Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

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Behavioral Health

Health News & Notes

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Healing of the Canoe

Dennis Donovan
University of Washington, School of Medicine
Director, Alcohol and Drug Abuse Institute
Professor, Psychiatry and Behavioral Sciences

The Healing of the Canoe: Community Pulling Together (http://healingofthecanoe.org/) is a collaborative project between the Suquamish Tribe, the Port Gamble S'Klallam Tribe (PGST), and the University of Washington Alcohol and Drug Abuse Institute (ADAI). It has led to the development and dissemination of the *Culturally Grounded Life Skills for Youth* curriculum, an evidence-based, strengths-based life skills curriculum for Native youth that uses culture to prevent substance abuse and connect youth to their tribal community and culture. It teaches Native youth the skills they need to navigate their life's journey without being pulled off course by alcohol or drugs, using tribal values, traditions, and culture both as a compass to guide them and an anchor to ground them.

The seeds for the project began in 2004 when the director of the Wellness Program of the Suquamish Tribe, which is located across Puget Sound from Seattle, approached ADAI. The community was concerned about increased alcohol and drug use among tribal youth and wanted to know if it would be possible to partner together to develop an intervention to address this problem. As we began to work together with the tribe's Cultural Co-Op, which is tasked by Tribal Council to assure that all programs entering the community are consistent with tribal values and culture, the National Institute on Minority Health and Health Disparities (NIMHD) had a call for proposals for projects utilizing community-based participatory research (CBPR) approaches to address health disparity issues. With a Tribal Council resolution approving the process and with memoranda of understanding and data ownership in place, ADAI and the Suquamish Tribe in

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Chairman's Notes

By Andrew Joseph, Jr.,
Colville Tribal Council
NPAIHB Chair

Hello!
Our people continue to be afflicted with mental illness and substance abuse issues more than any other race/ethnic group in America. This can be blamed on acts of Congress setting policy to coerce us from our traditional ways of living. Loss of our traditional lands where we would gather food and medicines, loss of our languages and traditional practices, displacement of our children into boarding schools, epidemics such as small pox, and other atrocities, have resulted in our people experiencing historical trauma and post traumatic stress disorder through multiple generations. I would call this an American Holocaust. So many of our people have been displaced, disconnected or have forgotten their ways and ceremonies that would give them the pride, energy and resilience to live and be part their communities and tribes.

Those who are hurting use alcohol and drugs to ease the pain which puts their lives in jeopardy and perpetuates the cycle of use and despair. We have developed behavioral health programs to help our people but with inadequate funding, we cannot provide the comprehensive services – prevention to recovery support - that our people need. Many of our people are overdosing or committing suicide due to lack of access to treatment. As a tribal leader, I sit on the Substance Abuse Mental Health Services Administration's Tribal Technical Advisory Committee (SAMSHA TTAC), and, in this role, I advocate for increased funding to tribes and for policy changes to get our traditional ways of healing reimbursed at the same rate as a licensed psychologist. I believe as my elders taught me, "[t]he answer to our healing is how we learn best and who we will listen to." On the coast, we have the canoe families and on my side of the mountains we have the longhouse families. This is where I see the real healing to address the behavioral health issues that afflict our people. I guess you can call this an evidence-based practice because it can cure dual diagnosis patients with both mental health and chemical addiction.

Way lím'límx (Thank you)
Yəx̌ʷyəx̌ʷúɬxn (Badger)

Andrew C. Joseph Jr.
HHS Chair
Colville Tribal Council
NPAIHB Chair
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Nurturing the Mind, Body, and Spirit Through Gardening

By Nanette Star, Nora Frank-Buckner, and Jenine Dankovchik
weave@npaihb.org

Anyone can garden and everyone can receive the gifts that come from the garden.

In recent years, there has been an increased interest in and momentum around improving food systems and how we interact with them. Tribal communities across Indian Country are taking the lead in increasing access to fresh produce and traditional foods through community gardens. There are many benefits to gardening that can improve various aspects of a person's life.

Mind

Gardens help us be aware of the present moment. We can learn when it is time to plant, when it is time to prune, when it is time to wait, and when it is time to harvest. Whether you are a Master or Beginner gardener, or you would rather sit and observe the garden, there is a stillness of thought and an opportunity for healing that comes from being around living plants.

Our lives are often fast paced and overly scheduled. When we stand next to or get the honor of working in a garden, we give ourselves the opportunity to learn about the nature that sustains us. We are given a direct line of interaction with nature.

There are many ways one can find mindfulness. Being in nature provides an opportunity to shift our thinking to the life around us, to the medicine food provides, and to the healing properties of life all around.

Body

Being in an outdoor garden provides the benefit of increasing Vitamin D intake provided by the sun. Whether indoors or out, all gardens provide us with cleaner air and an abundance of oxygen that helps decrease stress and may increase clarity

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Indian Health Update

By: Geoff Strommer
Hobbs, Straus, Dean & Walker LLP

This article briefly discusses some of the critical issues that face Indian health programs in FY 2018, along with updates on a number of other developments, including: an update on FY2018 appropriations; an Indian health legislative outlook as we move into 2018; a report on a favorable decision in the *Redding Rancheria* litigation and the status of proposed CHEF rules; a description of updates to Part 2 Substance Use Disorder Treatment Confidentiality Rules; an update on Section 105(l) lease proposals under the ISDEAA; and an update on new contract support costs developments.

Congress Working to Finalize the FY 2018 Omnibus Appropriations and to Reauthorize Funding for the Special Diabetes Program for Indians (SDPI) and the Children's Health Insurance Program (CHIP)

Once again, as for the last 20 plus years, Congress has relied on Continuing Resolutions (CRs) to avoid a partial government shutdown and to keep federal agencies funded. The current FY 2018 CR was necessary because Congress has not enacted any of the twelve FY 2018 appropriations bills. On December 21, the President signed a Continuing Resolution (PL 115-96) to keep federal agencies funded through January 19, 2018. Funds are, by and large, at FY 2017 levels and conditions. The current CR includes an "anomaly" for the Indian Health Service (IHS) of $12.8 million beyond that requested by the Administration to cover costs of staffing and operating of newly constructed facilities. The current CR funds programs generally at FY 2017 levels, which means that Congress has thus far rejected the Trump Administration's proposed large FY 2018 budget cuts for the IHS and other programs.

It is virtually a foregone conclusion that Congress will not be able to finish writing and pass any of its FY 2018 appropriations bills by January 19, *thus requiring enactment of another CR by January 19*. The major impediment is that congressional Republicans and Democrats have not been able to agree on amending the Budget Control Act to raise the spending caps for discretionary spending for defense and non-defense spending. Democrats are insisting that any statutory increase in the defense discretionary spending cap be accompanied by a like increase for discretionary domestic spending. Should an agreement be reached on raising the spending caps, there will need to be some re-working of House and Senate appropriations bills to distribute any increases. A likely area to realize an increase is the area of opioid abuse prevention and treatment.

An effect of relying on CRs, especially those that run longer than three months, is that it hamstrings agencies from soliciting grant applications, initiating new programs and making other changes – an issue on which the Defense Department is heavily lobbying Congress.

In addition to Congress grappling with FY 2018 appropriations, also hanging in the lurch is authorization and funding for a number of critical health programs, notably SDPI and CHIP. The current CR extends funding through March 31, 2018 for SDPI and CHIP as well as for community health centers.

Other legislation – not enacted – includes a House-approved bill covering CHIP and other health programs to fund SDPI for two years at its current level of $150 million. Also introduced, but not voted on by the House or Senate, are standalone bills to extend SDPI for five years through FY 2024 (HR 2545 and S 747) with annual adjustments for inflation. Those bills have not seen any action.

The CHIP program, which provides health coverage to low-income children and pregnant women whose income exceeds Medicaid eligibility criteria and who have no health insurance, is also grappling with uncertain funding. It appears that Congress has generally agreed to reauthorize CHIP for five years but has not been able to agree on how to offset the costs. The newly signed tax law (PL 115-97) appears to have

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Indian Health Update

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opened the way for the Congressional Budget Office to issue on January 5 a cost projection for CHIP that is significantly lower than the pre-tax bill projection, thus increasing its chances of a five-year extension. CBO projects that CHIP coverage will be lower than the marketplace exchange plan.

Finally, many members of Congress, regardless of political affiliation, are trying to increase funding in the final negotiations on FY 2018 to address the national opioid crisis. A number of federal agencies address opioid issues, including those related to research, prevention, treatment, and law enforcement. The 21st Century Cures Act (PL 114-255) includes funding for states for opioid prevention and response but does not include any direct funding for tribes for this purpose. On December 21, 2107, Senator Daines (R-MT) introduced S. 2270, the Mitigating the Methamphetamine Epidemic and Promoting Tribal Health Act to provide such grant funding to tribes. The bill, which was referred to the Health, Education, Labor and Pensions Committee, would allocate $500,000 specifically for tribes/tribal organizations. The bill provides that a tribe or state may use grants for prevention and treatment of the use of other substances, such as methamphetamines, if they have are having a substantial impact on the tribe or state. Co-sponsors are Senators Merkley (D-OR); Harris (D-CA); Klobuchar (D-MN); Murkowski (R-AK); and Baldwin (D-WI).

Indian Health Legislative Outlook 2018

Indian country breathed a collective sigh of relief when efforts to repeal the Affordable Care Act (ACA) and cap and block-grant the Medicaid program were narrowly defeated last year in the Senate. In the wake of last year's health reform debate, it appears unlikely that Congress will renew efforts to enact comprehensive health reform legislation in 2018. However, many congressional leaders have indicated a willingness to tackle discrete elements of health reform. While a number of such bills have been introduced and are pending in Congress, we believe three of them warrant special consideration.

The first, and most relevant to the Indian health system, is the "Restoring Accountability in the Indian Health Service Act of 2017," which was introduced on May 17, 2017 in both the House and the Senate (H.R. 2662 and S. 1250, respectively). The bill is currently under consideration by the Senate Committee on Indian Affairs, and the House Committees on Natural Resources, Energy and Commerce, Ways and Means, and Oversight and Government Reform. The bill is intended to increase transparency and accountability within the IHS. It provides for improved standards of care, increased congressional oversight of IHS activities, and staff recruitment and retention incentives.

The bill contains several provisions that contain a rule of construction that is intended to exempt contracting or compacting tribes from new requirements imposed on the IHS in the areas of medical credentialing, liability protections for volunteers, and fiscal accountability. As drafted, however, the rule of construction does not achieve that goal, and needs to be amended to simply state that the provisions do not apply to tribal health programs unless a tribe has expressly agreed to them. Congressional leadership has reportedly indicated that it will consider two bi-partisan bills in 2018 that are designed to stabilize the cost of insurance premiums in the individual insurance market: The "Bi-Partisan Healthcare Stabilization Act of 2017" sponsored by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), and the "Lower Premiums through Reinsurance Act of 2017," sponsored by Senators Susan Collins (R-ME) and Bill Nelson (D-FL). Both bills are designed to stabilize the individual insurance market and reduce increases in the cost of the premiums people have to pay in order to obtain coverage. With the repeal of the individual mandate to purchase health insurance by the recent Tax Reform bill, there is concern that premiums may rise significantly if younger healthier people decide to forego coverage.

The Alexander-Murray bill amends Section 1332 of the ACA, which allows States to obtain waivers of certain marketplace requirements in the ACA and design their own rules for the insurance market so long as consumer protections are maintained. The bill would rescind all previous regulations and guidance issued under

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The Opioid Epidemic

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

Every day, more than 90 Americans die after overdosing on opioids.[1] The misuse of and addiction to opioids—including prescription pain relievers, heroin and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.[2]

How did this happen?

In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates. This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive.[3-4] Opioid overdose rates began to increase. In 2015, more than 33,000 Americans died as a result of an opioid overdose, including prescription opioids, heroin, and illicitly manufactured fentanyl, a powerful synthetic opioid.[1] That same year, an estimated 2 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers, and 591,000 suffered from a heroin use disorder (not mutually exclusive).[5] Here is what we know about the opioid crisis:

- Roughly 21 to 29 percent of patients prescribed opioids for chronic pain misuse them.[6]
- Between 8 and 12 percent develop an opioid use disorder.[7-9]
- An estimated 4 to 6 percent who misuse prescription opioids transition to heroin.[7-9]
- About 80 percent of people who use heroin first misused prescription opioids.[7]

This issue has become a public health crisis with devastating consequences including increases in opioid misuse and related overdoses, as well as the rising incidence of neonatal abstinence syndrome due to opioid use and misuse during pregnancy. The increase in injection drug use has also contributed to the spread of infectious diseases including HIV and hepatitis C. As seen throughout the history of medicine, science can be an important part of the solution in resolving such a public health crisis.

What is NPAIHB doing?

In response to the opioid crisis, NPAIHB will be focusing on similar priorities as the U.S. Department of Health and Human Services:

- Improving access to harm reduction, treatment and recovery services.
- Promoting use of overdose-reversing drugs.
- Strengthening our understanding of the epidemic through better public health surveillance.

In order for NPAIHB to work around these priority areas, we have been collaborating with the IHS, CDC, universities and hospitals, and other Tribal Epi Centers and Health Boards. Work thus far includes education and technical assistance for tribes seeking information on harm reduction, treatment and recovery services and overdose reversing drugs; working with both the NW States and CDC to better understand what opioid use looks like for AI/AN people and communities; and conducting a research project to better understand what AI/AN people and communities need and want to address the opioid epidemic. We are currently working on developing a webpage for this material.

What is IHS doing?

CAPT Stephen "Miles" Rudd, MD, Chief Medical Officer and Deputy Director of the Portland Area IHS is chair of the IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE). The IHS HOPE committee's purpose is to:

- Promote appropriate and effective pain management.

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The Opioid Epidemic

- Reduce overdose deaths from heroin and prescription opioid misuse.
- Improve access to culturally appropriate treatment for opioid overuse disorders (OUD).

The HOPE committee has provided training opportunities for IHS clinicians in pain management and treatment of OUD, supported implementation of naloxone programs to reduce overdose deaths, and supported improved perinatal response to opiate use. The committee maintains two websites that host a variety of resources related to pain management and opioid use disorders to support a holistic response to the opioid crisis. The HOPE Committee is currently finalizing an opioid refresher training, a revision of the IHS pain management policy, developing dental acute pain management guidelines, and developing national metrics to assess the effectiveness of these efforts. In partnership with the University of New Mexico, the HOPE committee sponsors a Chronic Pain and Opioid Management TeleECHO Clinic for I/T/U facilities that includes weekly video conference that allows clinicians to consult with experts in pain management, addictions and behavioral health. To find out more about the Chronic Pain and Opioid Management TeleECHO Clinic please visit https://echo.unm.edu/nm-teleecho-clinics/chronic-pain-and-opioid-management/.

For more information, please contact Jessica Leston, jleston@npaihb.org or 907-244-3888

Other resources

Alcohol and Substance Abuse Program:
https://www.ihs.gov/asap/
Pain Management:
https://www.ihs.gov/painmanagement/
Opioid Dependence Management:
https://www.ihs.gov/odm
Methamphetamine and Suicide Prevention Initiative:
https://www.ihs.gov/mspi/
Youth Regional Treatment Centers:
https://www.ihs.gov/yrtc/
Tele-behavioral Health:
https://www.ihs.gov/telebehavioral/

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Off to a Strong Start: We R Native's I-LEAD Youth Development Project

Tana Atchley
I-LEAD Youth Engagement Coordinator
We R Native

The NPAIHB is pleased to announce it is one of thirteen grantees now funded by the Administration for Native Americans through the *Native Youth Initiative for Leadership, Empowerment, and Development* (I-LEAD) Awards.

The I-LEAD project will improve resilience and life skills among Native youth (14-24 years old) living in the Pacific NW, by increasing their participation and success in leadership positions, nurturing school and community engagement, and by helping to prepare them to join the public health workforce. Last year, the Board's Youth Committee recommended the proposed scope of work, wanting to better prepare Native youth to take-on leadership roles with-in and beyond their community.

NPAIHB Youth Council

To fulfill the proposed scope of work, the NPAIHB has partnered with EngenderHealth to create and launch a year-long training program for We R Native's **Youth Ambassadors** and a newly-formed NPAIHB Youth Council. Recruitment for the NPAIHB Youth Council will begin this Spring, and will involve 15+ NW youth, who will meet quarterly to inform health policy decisions under review by the NPAIHB.

We R Native's Youth Ambassador

Building off We R Native's existing Youth Ambassador program, over 100 youth from across Indian Country will be recruited each year to convene monthly, fostering school and community engagement opportunities.

Youth Leadership Trainings

Both sets of trainings will be delivered in-person and using Facebook, text messaging, and Zoom video-conferencing. The sessions will include activities derived from strength-based curricula (including the **Healing of the Canoe** curriculum and **We R Native Teacher's Guide**), promoting coping skills and historical strengths. Throughout the year, participants will use We R Native's communication channels to amplify their voice, promoting healthy social norms in their local communities and beyond.

Text Mentoring

The project is also partnering with Oregon Health and Sciences University and We Are Healers to build an interactive text message-based mentorship platform for AI/AN youth interested in the health professions. Participants will be matched to paid internships and professional mentorship opportunities, and will receive training in research and evaluation methods, community-based participatory research strategies, and data literacy. Interested youth can text "STEM" to 97779, to get involved.

Impact

Youth who participate in We R Native's I-LEAD project will acquire positive work habits and will be better equipped to work in public health service and medical professions.

Want to Learn More? Please reach out to our new I-LEAD Coordinator, Tana Atchley, at: tatchley@npaihb.org

(NW NARCH) Fellow Highlights

By Dr. Tom Becker
NW NARCH & Cancer Project Director

Greetings,
The NW Native American Research Centers for Health (NW NARCH) Fellowship Program is very proud of all of our graduates and we wanted to share a snapshot of some of our groundbreaking Native professionals. This program is designed to assist full-time students pursuing their research-related degrees and the goal is to increase the number of American Indian/Alaska Native (AI/AN) health professionals who are committed and prepared with the biomedical or social service research skills needed to conduct successful research projects.

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(NW NARCH)
Fellow Highlights

The program is funded by the Indian Health Service (IHS) and the National Institutes of Health (NIH) and The Northwest Portland Area Indian Health Board (NPAIHB) administers the grant and is able to provide a limited number of scholarships and fellowships to support research career development and ensure graduates in the field by providing financial assistance, mentorship, and culturally relevant training.

For more information, please contact Dr. Tom Becker, NW NARCH Director tbecker@npaihb.org or Tanya Firemoon, NW NARCH Coordinator tfiremoon@npaihb.org.

Nora Frank-Buckner (Nez Perce and Klamath)
Masters of Public Health: Health Management and Policy – Class of 2017

How did I learn about the NW NARCH Fellowship?
I found out through my supervisor and other coworkers.

Why did I choose my specific degree?
I really enjoy the field of Public Health and I wanted to gain more skills and knowledge around the management and policy side of things because most of my experience has been in health promotion and education.

After graduating, what are my career goals and/or educational goals?
I was recently promoted within my project at the Northwest Portland Area Indian Health Board. I am now a project coordinator and plan to use my education to support our tribal communities with developing and implementing programs or projects that address chronic disease.

How did the NW NARCH fellowship help in furthering my education?
This fellowship helped with easing the financial burden of going back to school.

What would you share with others who are seeking financial assistance?
I would say to keep searching for additional grants and scholarships to help pay for as much of their education as possible. Having student loan debt is not a great graduation present to yourself.

What is Mental Health?

By Kateri Daw,
WeRNative Youth Ambassador

Mental health is very important to me. It is something that more people need to understand. Self-care is important. However, there are ways to make sure you take care of yourself. When I was diagnosed with Generalized Anxiety Disorder I was terrified. I did not understand at the time what it meant to be diagnosed with such a disorder. Over time I started to do more research into the disease and what I could do to lessen the strain on my body. This helped me in the long run. Native youth should pay more attention to their mental health. Not only for understand their bodies, but to understand how to be treated. Mental illness can be scary but there are ways to get the proper treatment. Mental health and Self-care should be a priority.

About the author: Kateri, Navajo (Dine) (NM), helps youth in her community and other communities to succeed by finding hope where it doesn't seem to exist. Through her work with Honoring Native Lives, Kateri was part of the first youth group in the nation to organize a workshop. Although the process was stressful, she helped to create an engaging workshop that she presented in front of over 50 people! Kateri also volunteers helping people with gun safety and suicide prevention. Kateri feels good when she hears from other youth that they aspire to do what she is doing. Using her public speaking skills, Kateri will promote We R Native to other youth. When not volunteering, Kateri plays softball and reads about current events, which will aid her in her goal of becoming a journalist someday. She is a proud Lobo at the University of New Mexico! Keep an eye out for Kateri and We R Native at school, community, and national events this year!

FASD Project 2000-2017

Jacqueline Left Hand Bull
Administrative Officer
Northwest Portland Area
Indian Health Board

The end of 2017 was also the end of 17 years of the NPAIHB project focused on Fetal Alcohol Spectrum Disorder (FASD). We can be pleased about educational efforts aimed at prevention in tribal communities, but just as much as about the effort to improve the lives of those living with an FASD. Over the 17 years, the project conveyed understanding of a wide spectrum of alcohol impact as well as ways to walk with families, educators and community in including all persons with any amount of impacted functioning. "Blaming" was never part of the conversation. Learning how to make spaces that work best, to communicate with the hearer in mind, and even learning from those who may see things with a different lens made the efforts rewarding.

The program had two components. The first was a subcontract with the University of Washington's FADU (Fetal Alcohol and Drug Unit) for intervention with pregnant AI/AN women who were using alcohol, FASD diagnosis services, webinars for service providers and technical assistance. Although certain FASDs may seem apparent, an actual diagnosis is important if the child is to be eligible to receive appropriate specialized approaches to health care and education. The UW FADU is one of the few places in the northwest where such diagnosis can be made. FADU also worked with the court systems through education and advocacy; largely through its efforts, the American Bar Association passed a Resolution asking for acknowledgment of FASD in those who are arrested, and come before the courts.

The second component was subcontracting with two FASD Specialists, Carolyn Hartness, B.A., and Suzie Kuerschner, MEd, in order to provide northwest Tribes a direct consultation with schools, parents/families, health care providers and others regarding prevention as well as diagnostic information and accommodation. Although there were relatively few hours in their annual contracts, they were a resource to Tribal communities, including helping with setting up a "wrap-around" approach to addressing the needs of those living with an FASD. Over time, they developed materials, much of which will continue to be found on the NPAIHB website, and they each continue to be available, directly, to the tribal communities.

Baby Teeth Matter:

Bonnie Bruerd, DrPH,
Northwest Tribal Dental Support Center

Sarah Borgida, *ARCORA*
The Foundation of Delta Dental of Washington

The Northwest Tribal Dental Support Center, in collaboration with the ARCORA Foundation, launched an initiative for Tribal Dental Programs to improve the oral health status of young Native American children 0-5 years of age, with a focus on keeping young children in their Indian Health Service/Tribal dental home for dental care and treatment. The Collaborative seeks to focus on clinic policies and processes, as well as changes in dental care services to provide a sustainable, continuous improvement-based environment for best possible oral health outcomes. The objectives are to 1) increase dental access for children 0-5 years of age with an emphasis on 0-2 year olds, and 2) increase the number of children who receive comprehensive dental care, including preventive care and minimally invasive dentistry at their tribal dental clinic.

This has proven to be a highly successful collaborative. Eighteen of the 36 IHS/tribal dental programs in Oregon, Washington, and Idaho have participated in Baby Teeth Matter. Dental access for 0-5-year olds

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Baby Teeth Matter: Tribal Oral Health Collaborative

increased among all participating dental programs. Nine of the 13 clinics currently involved doubled their dental access during the first year of participation. Most dental programs decreased referrals to outside care at least 15 percent during he first year of participation, while 5 dental programs cut their referrals by more than half. Overall, 83 percent of participating dental programs had a referral rate less than 11 percent one year after joining the program.

The Northwest Tribal Dental Support Center and ARCORA Foundation are excited to engage even more IHS/tribal dental programs in Baby Teeth Matter and to share the Collaborative's strategies, best practices, and results nationally.

Nurturing the Mind, Body, and Spirit Through Gardening

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of thought. Gardening also provides physical exercise by moving the body when digging or planting, walking around the yard or greenhouse and stretching to reach those hard to get plants.

Spirit

There is an exchange that happens in the garden; it is personal and different for everyone. This may be settling your thoughts and connecting you with the Creator or it may be finding a purpose in serving your community and feeding your family.

Community

At the community-level, many tribal programs now have gardens for their members to use at their leisure. Much of the success comes from community volunteers, youth, and elders. In addition, many of the tribal gardens have formed partnerships between various tribal departments, such as family services, health and wellness, behavioral health, education, natural resources, and with other local partners like farms and grocery stores. These partnerships ensure sustainability and support. Intergenerational bonds are strengthened as elders and youth are given a space to share knowledge, pass along stories, and sustain culture.

"Working in the garden has helped me with my recovery. Putting my hands in the soil has been a healing experience." – Northwest Tribal Member

Response Circles is Back

By Colbie Caughlan, MPH

Federal data indicate that one in every three AI/AN women (34%) will have been raped in their lifetime, and close to 40% of Native women will experience intimate partner violence in their lifetime. While there are no comparable data for AI/ANs living in the Pacific Northwest, this national perspective reflects our NW experience, and has prompted the Northwest Portland Area Indian Health Board (NPAIHB) to continue to seek tools and resources to enhance culturally-relevant domestic and sexual violence prevention services for its member tribes as it did in 2010 when staff applied for the first Indian Health Service's (IHS) Domestic Violence Prevention Initiative (DVPI) opportunity.

The *Response Circles* Domestic and Sexual Violence Prevention Project, originated as an NPAIHB program from August 2010 to September 2015 with the DVPI funds. Now, two years later, the NPAIHB is happy to announce that DVPI funding for *Response Circles* has been awarded again! This funding is a three year cycle that began September 30, 2017 and will run through September 29, 2020; the project will address *Purpose Area 1: Domestic and Sexual Violence Prevention, Advocacy, and Coordinated Community Responses.* The *Response Circles* project will:

- Foster coordination and collaboration among DVPI service providers in the Pacific Northwest, by hosting regional Zoom webinars highlighting model programs and services (the first one is on January 29, 2018 from 10-11AM PST)

- Provide technical assistance Northwest tribes, improving their ability to carry out crisis intervention, counseling, advocacy, behavioral health, or case management services, and their prevention and intervention policies and protocols

- Provide training and travel scholarships to AI/AN medical professionals, first responders, and prevention staff who would like to attend regional trainings, meetings or conferences related to DVPI objectives

- Increase community awareness about domestic and sexual violence services, by disseminating the nationally-recognized, IHS-endorsed social marketing campaigns: *My Body, My Mind, My Spirit are Sacred* and *What is Done to One is Felt by All*

- Host one Social Marketing Bootcamp Training per year to design a youth-led marketing campaign that will be delivered nationally through www.weRnative.org

Collectively, this work will help build and maintain close working relationships with DVPI stakeholders in the region, and will inform the NPAIHB about new prevention strategies and intervention resources available to our NW tribes. Please check out our updated website at: http://www.npaihb.org/sexual-assault-prevention-project/.

With the new *Response Circles* project, there is only one former objective that is no longer being directly carried out. The 2010-2015 project established a baseline of reported sexual assault for tribal communities who participated and although this is not a current objective for the 2017-2020 project, staff can help provide assistance to any NW Tribe who has interest in establishing their own baseline. Please contact project staff at ccaughlan@npaihb.org and enewcomb@npaihb.org to connect about this.

Regroup Therapy

Forest County Potawatomi Partners with Regroup Therapy to Improve Access to Behavioral Health Clinicians through Telepsychiatry Services.

"We struggled to meet one of our highest priorities for our Tribal community: access to quality care. By using providers from Regroup our Tribal members are able to get appointments quickly and have begun building strong relationships with their providers that will build a foundation that I foresee as our future."

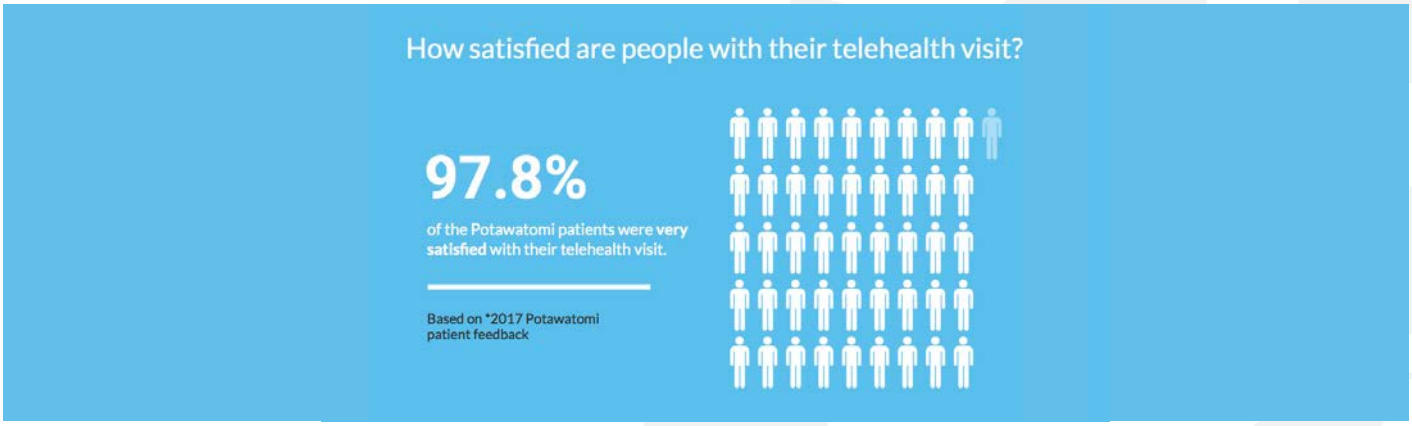
Julie Beeney, Interim Director Health Division and Clinical Services Administrator, Forest County Potawatomi

Background

Regroup Therapy's mission is to ensure that anyone in need of mental health care can access a clinically-appropriate, high quality behavioral health provider, regardless of where they live. Due to their tribal population's rural location, the Forest County Potawatomi community has experienced difficulty in recruiting culturally-sensitive clinicians for their tribal and local populations. Forest County Potawatomi ("Potawatomi") partnered with Regroup Therapy to use telepsychiatry to improve access to high-quality clinicians, including psychiatrists, advanced practice nurses and licensed clinical social workers.

Challenges

The nationwide shortage of psychiatrists, child and adolescent psychiatrists, psychologists and psychiatric nurse practitioners is compounded within Indian country, as it is especially difficult for entities that are serving populations with layers of intergenerational historical trauma, substance abuse, and suicide crises. Potawatomi staff were experiencing extreme difficulty in recruiting a high-quality adult psychiatrist, as a position had remained open for over six months. Referring patients to behavioral health providers outside of their facility was proving to be tremendously inconvenient for patients with travel times as long as two to three hours in each direction.



Regroup Therapy

Collaborative Solution

After speaking to the Regroup Therapy partnerships and clinical teams, Forest County Potawatomi partnered with Regroup Therapy to provide integrated telepsychiatry into their wellness clinic. Regroup Therapy clinicians are able to chart remotely into Potwawatomi's local EMR, which allows for close collaboration with local care teams and has resulted in high patient satisfaction. Potawatomi originally contracted for psychiatry and therapy services and are expanding to include psychological testing. They have seen improved, immediate and full-spectrum mental health services available for their patients.

Results

Potawatomi originally partnered with Regroup Therapy to provide an APN (advanced practice nurse) for 7 hours a week, and a psychiatrist for 25 hours a week, and then expanded to include a LCSW (licensed clinical social worker) for 24 hours a week. The results of integrating behavioral health services into its primary care setting has been positively received by the Potawatomi tribal community with reduced wait times, travel time, and increased patient engagement.

Interested in learning more about Regroup Therapy?
Reach out to naveen@regrouptherapy.com to hear more about serving your patient population's behavioral health needs today.

WWW.REGROUPTHERAPY.COM | INFO@REGROUPTHERAPY.COM | 4525 N. RAVENSWOOD AVE. SUITE 201 CHICAGO, IL 60640

Healing of the Canoe: A Culturally Tailored Substance Abuse Prevention Program for Native American Youth

continued from cover page

partnership submitted a proposal in April, 2005. Our proposal was one of 25 that was funded in this portfolio of CBPR grants, and one of only 3 dealing with American Indian/Alaska Native issues.

The overall NIMHD grant program was broken into three phases, all of which required evidence of progress and the submission of a competing application to continue from one phase to the next. Phase 1 was 3-years and was to focus on community engagement, needs/resources assessment, and intervention development. Using a CBPR approach and working with the Suquamish Cultural Co-Op as our community advisory board (CAB), the combined ADAI and Suquamish research teams conducted a community needs and resources assessment, based on key stakeholder interviews and focus groups with elders, youth, social service providers, and community members. The assessment once again identified youth substance use/abuse as a major community concern. It also indicated a strong sentiment that a major contributor to the substance use/abuse problem was that youth had drifted away from their tribal values, traditions, and culture. It was felt that any intervention to address the alcohol and drug use would need to reconnect youth to their cultural roots. Tribal elders, families, and traditions were seen as resources that could be used in this "reconnection" process.

At the same time, a major source of cultural resurgence in the Pacific Northwest was (and still is) the traditional canoe journey, initiated with the Paddle to Seattle in 1989. Each summer tribal canoes throughout the Salish Sea journey to a hosting community, stopping at communities along the way to share food, song, dance, and gifting. It is a period meant to be alcohol and drug free and a time in which tradition and culture are shared and reinforced. The canoe journey became the metaphorical vehicle chosen by the team through which to address the youth alcohol and drug problem. Colleagues at the University of Washington, in collaboration with the Seattle Indian Health Board, had developed the *Canoe Journey, Life's Journey* curriculum for use with urban Indian youth from multiple tribes. Working with a curriculum adaptation team composed of members of the Cultural Co-Op, the Suquamish community, and our research teams, this pan-Indian curriculum was adapted and made Suquamish tribal-specific, resulting in its own tribal Healing of the canoe curriculum named *Holding Up Our Youth*. The curriculum, as originally developed, consists of 11 modules, each of which includes focus on evidence-based, protective, and positive youth development social skills embedded in tribal traditions, values, and activities. An honoring ceremony celebrates the youth's achievements and they, in turn, honor mentors who have helped them. The curriculum was pilot tested with middle-school tribal youth in both summer school and an after school settings; it was found to be feasible to administer and acceptable to youth, their parents, and the community. The completion of Phase 1 was capped by our project being selected as one of 12 projects that best exemplified the principles of community engagement in a book on CBPR and community engagement.

We successfully competed and were funded for the 5-year Phase 2. During this time we focused on three main tasks. First, with the opening of a new Suquamish tribal high school, our CAB wanted the age focus to be shifted from middle-school, to high-school students. This required considerable modification of the curriculum, moving from

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Healing of the Canoe: A Culturally Tailored Substance Abuse Prevention Program for Native American Youth

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an 11-session intervention to an academic year-long class. Our tribal facilitators worked extensively with the new tribal school and were successful. Students were able to earn both high school credit and Running Start credits from the local community college for completion of the class. Second, we began working in partnership with the Port Gamble S'Klallam Tribe. PGST is only about 12 miles by car but 29 mikes by canoe from Suquamish; however, they are very different tribal communities with different native language and different reservation configurations. We wanted to examine the generalizability of the curriculum adaptation process with a different tribe and felt that the differences between Suquamish and PGST would provide a good test. Working with the PGST Chi-e-chee community advisory group and a community-based adaptation group, the *Navigating Life the S'Klallam Way* curriculum was developed, making it unique to Port Gamble S'Klallam traditions, values, and culture. Third, the Suquamish and PGST curricula were evaluated as delivered in three 2-1/2 day off-reservation intensive workshop retreats. Results indicated that youth who had attended the retreats, compared to those who had not yet attended, were less likely to be using substances, were more engaged in tribal traditions and activities, and had more positive future hope and optimism.

Phase 3, was meant to be a 3-year period (although we have been able to extend it to 5 years) to disseminate information about and help tribal communities implement the curricula. However, the canoe journey does not fit all tribal communities and the curricula developed by Suquamish and PGST are specific to their tribes and their unique traditions, values, and cultures. Given this, we developed a generic curriculum, *Culturally Grounded Life Skills for Youth*; it continues to present the evidence-based social skills while having "place holders" so tribes can adapt this generic template to fit their own communities' traditions and a better fitting metaphor. The curriculum has been expanded in collaboration with the Northwest Portland Area Health Board's THRIVE project to now also include two suicide prevention modules. Our team has been actively engaged in the dissemination process, conducting face-to-face trainings, which provide an overview of curriculum content and focus on community engagement, adaptation, implementation, and evaluation; these trainings are followed by ongoing technical assistance calls. To date we have trained a total of 350 attendees from 46 tribes and 14 tribal organizations from as far east as upper New York state, as far north as Fairbanks, as far south as Coos Bay, and as far west as Neah Bay. We have mostly shifted from hosting our own grant-supported trainings to providing training to communities and organizations when invited to do so. Training and technical assistance has also now been incorporated into trainings offered by the Northwest Addiction Technology Transfer Center (NWATTC) housed at the Alcohol and Drug Abuse Institute.

The generic curriculum template, the training manual, and all supporting materials are available on the Healthy Native Youth webpage
https://healthynativeyouth.worldsecuresystems.com/curricula/The-Healing-of-the-Canoe

With funds from the SAMHSA Garrett Lee Smith Youth Suicide Prevention Grant, the NPAIHB's suicide prevention project – THRIVE, has been able to support 4 NW Tribes (and counting) with their implementation of the HOC curriculum in their communities.

Indian Health Update

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Section 1332, and allow new waivers to remain in effect for 6 years with unlimited renewals of additional 6-year periods. It would allow States to create invisible risk pools, which are mechanisms designed to provide additional resources to keep costs down for individuals with significant and costly health needs. It would streamline the waiver approval process and increase resources for outreach and enrollment. It would give states significantly more flexibility to regulate their insurance markets, but also contains stopgaps that require states to provide plans and cost-sharing protections that are of "comparable affordability."

The Collins-Nelson bill would also amend Section 1332 of the ACA to set aside $4.5 billion ($2.25 billion annually) for fiscal years 2018 and 2019 to assist states in establishing these programs. Four types of programs would qualify for funding: (i) an invisible high-risk pool; (ii) a reinsurance program that operates "in a manner substantially similar" to those under section 1341 [i.e., the transitional reinsurance program]; (iii) a new reinsurance program; and (iv) a program based on another State's reinsurance program. The bill's goal is to reduce insurance premiums by partially or fully reimbursing insurers for the costs associated with high-cost claims.

Favorable Court Decision on CHEF and Tribal Self-Insurance

In November, 2017, the U.S. District Court for the District of Columbia issued a decision in favor of a tribal health care program in *Redding Rancheria v. Hargan*, No. 14-2035 (D.D.C. Nov. 7, 2017). The case was filed by the Redding Rancheria after the IHS rejected a contract proposal intended to clarify interaction of the Catastrophic Health Emergency Fund (CHEF) with the Tribe's tribal self-insurance plan, which Redding uses to supplement its Purchased/Referred Care (PRC) program. The IHS denied several CHEF claims submitted by Redding, in part on the grounds that the IHS considers the Tribe's self-insurance plan to be an "alternate resource" that the IHS believes should have paid for the care. The IHS also rejected a compact amendment proposed by Redding to clarify that the Tribe has a right to coordinate care between its PRC and tribal self-insurance programs without impacting its eligibility for CHEF coverage. Redding filed suit under the Indian Self-Determination and Education Assistance Act, alleging that the IHS's actions violated Redding's compact and the Act, as well as the IHS's own Indian Health Manual on PRC and tribal self-insurance plans.

In the *Redding* case, IHS maintained that under the agency's payer of last resort regulations at 42 C.F.R. § 136.61, tribal self-insurance plans had always qualified as alternate resources that must pay before CHEF funding would be available, because there was no regulatory exception for such plans. The IHS admitted that the agency historically made a "policy-based exception" to those regulations, exempting tribal self-insurance plans from the payer of last resort provision through guidance in the Indian Health Manual, but that the "policy-based exception" was invalidated by the payer of last resort rule that was enacted as Section 2901(b) of the Affordable Care Act (ACA) in 2010, codified at 25 U.S.C. § 1623(b).

While the case was underway—in January, 2016—IHS also published a proposed rule governing administration of CHEF to replace the IHS's existing internal CHEF guidelines. 81 Fed. Reg. 4239 (Jan. 26, 2016). That proposed rule would have defined "alternate resources" to include any "Federal, State, *Tribal*, local, or private source of reimbursement for which the patient is eligible… [including] *Tribal* or local health care programs … *and private insurance.*" The preamble to the proposed rule explained that IHS considers such "private insurance" to include Tribal self-insured plans. The IHS was also taking steps to revise and update its Indian Health Manual related to PRC, and proposed to redefine "alternate resources" to include tribal self-insurance plans. At the request of several tribes and tribal entities, like the Tribal Self-Governance Advisory Committee, the IHS agreed not to publish final CHEF regulations until after the *Redding* case was resolved, but did not made the same commitment for its PRC Manual, though any changes to the Manual on PRC have yet to be finalized.

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Indian Health Update

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This past November, 2017, the District Court issued its decision in the *Redding* case and rejected the IHS's arguments, ruling as follows: (1) tribal self-insurance plans are "health programs" operated by tribes/tribal organizations within the meaning of the payer of last resort language in Section 2901(b) of the ACA, and thus themselves have payer of last resort status under that provision, and (2) IHS cannot treat those plans as alternate resources for purposes of CHEF, nor for the underlying PRC program, without specific written permission of the Tribe. The Court remanded the case to IHS for re-consideration of Redding's CHEF applications, stating: "As this opinion makes clear, the Tribe's reimbursement requests were valid [PRC] obligations that warrant consideration by IHS." It remains to be seen at this point in time what decisions the IHS will make on the Redding Rancheria's CHEF claims, and what steps IHS intends to take with respect to its Manual and the proposed CHEF regulations.

New Updates to Part 2 Substance Use Disorder Treatment Confidentiality Rules

Last year the Substance Abuse and Mental Health Services Administration (SAMHSA) significantly revised the regulations governing the confidentiality of substance use disorder patient records, which are found at 42 C.F.R. Part 2. Those changes, which updated terminology and significantly revised the consent form requirements, among other changes, became effective on March 21, 2017.

On January 3, 2018, SAMHSA issued a second round of changes to the Part 2 regulations, specifically to correct a couple of typographical errors; to allow any lawful holder of patient information (i.e., "any person or category of persons identified or generally designated in the [patient's written] consent") to further disclose minimal information to their contractors, subcontractors and legal representatives as necessary for them to carry out payment and health care operations purposes on the lawful holder's behalf; and to update the rules governing use of information for audit and evaluation reasons. SAMHSA also added a new option for the notice to accompany disclosures, so that the longer statement previously required by the regulations (as updated last year) could be replaced with this simple statement: "42 CFR part 2 prohibits unauthorized disclosure of these records." While this shorter notice may be used in any instance when the notice is required by the Part 2 regulations, SAMHSA made this change mainly for the purpose of addressing concerns that the longer notice does not fit into free text fields in most electronic health records systems. These changes become effective as of February 2, 2018.

In revising the regulations to allow lawful holders of substance use disorder treatment information to redisclose a minimum amount of such information for payment and health care operations purposes pursuant to patient consent, Part 2 now requires specific contract provisions to be included in the contracts between the lawful holders and their contractors, subcontractors and legal representatives. Such contracts must be brought up to date and meet the new regulatory requirements no later than February 2, 2020.

SAMHSA rejected calls for improved alignment with HIPAA for the time being, but promised to give that additional consideration in the future. SAMHSA also specifically declined to allow sharing of substance use treatment information without patient consent for care coordination and case management purposes—that still requires patient consent.

SAMHSA sent out a "Dear Tribal Leader" letter dated December 28, 2017, announcing a virtual tribal consultation on Monday, January 22, 2018 from 11:30am-1pm PST on the proposed revisions to 42 CFR Part 2. The link to register for this Consultation is https://part2-tribal-consultation.eventbrite.com.

SAMHSA will also be convening a meeting of "relevant stakeholders" sometime before March 21, 2018, pursuant to the "21st Century Cures Act," in order to consider the effects of Part 2 on patient care, health outcomes and patient privacy. The result of that meeting could trigger additional changes to the Part 2 regulations in the near future.

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Indian Health Update

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Update on Section 105(l) Lease Proposals

The 2016 court decision in *Maniilaq Association v. Burwell* established the right of tribes and tribal organizations to propose, and be fully compensated for, a lease under section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA). A facility is eligible for a 105(l) lease if (1) the tribe or tribal organization owns or has a leasehold or trust interest in it; and (2) the facility is used to administer or deliver services under the ISDEAA. Such leases often result in significant increases in facilities funding.

Since the *Maniilaq* decision, IHS has negotiated and entered dozens of section 105(l) leases. By the end of FY 2017, IHS reported 35 lease agreements and proposals totaling $6,625,000. This amount can be expected to grow as familiarity with this funding mechanism spreads. In FY 2017, IHS paid its 105(l) lease obligations from a special $11 million appropriation for "operational costs of tribal clinics operated under an [ISDEAA] compact or contract." Some of these funds were also used to supplement Village Built Clinics funding in Alaska. If 105(l) leasing continues to expand, it is not clear where the funding will come from.

In its proposed FY 2018 budget language, the Trump Administration sought to make funding for 105(*l*) leases entirely up to the discretion of the Secretary, essentially nullifying the provision. Thankfully, Congress has ignored this proposal so far in its draft spending bills. As discussed above, however, no final FY 2018 spending bill has been enacted as of yet.

Contract Support Cost Issues Heat Up—Again

With revised contract support cost (CSC) policies in place and litigation winding down, the last year or so has been relatively quiet on the CSC front. Late last month, however, the Indian Health Service (IHS) ruffled that calm by abruptly revoking a key provision of its CSC Policy. Below we briefly describe the policy change and update you on a court case involving CSC for third-party-revenue-funded services.

In a "Dear Tribal Leader" letter dated December 21, 2017, IHS announced its unilateral decision to revoke, at least temporarily, a provision tribes and IHS had spent months negotiating before the new CSC policy was finalized in October of 2016. The policy allows IHS, under certain circumstances, to review a tribe's funding to ensure no duplication exists between indirect CSC and the "Secretarial" or program amount for service unit shares. The rescinded provision gave tribes the right to opt for a default "97/3" split in which 97% of the service unit shares is deemed program funding and 3% indirect-cost funding duplicative of CSC. Otherwise, the parties would conduct a costly line-by-line analysis. Modeled on the familiar 80/20 split for Area and Headquarters tribal shares, the 97/3 option provides a reasonable and efficient estimate and is popular with tribes. On January 3, Andy Joseph, NPAIHB Chairman and Tribal Co-Chair of the IHS CSC Workgroup, submitted a letter to IHS strongly condemning IHS's unilateral policy change. The letter pointed out that the parties agreed that the policy would be amended only after tribal consultation, and that IHS's action "disregards the bargain struck in government-to-government negotiations." The letter, which has been well received by tribal leaders and advocates across the country, called on IHS to reverse itself and implement the policy as written, including the 97/3 option, throughout the consultation process.

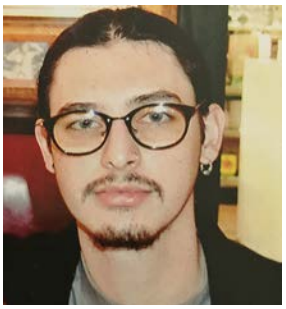
An important court ruling on CSC could soon be put to a federal appeals court. In *Navajo Health Foundation—Sage Memorial Hospital, Inc. v. Burwell*, the district court in New Mexico ruled that health care services provided under agreements with IHS but funded by third-party revenues—such as Medicare, Medicaid, and private insurance—are "Secretarial" funds that generate CSC just like IHS-appropriated funds. The court also sided with the hospital on how to interpret a provision of the Indian Self-Determination Act prohibiting duplication of funding. On January 3, 2018, the parties asked the court to issue final judgment in favor of Sage Memorial on its CSC claims, which would pave the way for IHS to appeal the decision to the Tenth Circuit Court of Appeals. IHS is expected to do just that. If the ruling stands, it could greatly expand the agency's CSC requirements.

New NPAIHB Members!

Tana Atchley is a citizen of the Klamath Tribes and is of Modoc, Paiute, and Karuk descent. She was raised in Sprague River, OR and graduated from Chiloquin Jr/Sr High School. She completed her undergraduate work at the University of Oregon and went to graduate school at Oregon State University. As a first generation college graduate, helping Native students get into and be successful in college has been a core component of her professional career. Tana has worked in higher education at colleges and universities throughout Oregon and at tribal organizations where she has focused on increasing the number of tribal members who pursue a college education, with an emphasis on Science, Technology, Engineering & Math (STEM).

Tana recently joined the NPAIHB as the Youth Engagement Coordinator with the I-LEAD Youth Engagement project. Her primary responsibility will be to support the goals and objectives for our new Native Youth Initiative for Leadership, Empowerment, and Development (I-LEAD) grant. The goal of the 3-year project is to improve resilience and life skills among AI/AN youth (14 to 24 years-old) by increasing their participation and success in leadership positions and by preparing them to join the public health workforce. Tana looks forward to working with the member tribes and connecting with the Youth Council!

Danica Brown is an enrolled member of the Choctaw Nation of Oklahoma. She has accepted the position of Health Communications Coordinator and her primary responsibility will be to support the goals and objectives for two new grants: A CDC Communicating with Youth to Prevent HIV, Other STIs, and Pregnancy: Identifying Key Messages, Messengers, and Communication Channels grant and an IHS Sexual Health Dissemination & Implementation grant. Danica was a NARCH fellow for several years and is soon to complete her doctoral degree in the School of Social Work at PSU. She has a fascinating dissertation project, and I recommend that you ask her about it. Some of you may have met Danica at Summer Institute last year, when she gave us a presentation on her dissertation topic. She is experienced in curriculum development, giving presentations and working with youth.



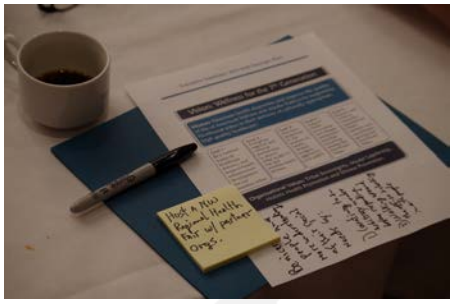
Ethan Newcomb is an enrolled member of the Confederated Tribe of Siletz Indians. He accepted the position as a project assistant for WEAVE and Response Circles. His interest in technology, social media, and art led him to this position where he feels he can apply his skills and have a positive impact in tribal communities.

Joshua Smith is an enrolled member of the Klamath Tribe. He accepted the position of NWTEC Health Communications Specialist. In this position, he will be responsible for developing and coordinating public health messaging and communication products and strategies for our EpiCenter. Joshua recently moved from Seattle where he worked as a Project Coordinator for UIHI (Urban Indian Health Institute). At UIHI, he was involved with innovating the way they presented health data in order to increase accessibility and understanding to laypeople.

Happy New Year!

NPAIHB Staff Pic

Staff Retreat Oct. 2017
Revisiting the Strategic plan



JANUARY

January 22-25
ATNI Winter Convention 2018
Portland, OR

FEBRUARY

February 6-8
WTDP national DMS training
Portland, OR

February 12-15
National Congress of American Indians Executive Council Winter Session
Washington, DC

February 13-14
IHS Direct Service Tribes Advisory Committee
Arlington, VA

February 21-22
Tribal Leaders Diabetes Committee Meeting
Division of Diabetes Treatment and Prevention, IHS

February 21-22
RPMS EHR for HIM Clinical Documentation Improvement training
Portland, OR

Upcoming Events

MARCH

March 6-8
WTDP DMS training
Portland, OR

March 27-28
Tribal Self-Govnerance Secon Quarterly Meeting
Washington, DC

March 29-30
NW Tribal Regional Diabetes Conference
Portland, OR

APRIL

April 3-4
Centers for Medicare &Medicaid Services ITU Outreach & Education Event
Seattle, WA

April 15-18
36th Annual Protecting Our Children
Anchorage, Alaska

April 17-19
NPAIHB Quarterly Board Meetings
Pendleton, OR

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

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

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

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

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OCTOBER 2017 RESOLUTIONS

RESOLUTION #18-01-02
NWTEC OHSU SEPA 2017

RESOLUTION #18-01-03
Addressing Suicide Research Gaps Understanding Mortality Outcomes

RESOLUTION #18-01-04
Urging AMA to Adopt a Policy Statement on ACE and Toxic Stress

RESOLUTION #18-01-05
Collaborative Minority Health and Health Disparities Research with Tribal Epidemiology Centers