including access, delivery, and status. Specialized training (medical, dental and behavioral health) and certification furthers those objectives by creating opportunities for health aides to focus their training and practice on particular health issues and delivery strategies. In 2016, the Indian Health Service (IHS) consulted with Tribes on expanding the CHAP, and in 2018, formed the CHAP Tribal Advisory Group (CHAP TAG) to begin expanding the CHAP to the contiguous 48 states.

C. Authorities.

1. Indian Health Care Improvement Act , 25 U.S.C. §1616l

2. Indian Health Service Tribal Consultation Policy, Circular No 2006-01

3. US Department of Health and Human Services Tribal Consultation Policy

D. Policy. It is the policy of the IHS that:

1. All CHAP providers trained and certified by the Alaska Community Health Aide Program Certification Board (Alaska CHAPCB) prior to the effective date of this policy are deemed certified in the contiguous 48 states by

submitting a copy of their certification to the IHS National CHAP Certification Board (CHAPCB).

2. Tribes and Tribal Organizations outside of Alaska may carry out CHAPs in their Indian Self-Determination and Education Assistance Act (ISDEAA) Title I and Title V agreements.

3. Tribes or Tribal Organizations seeking to include a CHAP as a program, service, function, or activity (PSFA) in their ISDEAA agreements must adhere to the all CHAP training and certification requirements.

4. At this time, IHS has not received additional funding and is not providing additional funding for the expansion of the CHAP outside of Alaska; however, Tribes and Tribal Organizations may propose to redesign or re-budget a PSFA in their ISDEAA agreement subject to any other applicable requirements to include this program.

5. Tribes and Tribal Organizations may elect to provide a CHAP (including dental health aide therapists (DHAT) by amending their ISDEAA agreements.

6. DHATs may practice only in states that authorize the use of DHAT services.

7. Currently, DHATs and Community Health Aides (CHAs) are not authorized to provide services in IHS operated health programs.

8. IHS operated health programs will not fill any vacancy for a certified dentist with a DHAT. ISDEAA Title I and Title V Tribal health programs are not subject to this restriction.

9. Behavioral Health Aides (BHAs) may be utilized in IHS operated health care programs using existing Office of Personnel Management (OPM) approved position description for mental health specialists (OPM Series 0181 Psychology Technician and/or GS 0186 Social Service Aid).

10. Expansion of CHAP will not reduce funding amounts of the Alaska CHAP. The policy intended to expand CHAP to the contiguous 48 states will not affect the operation of the Alaska CHAP, the Alaska CHAPCB (or its standards and procedures).

11. The National CHAPCB is a federal board under the direction and control of the IHS.

12. The Area CHAP Certification Boards (Area CHAPCB) constitute federal boards and their membership must include at least one federal representative appointed by the respective IHS Area Director

13. IHS, Tribes, or Tribal Organizations may participate in any program or provide any service authorized by other Federal law(s).

14. An IHS Area Director may elect to utilize and/or procure the certification services of another Area CHAPCB to certify CHAP providers in their respective areas. Furthermore, Area Directors may opt to form regional boards to certify CHAP providers across more than one IHS Area.

15. All CHAP providers trained and certified by the Alaska CHAPCB and other Area CHAPCBs will be recognized and have reciprocity in the applicable Area.

2. DEFINITIONS

A. Academic Review Committees (ARC). Specialized body of practitioners representing the behavioral, primary, and oral health fields that puts forth recommendations to the National CHAPCB on changes to the curriculum for all CHAP provider types. The composition of the ARC(s) is at the discretion of the IHS Chief Medical Officer (CMO) in consultation with the CHAP Tribal Advisory Group (TAG).

B. Area. Refers to one of the twelve (12) IHS service Areas: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

C. Certification Boards.

1. National CHAP Certification Board (National CHAPCB). The National CHAPCB is a federal board chaired by the IHS CMO, is under the direction and control of the IHS, and will be comprised of Federal and Tribal representatives from each Area CHAPCB.

2. Area CHAP Certification Board (Area CHAPCB). The Area CHAPCBs constitute federal boards and their membership must include at least one federal representative appointed by the respective IHS Area Director.

D. Provider Types

1. Behavioral Health Aide. Refers to a behavioral health aide I, II, III, and practitioner except when a level is specified. The specific roles and responsibilities of each level, will be defined in the National CHAP Standards and Procedures and other applicable Area CHAPCB requirements.

2. Community Health Aide. Refers to community health aide I, II, III, IV, and Practitioner, except when a level is specified. The specific roles and responsibilities of each level, will be specified in the National CHAP Standards and Procedures and other applicable Area CHAPCB requirements.

3. Dental Health Aide. Refers to a primary dental health aide level I-II, expanded function dental health aide level I-II, dental health aide hygienist, and DHAT except when the level is specified. The specific roles and responsibilities will be specified in National CHAP Standards and Procedures and other applicable Area CHAPCB requirements.

E. Standards and Procedures

1. National CHAP Standards and Procedures. Adopted in part from the Alaska CHAPCB Standards and Procedures, outlines the minimum program standards for all CHAP provider types operating in the contiguous 48 states. The National CHAP Standards and Procedures include, but are not limited to, the minimum training, training equivalency, supervision, and scope of practice requirements.

2. Area Standards and Procedures. Includes the National CHAP Standards and Procedures, any additional requirements developed by Area CHAPCB, for all provider types operating under that respective Area CHAPCB. Additional area requirements may exceed but will not replace National CHAP Standards and Procedures.

3. RESPONSIBILITIES

A. National CHAP Certification Board (National CHAPCB).

1. Establishes National CHAP Standards and Procedures that contain CHAP Training and Certification Standards, including developing the curriculum for all CHAP provider types for the Area CHAPCBs to ensure consistency across IHS areas.

2. Specifies requirements and scope of practice for all CHAP provider types, including community health aides and practitioners, dental health aides (including primary dental health aides, expanded functions dental health aides, dental health aide hygienists, and dental health aide therapists), and behavioral health aides and practitioners.

3. Conducts an annual review of CHAP operations to ensure consistency across all IHS Areas.

4. Convenes Area CHAPCBs periodically to review National CHAP Standards and Procedures.

5. Determines what will constitute equivalent training of providers as authorized in the IHCIA.

6. Maintains annual records of Area CHAPCB actions regarding certification of CHAP providers.

B. Area and/or Regional Certification Boards (Area CHAPCB).

1. Collects certifications of individuals previously trained and actively certified by the Alaska CHAPCB who works in the lower 48 contiguous states and maintains a record of all CHAP providers certified, denied, recertified, revoked, and approved after appeal.

2. Creates procedures that detail terms, chairmanship, quorum, meetings, duties, and transition functions.

3. Ensures National CHAP Standards and Procedures established by the National CHAPCB, as well as any additional requirements set forth by the Area CHAPCB for its applicable provider type, are met before certifying individuals for all

CHAP provider types identified in 2.D. An IHS Area Director or their federal designee's signature must be included on each certification.

4. Certifies the Area curriculum for each CHAP provider type on at least a three (3) year recurring cycle.

5. Adopts Area specific curriculum, consistent with the National CHAP Standards and Procedures established by the National CHAPCB, as needed, to ensure Area specific needs are met.

6. Ensures the National CHAP Standards and Procedures and the respective Area curriculum are culturally tailored and accessible to Area Tribal members.

7. Ensures the portability of health aide certification across Areas.

C. Academic Review Committees (ARC).

1. Conducts an independent review of the curriculum to ensure its alignment with the current health needs of American Indians and Alaska Natives.

2. Develops recommendations to the National CHAPCB on National CHAP Standards and Procedures.

4. EFFECTIVE DATE

This Circular becomes effective on the date of signature and will be superseded by the permanent policy once approved by the IHS Director.

Resolution No.

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

WHEREAS, CHAP has been an effective method for diminishing the health disparities of Alaska Natives by promoting access to health services for Alaska Natives residing in rural and remote communities; and

WHEREAS, CHAP grows midlevel providers from within Tribal communities who provide patient-centered, culturally relevant, quality care that comes from providers that understand the history, culture and language of their patients; and

WHEREAS, CHAP provides patient-centered primary care and delivers more care in the community rather than an acute care setting; and

WHEREAS, CHAP provides routine, preventative and emergent health care through Community Health Aides (CHA/Ps), Behavioral Health Aides (BHA/Ps), and Dental Health Aide Providers (DHA/Ts); and

WHEREAS, CHAP providers provide continuity of care in communities that face recruitment and retention challenges; and

WHEREAS, the Indian Health Service issued a Dear Tribal Leader Letter and draft policy statement on XX XX XXXX to solicit input from Tribes to create an area and national certification board under the provisions outlined in the Indian Health Care Improvement Act as amended at 25 U.S.C. § 1616 (l) and the CHAP as well as a national accreditation and review committee (ARC) for all disciplines of Tribal CHAPs in the IHS system; and

WHEREAS, Portland Area Tribes have established and continue to establish DHAT programs with several more students from our member tribes currently being trained as DHATs in Alaska; and

WHEREAS, our member tribes are interested in having BHA providers in the Northwest and NPAIHB completed a feasibility study that supports the establishment of a BHA program, among other activities; and

WHEREAS, our member tribes would benefit from the existence of a Portland Area CHAP Certification Board (PACCB) for certification of CHA/Ps, BHA/Ps, and DHA/Ts.

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board supports the creation of a PACCB; and

BE IT FURTHER RESOLVED that the Northwest Portland Area Indian Health Board supports the development of the PACCB with federal baseline standards for consistency of services provided by any CHAP program.

Public Health Emergency Preparedness
AIHC - Washington State Update

January 23, 2019

Lou Schmitz
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Heather Erb
heather@erblawfirm.com


MITIGATE
PREPARE
RESPOND
RECOVER

AIHC's PHEPR Priorities

- Strengthening Tribal Capacity
  - Tribal Community Emergency Preparedness Toolbox (2016)
  - Facilitated Community Preparedness Self-Assessments (2018)
  - Medical Countermeasures Distribution Tabletop Exercises (2018)
  - Proposed Legislation – Washington Emergency Management Council Representation (2019)
  - Emergency Vaccine Distribution Planning Meetings (2016)
  - Emergency Vaccine Distribution Tabletops (2016)
  - Tribal PHEPR Needs Assessments (2015)
  - Training and Technical Assistance (Ongoing)

AIHC's PHEPR Priorities

- Strengthening Relationships with PHEPR Partners
  - Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State (2017)
  - Cross-Jurisdictional Collaboration Planning Meetings (2018)
  - Advocacy with CDC on Medical Countermeasures Distribution to Tribes (2018)
  - Emergency Vaccine Distribution Planning (2016)
  - Training and Technical Assistance (Ongoing)

AIHC's PHEPR Work - National Efforts

- National Public Health Law Conference 2018
- National Academy of Science – Evidence-Based Public Health Emergency Preparedness Study
- Department of Homeland Security – Smart Cities Assessment Project
- National Indian Health Board – Public Health Emergency Preparedness and Response Initiative, January 30 Webinar

Work Ahead

- Develop draft language for CDC/ASPR
  - Clarify roles and responsibilities for CDC/ASPR, states, local governments, tribes
  - Clarify process for tribes who choose to work directly with CDC/ASPR
- Develop draft language for DOH
  - MCM Distribution to Tribes Guidance Document
  - Annex 9 revisions

Work Ahead

- Develop draft language for LHJs' plans
  - Process for including tribes in communication, decision-making and coordination of response actions during responses
- Develop Model Tribal MCM Plan
  - Host training webinar

Work Ahead

- Analyze WA State Pharmacy MOU
  - Determine whether it is a viable mechanism for tribes to access MCM
  - If not, develop a more appropriate alternative
- Develop system for tribes and other PHEPR partners to share essential information for public health emergency responses

Work Ahead

- Develop curriculum and provide training to tribes and urban programs on Point of Dispensing (POD) planning and operations

- Provide information and technical support for tribes to participate in the statewide T-Rex MCM distribution exercise

Work Ahead

- Host MCM distribution planning meetings for each of the 9 regions with tribes, LHJs, DOH and other PHEPR partners

- Host a Mutual Aid Agreement workshop for the tribes and LHJs in Region 9 (Colville, Kalispel, Spokane)

Washington State

CALENDAR OF PUBLIC HEALTH EMERGENCY PREPAREDNESS MEETINGS -- SAVE THE DATES

MCM=Medical Countermeasures
MAA= Mutual Aid Agreement

Date/Time	Event	Location
February 28 – 9am-12pm	Model Tribal MCM Plan Training Webinar All Tribes	Webinar – Register at: https://attendee.gotowebinar.com/register/5318057764293360898
March 7 – 9am-4pm	Region 6: MCM Planning Meeting Tribes – Muckleshoot, Snoqualmie	Muckleshoot Health and Wellness Center – ***Tentative***
March 11 – 9am-4pm	Region 2: MCM Planning Meeting Tribes – Hoh, Jamestown S'Klallam, Lower Elwha, Makah, Port Gamble, Quileute, Quinault, Suquamish	Jamestown S'Klallam Tribe – Fishbowl Room 70 Zaccardo Rd. Sequim, WA 98382
March 13 – 9am-4pm	Region 4: MCM Planning Meeting Tribes - Cowlitz	Cowlitz Tribe – Wellness Meeting Room 1044 11th Avenue, Longview, WA 98632
March 14 – 9am-4pm	Region 5: MCM Planning Meeting Tribes – Nisqually, Puyallup	Puyallup Tribe – Spirit House ***Tentative***
March 26 – 9am-4pm	Region 1: MCM Planning Meeting Tribes – Lummi, Nooksack, Sauk-Suiattle, Stillaguamish, Swinomish, Tulalip, Upper Skagit	Tulalip Tribes – Admin Building #162 6406 Marine Drive, Tulalip 98271
March 28 – 9am-4pm	Region 3: MCM Planning Meeting Tribes – Chehalis, Nisqually, Quinault, Shoalwater Bay, Skokomish, Squaxin Island	Nisqually Tribe – Youth Center ***Tentative***
April 2 – TENTATIVE 9am – 4pm	Tribal Point of Dispensing Planning and Operations Workshop (Eastern Washington) All Tribes and Urban Programs	Kalispel Tribe – Northern Quest Resort ***Tentative***
April 4 – TENTATIVE 9am – 4pm	Tribal Point of Dispensing Planning and Operations Workshop (Western Washington) All Tribes and Urban Programs	Port Gamble S'Klallam Tribe – The Point Resort ***Tentative***
April 22 – 9am-4pm	Region 7: MCM Planning Meeting Tribes – Colville	Colville Tribes – Twelve Tribes Casino 28968 US-97, Omak, WA 98841
April 24 – 9am-4pm	Region 9: MAA Workshop	Kalispel Tribe – Northern Quest Resort 100 N Hayford Rd, Airway Heights, WA 99001
April 25 – 9am-4pm	Region 9: MCM Planning Meeting	Kalispel Tribe – Northern Quest Resort 100 N Hayford Rd, Airway Heights, WA 99001
April 26 – 9am-4pm	Region 8: MCM Planning Meeting	Yakama Nation – Legends Casino ***Tentative***
May 6 – 14	Washington State Full-Scale MCM Distribution Exercise – "T-Rex"	Statewide – Tribes self-determine the extent of their participation

Contact: Lou.Schmitz.AIHC@outlook.com

Public Health Improvement & Training (PHIT) Updates

Bridget Canniff, PHIT Project Director

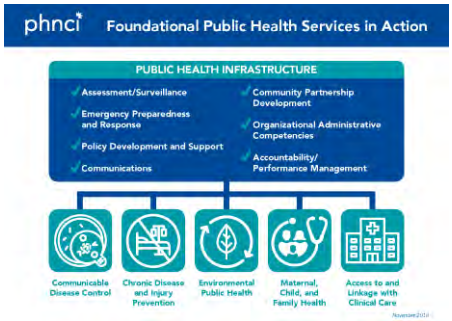
Taylor Ellis, PHIT Project Specialist

NPAIHB
Indian Leadership for Indian Health

Public Health Improvement & Training

- Tribal Public Health Capacity Building & Quality Improvement (QI)
- Oregon State Health Improvement Plan (SHIP)
- Tribal Public Health Emergency Preparedness

Foundational Public Health Services



Leaders in Public Health Modernization

Oregon

Washington

Quality Improvement (QI) in Public Health

"**Quality improvement in public health** is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measureable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community."

Riley, W., Moran, J., Corso, L., Beitsch, L., Bialek, R., and Cofsky, A. Defining Quality Improvement in Public Health. *J Public Health Management Practice* 2010; 16(1)5-7.

Public Health Improvement: QI, PM, WFD

Performance Management

- Systematic process which helps an organization achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining decision making

Workforce Development

- Attempt to improve health outcomes (→ healthier people) by enhancing the training, skills, and performance of public health workers

Public Health Foundation phf.org

Public Health Accreditation

Goal: Improve & protect the health of the public by advancing the quality & performance of Tribal, state, local, & territorial public health departments

- Measurement of health department performance against a set of standards
- Issuance of recognition of achievement of accreditation
- Continual development, revision, & distribution of public health standards

Public Health Accreditation Board phaboard.org

Public Health Improvement Resources

- American Public Health Association apha.org
- Public Health Accreditation Board phaboard.org
- Public Health Foundation phf.org
- National Network of Public Health Institutes & Public Health Learning Network nnphi.org
- Public Health Institutes & Regional Public Health Training Center: Oregon Public Health Institute ophi.org, Northwest Center for Public Health Practice nwcphp.org
- State Health Departments (WA DOH, OHA, ID DHW)
- Seven Directions, Indigenous Voices for Public Health indigenousphi.org
- National Indian Health Board nihb.org

Public Health Capacity Building & QI

- **NEW funding:** CDC Tribal Public Health Capacity Building & QI umbrella grant
  - $22K for public health capacity & QI training/TA
  - $258K for opioid response strategic planning
  - $2.6M for national death index data linkages

Public Health Capacity Building & QI

- Provide technical assistance (TA) and training to Northwest Tribes
  - Discussion group: public health infrastructure & improvement, QI, accreditation readiness
  - Training: 1 session in FY2019 – date, location, topic(s) TBD
    - What's on your tribe's wishlist?

OR State Health Improvement Plan

- NPAIHB: 1 of 7 community organizations receiving mini-grants from Oregon Health Authority (OHA)
- Survey outreach to AI/AN residents of Oregon
  - Tribes, Tribal/Urban Indian Organizations, other Native-serving groups
- One week left to respond – help spread the word! Visit NPAIHB Facebook page or bit.ly/2020SHIP
- Report due to OHA January 31

Public Health Emergency Preparedness

- 2019 NW Tribal Public Health Emergency Preparedness Conference & Training
- Early June, exact dates & location TBA
- Funded by WA DOH, OHA, NPAIHB/NWTEC
- In partnership with NW Tribes, AIHC, NW Center for Public Health Practice
  - Tribal reps needed for planning committee!

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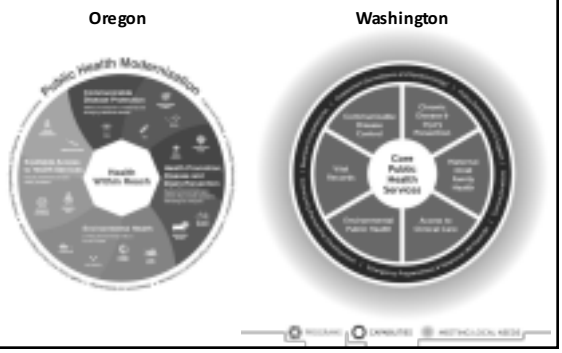

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Introducing Community and Behavioral Health Aide Services in Washington State: A Gap Analysis

Assessing mid-level provider staffing needs in tribal and urban Indian health and behavioral health clinics in Washington State

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

jba JAMES BELL ASSOCIATES

This presentation and the accompanying crosswalk document were prepared for the Northwest Portland Area Indian Health Board by James Bell Associates, Inc.

JBA CONTRIBUTORS:
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Amy Stiffarm, M.P.H.
Erin Geary, Ph.D.

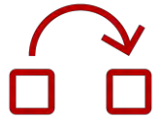
IN CONSULTATION WITH:
Susan Steward, NPAIHB CHAP Project Director

BACKGROUND

Why a Gap Analysis?

- Describing the existing landscape of Washington tribal medical and behavioral health services
- Understanding the need for additional training and licensing pathways for mid-level providers in tribal communities

Getting from where we are to where we want to be



Overview of Gap Analysis Methodology

- Determining where there is a need, deficit, or breakdown (i.e. a gap) between the current and ideal situation
- Determine the root causes of the gap
- Analyze proposed solutions; And/Or,
- Identify root causes that are more versus less subject to influence based on things like: character of the issue, time and monetary parameters, available solutions

Goals of this Gap Analysis

1. Understand what underlying factors contribute to the need for mid-level medical and behavioral health providers in Washington Tribal and urban Indian communities
2. Describe specific data points and qualitative information characterizing this regional demand, meaning how do we know there's a shortage and what does it look like on the ground?
3. Analyze the potential of the Community and Behavioral Health Aide program to address the provider shortage

A quick footnote

- What do the terms "mid-level" and "paraprofessional" refer to?
- Both terms can be used to refer to positions in the medical and behavioral health field that do not require graduate degrees, such as nurses, nurse assistants, mental health counselors, chemical dependency professionals, etc. We use "mid-level" in this analysis and presentation.
- "Mid-level provider" has in the past been used by some in the medical field to refer to Nurse Practitioner and Physician Assistant providers, but those professionals are now commonly referred to as "Advance Practice Providers."

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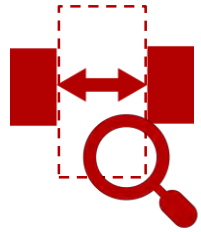
9

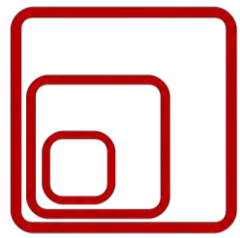
Gap Analysis Overview

- Community Health Aides (CHA/Ps)
- Behavioral Health Aides (BHA/Ps)



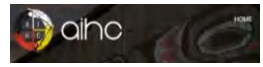
Methods

- Tiered data collection strategy
  - Review of existing data
  - Tribal and urban clinic outreach
  - Key informant inquiries



Existing Data Sources

- Health Provider Shortage data
- BHA Program Roll Out Feasibility Report conducted by Cumming
- AIHC Health Profiles
- Data from the Alaska CHA/P & BHA/P Programs



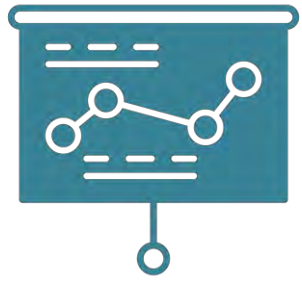
Tribal and Urban Clinic Outreach

- Clinics/programs were sampled in order to reflect a diversity of: geography, proximity to urban area; service population size; IHS vs. tribally-run
- We asked program personnel about: Current staffing levels; Turnover; Ease of filling open positions; Capacity to meet service demands; Factors influencing overall capacity to provide services

Key Informant Interviews

- Clinic/Program Managers
- Consultants
- Advisory Committee Members

Findings



AIM 1

Understand what underlying factors contribute to the need for mid-level medical and behavioral health providers in Washington Tribal and urban Indian communities

Aim 1 Overview

- Background Aim
- Establishing considerations underpinning Aims 2 & 3
- Drawing on existing data from key informants closely involved in CHAP implementation

Identifying Underlying Issues

- We will present information related to current provider shortages; however, identifying the underlying factors contributing to these shortages is key to understanding how the addition of Community and Behavioral Health Aide providers and the associated training and funding infrastructure can address these shortages.

These issues include

A Trained Workforce

Community/ Clinic Infrastructure

Position Funding

A Trained Workforce

- Training that is affordable, culturally and contextually specific, and accessible for tribal students can be very challenging
- The CHA/P and BHA/P program implementation is working towards an accompanying community-partnered education training program through a local tribal college and/or community college partnership

Community/Clinic Infrastructure

- It is critical that infrastructure to support new providers is developed alongside the positions themselves in order for providers and programs to benefit
- Programs will be developed in partnership and support NPAIHB, and funding structures will be in place for program implementation as well as ongoing services and administration.

Position Funding

- New positions must be able to bill against existing funding sources or access new revenue streams
- Exact billing details have not been finalized for the CHA/P and BHA/P programs, but they will be an essential component of implementation

AIM 2

Describe specific data points and qualitative information characterizing this regional demand

Aim 2 Overview

- Central component of this gap analysis
- Examining concrete metrics and on-the-ground expertise
- Triangulating quantitative and qualitative data sources to gather a richer picture of regional provider demand

Health Provider Shortage Areas

- A Health Provider Shortage Area (HPSA) is a regional designation that indicates practitioner shortages in dental health, behavioral health, or primary care.
- The National Health Service Corps developed a HPSA scoring system to determine regional-level health provider shortages and to thereby prioritize areas of greatest need.
- Scores range from 1 to 26, with 26 being the highest priority.
- A such, we categorized programs into low (1-9), moderate (10-16), and severe (17+) HPSA score groups, indicated by light, medium, and dark blue dots on the following maps

WA Tribal and UIHP Clinic Medical Provider HPSA Designations

WA Tribal and UIHP Clinic Mental Health Provider HPSA Designations

Notable Findings from the Cumming Report on BHA rollout

- AIAN individuals and communities experience a large unmet need for providers and access to providers
  - "Of those with a mental [health] disorder, only 32 percent had received mental health or substance abuse services."
  - Nationally, AIAN individuals have access to 42% fewer providers per 100,000 population than whites
- Demand projections suggest that most tribes in WA could use 1 BHA provider initially, with larger communities eventually adding a 2nd BHA provider

Continuing Beyond the Cumming Report on BHA rollout

- List of BHA training and program needs in the Cumming Report offer a starting point, but will need to be further updated for Washington's program
- The forthcoming demonstration project with 3-6 students starting later this year will provide key insights for continued planning and roll-out activities

American Indian Health Commission Data

- Data on current behavioral health staffing was a starting point for sampling and outreach to programs (CHAP-comparable provider data not available)
- Service population data provides greater specificity than census or other sources
  - Most programs serve a broader population than solely their tribal members

American Indian Health Commission Data

- Overview of range of services provided
  - Primary and emergency care
  - Obstetrics
  - Youth and elder specific programs
  - Physical therapy
  - Community health services
  - Case management, home-based, and care coordination services
  - Outpatient and Inpatient treatment
  - Individual, family, and group counseling
  - Psychiatric care
  - Suicide prevention

Qualitative Interview Findings

- Behavioral health integration is a key contextual issue when thinking about existing and new providers' roles and capacity
- There is interest in CHA/Ps and BHA/Ps at some facilities because these providers can meet a wide range of service needs whereas other providers may need to be more honed in on a certain scope of practice
- Similarly, there are many instances where current providers *are* practicing beyond the scope of their core duties (e.g. offering transportation, conducting community or home-based outreach, etc.) and that limits their ability to fully do their assigned job or serve more patients

Qualitative Interview Findings

- Varies from agency-to-agency, but both finding and retaining qualified providers at the mid-level is an issue for many agencies
- Other related issues tribal and urban medical and behavioral health programs face include working to offer attractive/competitive salaries, infrastructure barriers to adding providers (e.g. space, funding, equipment),
- Connection to community and service orientation helps retention
- Patient and community outreach benefit health outcomes; asks more of providers and other staff, but is effective for getting patients through the door

AIM 3

Analyze the potential of the Community and Behavioral Health Aide program to address the provider shortage

Aim 3 Overview

- Understanding how the CHAP program may be able to address the underlying issues established in Aim 1 and the shortage described in Aim 2
- Drawing on data from the Alaska program and Key Informant consultation with those closely involved with CHAP implementation

Advantages of CHA/P and BHA/P staffing in tribal clinics

- Growing our own
- Training/educational investment promotes retention
- Filling a needed service gap

Successes in Alaska

- Increased access to care and provision of services: 550 CHAs in over 170 villages
  - CHA/Ps offer consistent local access to primary care and local emergency response
- Health outcomes have improved in a variety of metrics since CHAP introduction (access to care, infant mortality, life expectancy, hospitalization rates)
- Patients and providers report very favorably about their experiences with CHA/Ps and the impact of their work
- Cost savings related to transport and contract care

Resources and Partnerships to Support the Programs' Success

- Training and education program structure
- NPAIHB CHAP Project
- Alaska program resources, AK CHAP staff, and the Alaska CHAP certification board
- Washington Dental Health Aide Therapy Program

Outstanding Areas to Address

- Certification
- Funding and billing
- Training program curriculum

Final Thoughts

Limitations

- Staffing data more limited at the mid-level
- Employment numbers and service gaps are in a state of constant flux
- Staffing need is more complicated than vacancies; funding and billing specifics also play an important role

Conclusions

- The need for mid-level medical and behavioral health providers in tribal and UIH programs is well supported by available data
- The broader structure of the Community and Behavioral Health Programs will be critical to their success and merits uniquely focused attention alongside the tasks of recruiting, training, placing, and supporting individual providers

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

Crosswalk Comparison of Community and Behavioral Health Aides and Existing Providers in Washington State

January 2019

Crosswalk Comparison of Community and Behavioral Health Aides and Existing Providers in Washington State

January 2019

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Table of Contents

Introduction

Background

The Community and Behavioral Health Aide Program (CHAP) is designed to promote behavioral and wellness in Native American individuals, families, and communities. The CHAP expansion into regions outside of Alaska will establish a new source of community-based, cost effective, and quality care that addresses health disparities from a culturally and professionally knowledgeable lens. As the work on CHAP implementation in the Portland Area Indian Health Service (IHS) Region (Washington, Oregon, and Idaho) unfolds, stakeholders want to understand how Community and Behavioral Health Aide Providers (CHA/Ps and BHA/Ps)[1] will fit into the existing provider landscape. Portland Area CHAP expansion project stakeholders have asked for specific information comparing and contrasting the training and scope of practice of CHA/Ps and BHA/Ps with existing mid-level provider types who have similar levels of education and responsibility.

This document provides that comparison. The crosswalks and accompanying text provide an overview of the training, skills, scope of practice, and other key domains of CHA/Ps and BHA/Ps as compared with existing comparable medical and behavioral health providers.

Community Health Aide Overview

Community Health Aides are allied health professionals who work with supervising physicians to help extend their reach. The CHA/Ps in Alaska are community members serving their own rural Alaska Native villages. A program similar to the one in Alaska is being developed in Washington and the greater Portland IHS Region. However, the specifics will be determined by project stakeholders whose goal is to create a unique program that meets the needs of the region, including the potential to incorporate urban Indian health program (UIHP) CHA/P providers.

A primary advantage of the CHA/P role is the diversity of roles these providers can fill. Depending on the CHA/P's level of training, she or he can perform tasks ranging from administrative duties, emergency response, dispensing medication, medical record clerk, medical services provider, pharmacy technician, to home health visitor. Fully trained CHA/Ps have benefitted rural Alaska Native communities through their ability to dispense medication under standing orders. And CHA/Ps of all levels can extend both rural and urban clinics' reach through their capacity to conduct home visits, follow-up on referrals, and carry out other big picture case management activities. As with the overall CHAP structure, the specifics of licensed CHA/P duties and training will be tailored in the course of program roll-out in Washington.

[1] Throughout this document, the CHAP acronym is used to refer to the overarching Community Health Aide Program that includes administration and certification of Community and Behavioral Health Aide services. The CHA/P and BHA/P acronyms are used to refer to Community and Behavioral Health Aide providers.

Provider Crosswalks

Community Health Aide Crosswalk

Provider Types Included in the CHA/P Crosswalk

There are many state licensed and non-state licensed health professions operating in Washington's many health and social services facilities. Providers in this crosswalk were selected on the basis of training requirements, scope of practice, and representation in tribal clinics and UIHPs. The selection of providers includes—

- Traditional Healer*
- IHS Community Health Representative (CHR)*
- Community Health Worker (CHW)*
- Home Care Aide
- Certified Nurse Assistant (CNA)
- Licensed Practicing Nurse (LPN)
- Registered Nurse (RN)

*Traditional Healers, IHS CHRs, and CHWs are not state-licensed provider types.

CHA/P Crosswalk Table

Community Health Aides' work and training have similarities to the other providers included in the crosswalk. A side-by-side comparison makes it clear where those similarities lie and where there are differences. The crosswalk table below details the scope of practice, education and training requirements, supervision requirements, and typical practice settings for each type of provider. Following the table, there is a comparison and description of average wages and billing structures. Finally, there is a summary of key elements that characterize CHA/P practice and make them a unique and valuable addition to the provider landscape.

Table 1. Existing Provider and Community Health Aide Crosswalk

Provider Type	Scope of Practice Details	Education and Training Requirements	Supervision Requirements	Typical Practice Settings
Traditional Healer	Provides healing services based in traditional knowledge and practices of the community and/or the provider's traditional teachings and training (i.e. in a multi-cultural indigenous setting such as a city); may include a variety of healing modalities.	No state-mandated training or education requirements; established by tribe/tribal department/urban Indian health program (UIHP)	Established by employing tribe/tribal department/UIHP	Tribal clinics, UIHPs, other tribal/urban agencies, or outside of a formal agency
IHS CHR	Provides healthcare, health promotion, and disease prevention services in their own tribal communities.; specific program priorities and services are set by individual tribal programs.	Two-week in-person course and pre-course web training modules; web-based refresher training every 3 years	Established by employing tribe and/or tribal department; however, CHRs are members of a larger healthcare team	Indian Health Service facilities
CHW	Has a variety of roles in healthcare and social services settings centered around patient outreach, peer counseling, health education, advocacy/navigation, and/or similar duties.	No current professional credential in the state; however, optional DOH training available and state recommendations exist for training and education	Established by employing agency	Healthcare or social service agencies, such as community-based organizations, clinics, hospitals, health centers, schools, etc.

Provider Type	Scope of Practice Details	Education and Training Requirements	Supervision Requirements	Typical Practice Settings
Home Care Aide	Provides personal care services to individuals with disabilities and the elderly in need of long-term, hands-on care.	75 hours DSHS-approved training and must successfully pass the home care aide certification examination	None required by the state; established by employing agency if agency-employed	Patient's home or long-term care facility; may offer transportation services both healthcare related and related to other errands
CNA	Helps patients with activities of daily living and other healthcare needs under the direct supervision of an LPN or RN.	Minimum of 85 hours of training through a state-approved program; pass competency exam	Assists in patient care under the direct supervision of an RN or LPN	Primarily hospitals, clinics, and other healthcare agencies
LPN	Provides nursing care that can include administering medication, treatment, or tests under the direction and supervision of a senior medical professional.	Graduate from a nursing program approved by the state nursing care quality assurance commission and pass the NCLEX-PN	Practices under the direct supervision of an MD, DO, DDS, PA-C, NP, or RN	Primarily hospitals, clinics, and other healthcare agencies
RN	Performs nursing care. Under direction of a physician, may administer medication, treatment, or tests; may delegate to and supervise nursing care by others.	Graduate from commission-approved nursing program and pass NCLEX national nursing exam	Practices under the orders of an MD, DO, DDS, PA-C, or NP; however, specific supervision requirements are set by the employer	Primarily hospitals, clinics, and other healthcare agencies

Provider Type	Scope of Practice Details	Education and Training Requirements	Supervision Requirements	Typical Practice Settings
CHA/P	Offers emergency, acute, chronic, and preventive care in a clinical setting, similar to a nurse. Fully trained CHAPs can store and dispense prescriptions according to their medical standing orders (MSO). CHA/Ps do not need constant direct supervision in order to provide care.	In Alaska, CHA/P certification is a multi-level provider model which includes CHA Trainee (non-certified), CHA levels I, II, and III, and CH Practitioner (CHP). To become a certified CHA or CHP, individuals must participate in four 3-4-week long training sessions interspersed with on-the-job clinical training. In order to achieve full CHP certification through the Community Health Aide Program Certification Board (CHAPCB), individuals must complete a skills list, practicum, clinical skills preceptorship, and examination	CHA/Ps work under the license and supervision of a physician; standing orders may allow the CHA/P to offer treatment without case-by-case consultation.	Must be employed by an IHS facility, a tribe, or a tribal health organization that operates a community health aide program.

Wages and Billing

Table 2. Mean Annual Wages in Washington State

Provider Type	Average Annual Wage May 2016
Traditional Healer	Data not available
IHS CHR	Data not available
CHW	$40,870
Home Care Aide	$28,620
CNA	$30,410
LPN	$53,150
RN	$79,810

It is expected that, just as in Alaska, CHA/Ps will be able to bill at a percentage of the applicable encounter rate. This will be solidified once a formal policy and program are in place in Washington. In Alaska, the CHA/P license allows billing for all services provided within the village as a whole. The Portland Area CHAP expansion project plans to include similar language in the Washington State plan amendment process to enable billing for home- and community-based services. Further state consultation will be needed to determine how this might be accomplished given existing Centers for Medicare & Medicaid Services policy regarding the "four-walls" rule. That rule currently prevents tribal facilities from billing Medicaid for any services provided outside of their physical clinic buildings.

Summary

CHA/Ps' scope of practice overlaps with each of the other providers detailed here to some extent. Fully trained CHA/Ps carry out similar duties to nurses but can also fill in service gaps and outreach needs. CHA/Ps have benefitted Alaska Native communities through their ability to dispense medication under MSOs and can extend clinics' reach through their capacity to conduct home visits, follow-up on referrals, and carry out other big picture case management activities. Similar benefits are expected in both rural and urban clinics in Washington.

In Washington, CHA/Ps will be certified provider type trained through a dedicated education program to be established through a local community and tribal college partnership. This training will exceed what is required for many similar mid-level positions but will not be as extensive as LPN or RN education requirements. CHA/P supervision and continuing education requirements, however, will be similar to that of an RN. CHAP/s can practice in any tribe, tribal health, or IHS facility with a licensed Community Health Aide program. They would therefore largely be operating in the same setting as the other providers featured in the crosswalk. A key distinction is CHA/P's expected ability to provide and bill for home-based and outreach services outside of a clinic building.

Behavioral Health Aide Crosswalk

Like CHA/Ps, BHA/Ps are allied health professionals and community members. They work with supervising mental health professionals at the community level to extend their reach. Some examples of the roles BHA/Ps can fill – in the line with the level of training they've completed – include front office manager/receptionist, admissions and registration or records clerk, mental health and substance use counseling provider, and behavioral health educator.

Provider Types Included in the BHA/P Crosswalk

As with the medical field, there are many providers in the behavioral health field. The following providers were included in this crosswalk due to their relevancy and similarities to BHA/Ps:

- Agency Affiliated Counselor (AAC) (included Certified Peer Counselors)*
- Traditional Healer*
- Certified Counselor
- Chemical Dependency Professional (CDP)
- Chemical Dependency Professional Trainee (CDPT)

*Agency Affiliated Counselors and Traditional Healers are not state-licensed provider types.

BHA/P Crosswalk Table

The table below details the extent to which each provider offers mental health counseling and mental health disorder diagnosis and treatment; provision of substance use counseling and substance use disorder diagnosis and treatment; education and training requirements; and supervision requirements. Following the table, there are sections describing case management services, typical practice settings, and details regarding wages and billing.

Table 3. Existing Provider and Behavioral Health Aide Crosswalk

Provider Type	Provision of Mental Health Services	Substance Use Counseling Services	Education and Training Requirements	Supervision Requirements
Agency Affiliated Counselor	Supports clients related to diagnoses from mental health counselors and other mental health professionals, but does not diagnose or implement treatment plans.	Supports clients related to diagnoses made by CDPs and other chemical dependency professionals, but does not diagnose or implement treatment plans.	No state mandated minimum education or experience required; becoming a Certified Peer Counselor, however, requires peer counselor training and certification.	Set by employing agency or facility.
Traditional Healer	Provides services - usually incorporated into agency services – such as groups, 1:1 meetings, and/or referral.	Provides services - usually incorporated into agency services – such as groups, 1:1 meetings, and/or referral.	N/A	Set by employing agency or facility.
Certified Counselor	Provides mental health counseling services and is authorized to diagnose and treat DSM-5 classified mental health disorders	Does not diagnose or treat substance use disorders; coordinates with and refers to CDP.	Bachelor's degree or higher from accredited program; pass state exam; written supervisory agreement in place; 36 continuing education units (CEUs) every 2 years.	Can practice without the direct supervision of a senior mental health professional but must have a trained clinical supervisor available to consult with.

Provider Type	Provision of Mental Health Services	Substance Use Counseling Services	Education and Training Requirements	Supervision Requirements
CDP	Does not diagnose or treat mental health disorders; coordinates with and refers to mental health counselors in cases of dual mental health and substance use disorder diagnosis.	Provide a full range of substance use counseling services including evaluation, ASAM diagnosis, individual service plan (ISP), individual and group counseling, case management and any referral services based on the diagnosis or ongoing needs.	Associate's degree in human services or related field, or successful completion of 90 quarter or 60 semester college credits in courses from an approved school with a minimum number of credits in CD areas.	Can practice without the direct supervision of a senior mental health professional but must have a clinical supervisor available to consult with who is either a CDP who is trained as a clinical supervisor or a more senior clinician.
CDPT	Does not diagnose or treat mental health disorders; coordinates with and refers to mental health counselors in cases of dual mental health and substance use disorder diagnosis.	Offers the same services as CDPs, consistent with education, training, and experience as documented by the approved supervisor.	Enrolled in an approved school and gaining the experience required to receive a chemical dependency professional certification.	Operates under an approved supervisor (CDP or professional who meets or exceeds CDP qualifications and eligibility standards).

Provider Type	Provision of Mental Health Services	Substance Use Counseling Services	Education and Training Requirements	Supervision Requirements
BHA/P	Provides counseling, health education, and advocacy to help address individual and community-based behavioral health needs, including those related to mental health problems such as grief, depression, suicide, and related issues.	Offers substance abuse assessment and treatment. Can offer counseling services for alcohol, drug & tobacco abuse. Offers rehabilitative services for clients with co-occurring disorders. Can offer quality assurance case reviews.	BHA/P certification is a multi-level provider model which includes BHA Trainee (non-certified), BHA levels I, II, and III, and BH Practitioner (BHP). To become a certified BHA or BHP, individuals must: • Complete Community Health Aide Program Certification Board-specified training, practicum and work experiences • Gain the scope of the Knowledge and Skills Checklist to support them in their job duties • Provide a broad range of services under varying levels of clinical supervision, including general • Maintain their certification by completing continuing education credits	Can only provide services under the clinical supervision of a master's level clinician.

Case Management Services

Agency affiliated/peer counselor, certified counselor, CDP, and CDPT positions – consistent with the individual provider's education, training and experience – can all include case management activities such as making and accessing referrals to legal, family, vocational rehabilitation, parenting, housing, and medical services; liaising with staff at referred agencies; providing transportation to services; and similar functions. However, caseload and competing professional demands can be determining factors in how much time is available for these case management activities. BHA/Ps can offer case management for individuals, elders, and families. Case management can be related to substance abuse and suicide prevention, as well as mental health and physical wellbeing. Because case management is a key BHA/P function and area of focus, there is an opportunity for BHA/Ps to fill in the need for additional case management when other behavioral health staff are not available or have other critical priorities.

Typical Practice Settings

In tribal behavioral health programs and UIHPs, certified counselors, CDP(T)s, traditional healers, and peer counselors typically offer services in outpatient behavioral health settings, inpatient treatment facilities, or integrated clinical and behavioral health centers. In Alaska, BHA/Ps must be employed by an Indian Health Service facility, a tribe, or a tribal health organization that operates a community health aide program. They can provide services outside the clinic, if and when it is clinically appropriate to do so. This is included in the Alaska CHA/P and BHA/P certification, which allows providers to bill for these home- and community-based services. It is expected that these certification and licensure specifics will look similar in Washington. The ability to bill for services outside of the physical clinic location would be a novel and advantageous feature of the CHA/P and BHA/P programs if successfully included in the state plan amendment.

Wages and Billing

Because the bureau of labor statistics (BLS) only reports on a catch-all category of "Substance Abuse, Behavioral Disorder, and Mental Health Counselors," there is not specific data available for the salaries of each profession included in the crosswalk. The annual mean wage in the available BLS category in the May 2016 report was $45,850. Informal data and education and certification requirements suggest that Certified Counselors and CDPs make on average slightly more than this amount, whereas trainees and peer counselors make slightly less. Data are not available on Traditional Healer salaries as these roles are specific to the community, agency, and individual. It is expected that, just as in Alaska, BHA/Ps will be able to bill at a percentage of the applicable encounter rate. This will be solidified once a formal policy and program are in place in Washington. Additional funding sources for BHA/P services are also being considered and sought.

Prevention Specialists

Agencies may have a prevention specialist(s) under a grant from the state. In addition to the providers and services already discussed in this document, prevention activities may also overlap with and complement the BHA/P and CHA/P role. Prevention specialists are not currently state-licensed, but that may change due to the efforts of some agencies. Despite the lack of licensure standards, grants that fund these positions require certain activities to occur and be reported on quarterly. Beyond these required activities, programs can design prevention programs to meet specific local needs and interests.

Summary

BHA/Ps offer counseling and basic mental health support to clients and connect clients with other providers and services. They offer substance use counseling, assessment, and treatment similar to CDP(T)s and can treat clients with co-occurring disorders. Once the Washington CHA and BHA programs and licensing processes are in place, BHA/Ps will be a certified provider type trained through a dedicated education program operated through a local community and tribal college partnership. In Alaska, both CHA/Ps and BHA/Ps attend four 3-4-week training sessions for each certification level and return to practice in their home clinic between sessions to complete required patient contact hours and other duties. Because the Washington education program is being designed as a two-year degree granting program, the on-the-job training specifics will look different. Exact details are not yet available.

BHA/P education and experience requirements will be similar to those of CDPs and certified counselors, with an added emphasis on community and cultural alignment. Agency affiliated/peer counselors and traditional healers obtain training according to employing agency requirements and training opportunities. Traditional healers' training and knowledge are usually obtained from traditional learning, apprenticeship, and ceremony outside of the institutional education or training program setting. CDPT training requirements focus on their work toward the CDP credential, and CDPTS do not have CEU requirements until they are licensed CDPs.

Continuing education requirements for BHA/Ps are also expected to be similar to the established requirements for licensed counselors and CDPs, which include required and optional training topics totaling a minimum number of hours every two years. In Alaska, CHAs and BHAs are required to obtain 48 hours of CEUs every two years once done with all four levels of training.

BHA/Ps will be able to provide services similar to those offered by existing behavioral health providers, with the expected additional flexibility of offering services outside of the counseling or treatment center facility. Both CHA/Ps and BHA/Ps will have a specific billing structure and agency licensure process that will support integration into their employment agency.

Next Steps

- Identify practicing mid-level providers or other individuals who could matriculate into the health aide role
- Launch a demonstration project in September 2019 with a small cohort of students
- Plan, fund, and implement the training education program
- Adapt the Alaska model into a 2-year degree program
- Identify educators and mentors to staff the degree program

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NW TRIBAL JUVENILE JUSTICE ALLIANCE

Danica Love Brown, MSW, CACIII, PhD
Stephanie Craig Rushing, PhD, MPH

TRIBAL-RESEARCHER CAPACITY BUILDING GRANT

- U.S. Department of Justice (DOJ)
- Office of Justice Programs (OJP)
- National Institute of Justice (NIJ)
- Northwest Portland Area Indian Health Board

Planning Grant: Will form a new inter-tribal workgroup
- NW Tribal Juvenile Justice Alliance (NW TJJA)
- **Dates:** 01/01/19 - 06/30/2020

AIM: FACILITATE A STRATEGIC PLANNING PROCESS

While AI/AN youth in the region experience disproportionate rates of juvenile justice involvement, no planning body is presently convening decision-makers to elevate these important health and safety research questions in AI/AN communities.

JUVENILE JUSTICE: A PUBLIC HEALTH ISSUE

Risk Factors:
- Historical trauma
- Poverty
- Victimization and violence
- Mental health and suicide
- Substance abuse and dependency
- HepC and HIV

TABLE 1. SELECTED DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS FOR AI/AN AND THE TOTAL POPULATION IN IDAHO, OREGON, AND WASHINGTON.

	AI/AN	Total population
Median Age (years)	29.8	37.0
Percent of population between 10 and 24 years of age [b]	26.0	20.6
Percent of adults with less than a high school degree	15.6	10.2
Unemployment rate among people 16 years and older	10.8	6.6
Median per capita Income (dollars)	$16,155	$25,925
Poverty rate	27.1	15.5
Childhood poverty rate	31.4	20.5
Percent of households receiving Food Stamp benefits	32.3	15.5
Percent of population without health insurance	23.8	15.6

All data from U.S. Census Bureau 2010-2012 American Community Survey 3-year estimates except: b. 2010 Census American Indian and Alaska Native Summary File.

ESTABLISH TRIBAL-RESEARCHER PARTNERSHIPS TO:

- Identify, test and expand best practices that improve Juvenile Justice systems for Tribes in the Pacific Northwest,
- Ensure that non-Native justice systems are improving life outcomes for AI/AN youth who interact with their services, and
- Build tribal capacity to access and utilize data that support quality improvement at the community-level.

AIMS FOR THE NW TRIBAL JUVENILE JUSTICE ALLIANCE:

AIM 1: Convene, monitor, and support collaborative research and surveillance activities carried out by a network of research partners and community experts, by planning and facilitating 6 regional planning meetings and quarterly NPAIHB Board Meetings.

AIM 2: Support bi-directional communication between research partners, NW Tribes, local tribal governments, OJJDP grantees, topical experts and other regional stakeholders.

AIM 3: Design and submit a DOJ study, aimed to improve Juvenile Justice systems for Tribes and AI/AN youth in the Pacific Northwest.

PARTNERS

The Northwest Portland Area Indian Health Board (lead)

Tribes in the Pacific Northwest (Oregon, Washington, and Idaho)

- Confederated Tribes of the Colville Reservation, WA
- Confederated Tribes of the Umatilla Indian Reservation, OR
- Cowlitz Indian Tribe, WA
- Kootenai Tribe of Idaho, ID
- Confederated Tribes of Warm Springs, OR
- Shoalwater Bay Indian Tribe, WA
- Spokane Tribe of Indians, WA
- Lower Elwha Klallam Tribe, WA
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians, OR

Other member-Tribes of the NPAIHB, during QBM updates

NPC Research (Topical Expert)

State Juvenile Justice Departments in the Pacific Northwest

TIMELINE: 01/01/19 - 06/30/2020

	2019				2020			
Milestones (Lead Organization)	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
NPC MOA and Contract (NPAIHB and NPC)								
Project Kick off – January QBM (NPAIHB Host)								
Identify Juvenile Justice Best Practices (NPAIHB and Tribes) • Best Practices • Research Priorities								
Create and Administer Data Collection Tools (NPC) • Identify Data Sources • Lit. Review, Stakeholder Survey, Key Informant Interviews								
Collaborative Planning Process (NPAIHB) • NW Tribal Juvenile Justice Alliance meetings (N = 6) • NPAIHB Quarterly Board Meetings (N = 4) • NW Native Adolescent Health Alliance meeting (N = 2) • Youth Input: NPAIHB Youth Delegates (N = 2)								
Brainstorm: Study Aims and Study Design (NPAIHB)								
Draft, Review, Finalize and Submit DOJ Study (NPAIHB) • Identify Study: Aims, Methods, Sites, Participants								
Create and Implement Dissemination Plans for Effective Strategies (NPAIHB)								
Report milestones in annual reports (NPAIHB)								
Publications and Presentations (All Partners)								

CREATE AND ADMINISTER DATA COLLECTION TOOLS (WITH NPC) TO:

Identify **Data Sources** that could inform our understanding of Juvenile justice disparities or concerns for our NW Tribes

Identify **Best Practices** & **Research Priorities**:

- Literature Review
- Stakeholder Surveys
- Key Informant Interviews

PLANNING DELIVERABLES

- **Final Research Proposal**
- **Special Report:** Lessons learned, reflections on the process
- **Required Data Sets and Associated Files and Documentation**
- **Publications**

DANICA LOVE BROWN, MSW, PHD

Choctaw Nation of Oklahoma
Northwest Portland Area Indian Health Board
Behavioral Health Manger
503-416-3291
dbrown@npaihb.org

ELDERS COMMITTEE

Tuesday January 22, 2019
Suquamish Clearwater Casino Resort
Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Theresa R. Lehman	Jamestown	Lehman1949@hotmail.com
2	Dan Gleason	Chehalis	
3	[illegible]	Colville	
4	Twila Teeman	Burns Paiute	
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6	Clarice Charging	NPAIHB staff	cchargingnpaihb.org
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Elder Committee Meeting Minutes

January 16, 2018

Embassy Suites by Hilton Airport

Portland, OR

Members: Patty Kinswa – Gaiser, Cowlitz Tribe, Janice Clements-Warm Springs Tribe, Twila Teeman – Burns Paiute Tribe, Louella Azule – Confederated Tribes of The Umatilla Indian Reservation/NPAIHB staff, Andy Joseph – Colville Tribe, Dan Gleason, Chair – Chehalis Tribe

NPAIHB Staff: Clarice Charging

Dan asked Andy for the opening prayer.

Dan asked for a motion to approve October 2017 minutes. Twila motioned. Andy seconded. Motion approved.

Updates:

Burns Paiute: Elders and youth are meeting at the tribal community center and continuing their work with their language project.

Colville: Tribal elders are updating their tribal code and have requested from Washington state their elder code guidelines.

Cowlitz: Elders are working on community gardens at Saint Mary's mission. They are taking trips and working together to build their community.

Chehalis: Classes have been provided to elders on plants, herbal medicines etc. Tribe held a grand opening of their second hotel, Fair Child Marriott. Elders were invited to stay overnight.

Warm Springs: Tribal council are working with elders, several have water and well problems at their residences. Wilson Wewa, Tribal Elder Program Director is applying for grants to secure additional funding for elders.

PUBLIC HEALTH COMMITTEE

Tuesday January 22, 2019
Suquamish Clearwater Casino Resort
Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Heidi Love Jos, Epidemiologist	NPAIHB	
2	Karuna Tirumala Biostatistician	"	
3	Buck Jones	CRITFC	
4	Kela Little	Coquille Indian Tribe	
5	Ali Desautel, HCA	Kalispel Tribe of Indians	
6	Tam Lutz	NPAIHB	
7	Chelsea Jensen	NPAIHB	
8	Andrew Shogren	Suquamish	
9	Victoria Warren-Means	NPAIHB	
10	Bridget Canniff	"	
11	Nora Frank-Buckner	"	
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Northwest Portland Area Indian Health Board
January 2019 Quarterly Board Meeting
Public Health Committee

Attendees: Ali Desautel (Kalispel), Kelle Little (Coquille), Andrew Shogren (Suquamish), Buck Jones (CRITFC)

NPAIHB Staff: Victoria Warren-Mears, Bridget Canniff, Nora Frank-Buckner, Chelsea Jensen, Heidi Lovejoy, Tam Lutz, Karuna Tirumala

Model Tribal Food and Agriculture Code Project, University of Arkansas School of Law, Indigenous Food and Agriculture Initiative

Buck Jones from the Columbia River Inter-Tribal Fish Commission (CRITFC) was invited by WEAVE-Northwest staff to present on a food and agriculture project that he's been involved in. Buck has been active member of NPAIHB's WEAVE-NW Food Sovereignty Coalition, as well as on national efforts.

The Model Tribal Food and Agriculture Code project has been funded since 2015. It came out of a recognition of the need for tribal food codes, to protect tribal sovereignty and prevent jurisdictional confusion and overreach by state and local regulators. The project initially developed to provide food code models for fisheries, and then was approached to roll out this model nationally. There are of course other tribal-specific model codes that have been developed and shared in the past, such as housing codes, probate codes, etc.

The project has produced a 21-chapter publication that outlines different code topics, such as traditional foods and seeds, health and nutrition, land use, bees and honey production, water, agricultural labor, etc. Note that the codes are recommendations and are not comprehensive, but the project would like to continue their work by reaching out to tribes interested in sharing and working on food and agriculture codes. Next steps also include presentations to committee chairs at the ATNI meeting in Portland next week.

WEAVE-NW's Tribal Food Sovereignty Coalition has been looking at strategies for sustainability, including policy work or projects that can be promoted at the national level. The committee agreed that ATNI is a good place to do this. There may be an opportunity to propose a subcommittee under natural resources or health. We should also ensure that AIHC is aware of this effort, and that the tribes weave this into public health modernization work. Andrew Shogren identified the NIH Traditional Foods summit planned for this fall as another opportunity for outreach – for more information about that summit, please contact Andrew at Suquamish.

For more information about the Model Tribal Food and Agriculture Code project, contact Buck Jones at buck@critfc.org or visit their webpage at www.tribalfoodcode.com.

NPAIHB Behavioral Health Committee – Meeting Minutes

Suquamish WA-January 2019

Participants: Vicki Lowe, Darryl Scott, Marilyn Scott, Susan Scheoships, Alan Ham, Tracy Rascon
Staff: Danica Love Brown

- **Introduction and conversation of interest in this committee**
- **Review of October meeting notes**
- **Introduction of Danica Love Brown and the new Behavioral Health Manager position**
    - Danica Asked: What would you like to see form this new position?
        - Newletter/eMARS reports with current information about happenings in NW and Behavioral Health projects
        - To connect with committee members to communicate needs of NW tribes
- **Review of Tribal Opioid Response**
    - Overview of the TOR
    - Committee members shared what their tribes are doing in this area
- **Review of Tribal Juvenile Justice Alliance**
    - Overview of project
    - Opportunities for tribes to be involved
- **2019 LEGISLATIVE AND POLICY REQUESTS**
    - The majority of the meeting was dedicated to discussion about legislative and policy requests, with discussion and networking around tribal needs

Request (What is the ask?)	**Reason (Why?)**
E.g., Ensure that future SAMHSA opioid funding opportunities allow a tribe to address other substance use issues.	E.g., Opioid funding opportunities are too restrictive. AI/AN in many communities are dealing with other substance use issues, not just opioids.
Regional Residential Treatment Centers for youth • Aftercare and transitional living • Substance use and mental health	In Oregon, the only RTC is NARA located in Portland, there is a need to keep and treat

More access to MAT	There are not enough prescribers who have taken the Data Waver training and are able to prescribe MAT
Identify EHR systems	Need for funding assistance for start-up of these systems
CFR-42	There is not clear guidance for tribes how information can be shared across jurisdictions
Training opportunities for mid-level SUD providers	There is a lack of trained providers, and there is a lot of staff turnover.
Trainings and development of peer counselors for SUD	There is a lack of trained peer counselors
BHAP/CHAP Approval	

- **Committee Report on Thursday:** Danica Love Brown

PERSONNEL COMMITTEE

Tuesday January 22, 2019
Suquamish Clearwater Casino Resort
Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Andra Wagner	NPAIHB	awagner@npaihb.org
2	Cassandra Sellards	NPAIHB	csellardsreck@hotmail.com
3	Shawna Gavin	NPAIHB	shawnagavin@npaihb.org
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Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Notes

January, 22 2019

Start Time: 12:00 pm

Members Present: Cassandra Sellards-Reck, Shawna Gavin

Staff Present: Andra Wagner

- Personnel update was reviewed.
    - _6___ new hires
    - _4___ promotion/transfers
    - _2___ temps
    - _0___ resignations
- Clarice Charging received recognition for 15 years with the Board.
- Nora Frank-Buckner won 2018 Employee of the Year
- Staff was trained on Email and Internet Security on January 10th & 16th.

Adjourned at 12:20 p.m.

YOUTH COMMITTEE

Tuesday January 22, 2019
Suquamish Clearwater Casino Resort
Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Shan Stafford PRC	Stillaguamish	SStafford@stillaguamish.com
2	Health Director	Shoalwater Bay	kzellyett@shoalwaterbay-nsn.gov
3	Nicholaus Lewis Council member	Lummi	nicholauslelummi-nsn.gov
4	Sabido Hodges, Charity Cowlitz Health Board	Cowlitz	charity.sabido@gmail.com
5	Sadie Olsen Youth Delagate	Lummi	sadieolsen20@gmail.com
6	Lindsay Pasena-Littlesky Youth delagate	UMCHILLA	lindsaypasena@icloud.com
7	William Lucero Youth Delegate	Lummi	williamlucero74e gmail.com
8	Tona Atchley NPAIHB	NPAIHB	tatchley@npaihb.org
9	Cassandra S Red	NPAIHB / Coulitz Indian Tribe	csellardsreed@hotmail.com
10	Tommy Ghostdog	NPAIHB	
11	Stephanie Craig Rushing	NPAIHB	
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Youth Committee- January QBM

Tuesday January 22, 2019
Suquamish, WA

Attendees (11)

Delegates/Tribal Staff
Shon Stafford (Stillaguamish)
Health Director (Shoalwater Bay)
Nickolaus Lewis (Lummi)
Charity Sabido Hodges (Cowlitz)
Cassandra Sellards Reck (Cowlitz)

Tribal Youth Delegates
William Lucero (Lummi)
Lindsay Pasena Little Sky (Umatilla)
Sadie Olsen (Lummi)

NPAIHB Staff
Tana Atchley-Culbertson
Tommy Ghost Dog
Stephanie Craig Rushing

Youth Delegate Discussion

Tribal Youth Delegates engaged the Youth Committee, sharing updates on the projects they have been working on lately. These included the Resolution for formal recognition by the NPAIHB (which the other Youth Delegates were presenting to the Legislative/Resolution Committee). They also asked for advice on the Bylaws that they are creating as well as their recruitment process for subsequent years.

Legislative & Policy Priorities

A longer discussion took place on the needs that the TYD saw in their communities. Among the issues of concern were: mental health, suicide prevention, and a need for more funding across the board to include youth focused initiatives.

LEGISLATIVE/RESOLUTION COMMITTEE

Tuesday January 22, 2019
Suquamish Clearwater Casino Resort
Suquamish, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Joe Finkbonner	NPAIHB	jfinkbonner@npaihb.org
2	Sue Steward	NPAIHB	SSteward@NPAIHB.org
3	Tino Batt	Shoshone Bannock Tribes	tbatt@sbtribes.com
4	CHERYLE KENNEDY	Confed Tribes Grand Ronde	
5	Greg Abrahamson	Spokane Tribe	Gregabe@aol.com
6	Shawn Stanphill	Cow Creek	SStanphill@cowcreek.com
7	Ray Culbertson	Coalition	Kculbertson@coalition.org
8	Adrian(V) Hart	NPAIB	30007@pendletonsd.org
9	Josiah Spino	NPAIHB	Josiahrspino@icloud.com
10	CHERYL RASAR	SWINOMISH	crasar@swinomish.nsn.us
11	Christina Peters	NPAIHB	cpeters@npaihb.org
12	Dakota Brown	NPAIHB	~~Stanphill@~~ DakotaBrown@Gmail.com
13	Stephanie Craig	NPAIHB	scraig@npaihb.org
14	Gerald Hill Jr	Klamath Tribes	gerald-L-Hill@gmail.com
15	Jeidah DeZurney	NPAIHB	jdezurney@willamette.edu
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Legislative Committee Report
January 22, 2018

Attendees: Tino Batt (Shoshone-Bannock), Cheryle Kennedy (Grande Ronde), Greg Abrahamson (Spokane), Sharon Stanphill (Cow Creek), Kay Culbertson (Cowlitz), Cheryl Rasar (Swinomish), Gerald Hill (Klamath)

Youth delegates: Josiah Spino, Nakota Brown, Adilia Hart, Jeidah DeZurney

Staff: Joe Finkbonner, Laura Platero, Michelle Singer, Sue Steward, Christina Peters, Sarah Sullivan

Four resolutions were considered and acted upon:

1. **We R Native: "How Can Technology Support and AI/AN Adolescent Mental Wellness?"**

   This resolution endorses and supports efforts by staff of the NW Tribal EpiCenter – We R Native – under the guidance of the Executive Director, to pursue funding through the Technology and Adolescent Mental Wellness (TAM) proposal. Executive Committee approved this resolution on December 17, 2018.

   Actions: It was approved by the Executive Committee on December 17, 2018 and required ratification by the full Board. Motion by Klamath; second by Spokane; and unanimous vote to pass the resolution to the Board for ratification.

2. **Advance Appropriations for the Indian Health Service.**

   Under this resolution, the NPAIHB requests that Congress: amend the Indian Health Care improvement Act to authorize Advance Appropriations for the Indian Health Service (IHS); include NPAIHB recommendation for IHS Advance Appropriations in the Budget Resolution; and include in the enacted appropriations bill IHS Advance Appropriations.

   Action: Motion by Spokane; second by Shoshone-Bannock; and unanimous vote to pass the resolution to the Board for consideration.

3. **Request that Affiliated tribes of Northwest Indians (ATNI) Establish a Food Sovereignty Sub-Committee**

   Under this resolution, NPAIHB requests that the Affiliated Tribes of Northwest Indians (ATNI) establish a Food Sovereignty Sub-Committee under the Natural Resources and/or the Health Committee.

Action: Motion by Klamath; second by Colville; and unanimous vote to pass the resolution to the Board for consideration.

4. **FORMAL RECOGNITION OF TRIBAL YOUTH DELEGATE PROGRAM**

Tribal Youth Delegate, Jeidah DeZurney, presented to the Committee on the resolution for NPAIHB support of the Tribal Youth Delegate program. Committee members asked Jeidah about current representatives and age range of youth delegates. Youth Delegates attend two NPAIHB quarterly board meetings per year. Since the July meeting, they have been working on their bylaws and resolution process. Committee members discussed the Youth Delegate's resolution and suggested stronger language in the first resolved clause as to NPAIHB "support."

Under this resolution, NPAIHB supports Tribal Youth Delegate program as the official youth policy body for the Board and its member tribes; and encourages our member tribes to recruit Tribal Youth Delegates to represent their communities to expand involvement of youth in policy development and in setting priorities that address the issues important to their youth populations.

Action: Motion by Colville; second by Spokane; and unanimous vote to pass the resolution to the Board for consideration.

In addition, the Committee considered legislation, appropriations and policy requests for FY 2019 for Board consideration.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Tribe
Cowlitz 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 Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

2121 SW Broadway
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Portland, OR 97201
(503) 228-4185
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RESOLUTION # 19-0201

WE R NATIVE: *"HOW CAN TECHNOLOGY SUPPORT AI/AN ADOLESCENT MENTAL WELLNESS?"*

WHEREAS, the Northwest Portland Area Indian Health Board {hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 uses §450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, to support Native youth, the Northwest Portland Area Indian Health Board launched We R Native in 2012, a holistic health resource for Native youth, by Native youth. The multimedia service includes an interactive website (www.weRnative.org), an Ask Auntie Q&A service, a text message service (text NATIVE to 97779), a YouTube channel, and social media accounts (Facebook, Instagram, Twitter). In 2018, the website received over 124K unique sessions, and the SMS service had over 5,500 subscribers. Altogether, the service reached nearly 31,000 viewers per weeks across its messaging channels. Notably, nearly 20% of WRN's users visited mental health topics on the website; and

WHEREAS, mental wellness is a critical component of adolescent health and wellbeing. AI/AN youth report frequent technology use and poor mental health outcomes, including historical trauma, stress, anxiety, depression, and suicidality. The potential for technology to assist with prevention, identification, and intervention deserves more robust investigation; and

WHEREAS, systematic research is needed to determine which components of We R Native's messaging strategies most effectively promote mental health and wellbeing, gaps that could be filled with additional content. We R Native is authorized to carry out the proposed research aims; and

WHEREAS, the Social Media Adolescent Health Research Team, University of Wisconsin – Madison is eliciting project proposals that

are consistent with the goals and objectives of both the NPAIHB and the NW Tribal Epicenter; and

NOW, THEREFORE, BE IT RESOLVED, that the Board endorses and supports efforts by staff of the NW Tribal Epicenter - We R Native -- under the guidance of the Executive Director, to pursue funding through the Technology and Adolescent Mental Wellness (TAM) proposal.

CERTIFICATION
NO: 19-02-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 4 for, 0 against, 0 abstain on December 17, 2018

Andrew C. Joseph Jr.

Chairman

December 17, 2018

Date

Gregg J. Abrahamson

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Tribe
Cowlitz 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 Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

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RESOLUTION # 19-02-02

ADVANCE APPROPRIATIONS FOR INDIAN HEALTH SERVICE

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 (ISDEAA) (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington ("member tribes"); and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member tribes; and

WHEREAS, the United States has a unique and special relationship with American Indians and Alaska Natives (AI/ANs) to provide health care as established through the U.S. Constitution, Treaties, U.S. Supreme Court decisions and federal legislation; and

WHEREAS, although the trust relationship requires the federal government to provide for the health and welfare of tribal nations, the Indian Health Service (IHS) remains chronically underfunded and American Indians and Alaska Natives (AI/AN) suffer from among the lowest health status nationally; and

WHEREAS, IHS, an agency within the Department of Health and Human Services, administers health care to 2.2 million AI/ANs residing in tribal communities in 35 states, directly, or through contracts or compacts with tribes and tribal organizations under the ISDEAA; and

WHEREAS, in recent years, federal appropriation bills have not been enacted in a timely manner, thus hampering tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts; and

WHEREAS, since Fiscal Year 1998, there has only been one year (FY2006) in which the Interior, Environment and Related Agencies Appropriations bill has been enacted before the beginning of the new fiscal year; and

WHEREAS, the budgetary solution to this failure to uphold the federal trust responsibility, and the one which does not require the Congressional appropriations committees to count Advance Appropriations against their spending cap is Advance Appropriations; and

WHEREAS, the NPAIHB believes that moving to the Advance Appropriations process protects tribes and tribal organizations and the IHS direct service units from cash flow problems that regularly occur at the start of the federal fiscal year due to delays in enactment of annual appropriations legislation; and

WHEREAS, Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle through enactment of the Veterans Health Care Budget Reform and Transparency Act of 2009 (PL 111-81), which authorized Advance Appropriations for Veterans Administration (VA) medical care programs; and

WHEREAS, the IHS should be afforded the same budgetary certainty and protections extended to the VA which is also a federally-funded provider of direct health care; and

NOW THEREFORE BE IT RESOLVED, that the NPAIHB requests that Congress amend the Indian Health Care Improvement Act to authorize Advance Appropriations for the Indian Health Service (IHS); and

BE IT FURTHER RESOLVED, that the NPAIHB requests that Congress include our recommendation for Advance Appropriations for IHS in the Budget Resolution; and

BE IT FURTHER RESOLVED, the NPAIHB requests that Congress include in the enacted appropriations bill Advance Appropriations for IHS.

CERTIFICATION

NO. 19-02-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 26 for, 0 against, 0 abstain on January 24, 2019.

Andrew C. Joseph Jr.

Chairman

January 24, 2019

Date

Gregg J. Abrahamson

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Tribe
Cowlitz 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 Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

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RESOLUTION # 19-02-03

FORMAL RECOGNITION OF TRIBAL YOUTH DELEGATE 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 ("member tribes"; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member tribes; and

WHEREAS, developing leadership skills of our younger populations will provide the opportunity to improve health services and policy in a more inclusive and diverse manner; and

WHEREAS, opportunities for youth to learn about health careers, governance structures, and policy will long term positive effects for Indian communities; and

WHEREAS, engaging our youth in the development of approaches to wellness and solutions to their health issues is more likely to ensure their participation and have better outcomes.

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board recognizes the Tribal Youth Delegate program as the official youth policy body for the Board and its member tribes; and

BE IT FURTHER RESOLVED, the Northwest Portland Area Indian Health Board encourages our member tribes to recruit Tribal Youth Delegates to represent their communities to expand involvement of youth

CERTIFICATION

NO. 19.02.03

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 26 **for,** 0 **against,** 0 **abstain on** January 24**, 2019.**

Andrew C. Joseph Jr.

Chairman

January 24, 2019
Date

Gregg J. Abrahamson

Secretary