



National Indian Health Board

Health Reporter

Fall 2015

ACA Training on the Road: Targeting Denver and Albuquerque Areas



► In March and April 2015, the National Indian Health Board’s (NIHB) Tribal Health Reform Team along with the National Indian Health Outreach and Education (NIHOE) National Partners – the National Congress of American Indians and the National Council of Urban Indian Health (NCUIH) – traveled to Denver, Colorado and Albuquerque, New Mexico respectively, to provide Affordable Care Act (ACA) training on the American Indian and Alaska Native (AI/AN) special protections to Tribes in the areas.

In Denver, NIHB partnered with the Denver Indian Health and Family Services to host two ACA trainings – one for non-Native enrollment assistors helping Tribal members through the Health Insurance Marketplace application process and the second specifically for Tribal members wanting to learn more about their health insurance options, either through the Marketplace, Medicaid or the Children’s Health Insurance Program (CHIP). Both trainings were held at the Denver Indian Center on March 19, 2015.

One non-Native Navigator training attendee said she now has a better understanding of an underserved demographic, and the AI/AN benefits is a good resource to have when helping Tribal members enrollment in the Marketplace.

The NIHOE National Partners and DIHFS volunteers set up an ACA outreach and education exhibit booth at the Denver March PowWow, which showcased the NIHB’s ACA Elder and Youth Toolkits, Centers for Medicare and Medicaid Services (CMS) brochures and information specific for Tribal members living in Colorado. The PowWow is held at

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Senate Committee on Indian Affairs Examines the Issues of Suicide, Alcohol, and Drug Abuse in Indian Country



► This summer, The Senate Committee on Indian Affairs has held two hearings on critical topics relating to Indian health – suicide and alcohol and drug abuse. On June 24, 2015, the Committee held a hearing called “Demanding Results to End Native Youth Suicides” a little over a month later the committee examined on July 29, 2015 “The True Costs of Alcohol and Drug Abuse in Native Communities.” In both cases the National Indian Health Board (NIHB) submitted testimony for the record, and worked with Committee staff as they developed the hearings.

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From the Chairperson

Dear Indian Country Friends and Advocates,

► After a productive and eventful summer, NIHB is eager to continue our work to support the advancement of Indian health! This edition of Health Reporter will update you on some of our top priority issues, including new developments in policy, Affordable Care Act (ACA) trainings, increasing the IHS Budget, expansion of oral health access in Indian Country and public health accreditation new changes to the Special Diabetes Program for Indians.

We look forward to seeing many of you at our 32nd Annual Consumer Conference in Washington, DC from September 21-24, 2015! This year's theme, the "Native Health 2015: Policy, Advocacy and the Business of Medicine" will focus on many of the new policy changes we have seen with the ACA, and other ways for Tribes to increase access to health care in their communities. With several Tribal Consultations and Listening Sessions, an address by the Secretary of the Department of Health and Human Services, and our annual Native Health Awards Gala, it is not an event to be missed!

NIHB has been on the road conducting outreach and education on the Affordable Care Act for Tribes. Since April 2015, NIHB's ACA outreach and education team has provided 28 trainings and had over 850 attendees at these events! We are excited to see the enthusiasm in Indian Country for increasing access to health coverage. If you'd like to have an ACA training in your area, please contact our offices.

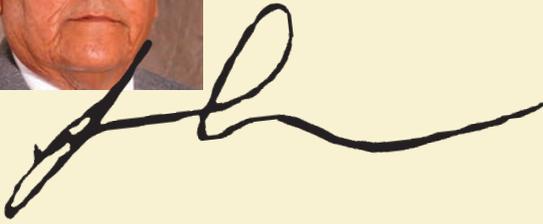
On June 25, 2015, the United States Supreme Court ruled on the King v. Burwell case, rejecting the challenge to the Affordable Care Act's insurance subsidies in a 6-3 decision. The Justices ruled that the subsidies are allowable in those states that refused to set up their own insurance exchange. This decision allows premium assistance to 6.4 million Americans, including American Indians and Alaska Natives, who live in the 34 states that rely on the Federally Facilitated Marketplace. States which had set up their own state exchanges or marketplaces are not affected. NIHB's policy department also convened a working group to develop comments on a "Medicare Managed Care" rule that was released by the Centers for Medicare and Medicaid Services earlier this summer. You can read more about that work in this issue.

THE NATIONAL INDIAN HEALTH BOARD

ONE VOICE AFFIRMING AND EMPOWERING
AMERICAN INDIAN AND ALASKA NATIVE
PEOPLES TO PROTECT AND IMPROVE HEALTH
AND REDUCE HEALTH DISPARITIES.



LESTER SECATERO



We have been making exciting progress on Capitol Hill too! Earlier this summer, two bills were introduced that would exempt Tribes from the Employer Mandate to provide health insurance under the ACA. Many Tribes have noted that this requirement will be very costly and force them to cut jobs or services for their Tribal members. NIHB has also been working with the White House on a solution to this issue. We were also excited to see several important provisions supporting Indian health in the FY 2016 draft Appropriations bills – you can also read more about that in this edition of Health Reporter.

Much has also been happening in our Public Health Programs and Policy Department. Last spring, IHS announced that it would make some changes to the Special Diabetes Program for Indians (SDPI) funding formula. NIHB has been participating in calls and assisting Tribes with questions on the new application. NIHB’s Public Health team has also been supporting Tribes as they pursue Public Health Accreditation through a grant program. Finally, NIHB, IHS and SAMHSA have partnered to help develop the “Tribal Behavioral Health Agenda.” There will be several sessions on this at the NIHB’s Annual Consumer Conference to discuss the agenda.

We look forward to hearing from you on these and other important issues as we work to advance healthy Native communities! As always, please reach out to NIHB with any of your comments, questions, or concerns – we are here to serve you!

Yours in Health,

Lester Secatero
Chairperson

THE WORK OF THE NATIONAL INDIAN HEALTH BOARD

The National Indian Health Board (NIHB) advocates on behalf of all federally-recognized Tribal governments – both those that operate their own health care delivery systems and those receiving health care directly from the Indian Health Service (IHS).

Located on Capitol Hill in Washington, D.C., NIHB provides a variety of services to Tribes, area Indian health boards, Tribal organizations, federal agencies, and private foundations, including advocacy, policy formation and analysis, legislative and regulatory tracking, direct and timely communication with Tribes, research on Indian health issues, program development and assessment, training and technical assistance programs, and project management. NIHB is a 501(c)3 charitable organization.

Upcoming Events

Tribal Leaders Diabetes Committee Meeting
September 24-25, 2015
Washington, DC

Tribal Self-Governance Advisory Committee Meeting
October 6-7, 2015
Washington, DC

United South and Eastern Tribes Annual Meeting
October 26-28, 2015
Choctaw, MS

National Congress of American Indians Annual Convention and Marketplace
October 18-23, 2015
San Diego, California

Direct Service Tribes Quarterly Meeting
November 4-5, 2015
Oklahoma City, OK

Medicare, Medicaid Policy Committee Meeting
November 17, 2015
Washington DC

Tribal Technical Advisory Group Meeting
November 18-19, 2015
Washington, DC

Secretary’s Tribal Advisory Committee Meeting
December 1-2, 2015
Washington, DC



FY 2016 Appropriations Heats Up as Congress Races to September 30

► Here we are yet again. The federal fiscal year will end on September 30, without a single of the 12 annual Appropriations bills enacted into law, and without an idea on how Appropriations will end for Fiscal Year (FY) 2016. Six appropriations bills have passed the House, but none have passed the Senate. Both chambers have passed all 12 bills out of the Appropriations Committee, setting a blueprint for how FY 2016 Appropriations could proceed.

At the time of this article, it is unclear how things will shake out for Indian health funding in FY 2016, but according to the Congressional Budget Office, the House drafted bills break the statutory “cap”¹ for federal non-defense spending by \$1.8 billion. That means, unless Congress can come to a compromise to raise the budget caps, legislators will have to roll back funding from non-defense spending from the already austere proposed bills.

With these budget limits in mind, Congress has a few options. It is likely that they will pass a continuing resolution (or “CR”) to keep the government funded past September 30, but with Republicans looking to use the appropriations process to defund Planned Parenthood, anything is possible – including a government shutdown. Even if a CR does get enacted, this would not be ideal for IHS and Tribal health facilities, as they would be forced to run their health services on only a couple weeks or months’ worth of funds. This is why Tribes continue advocate for “Advance Appropriations” for IHS to ensure IHS appropriations are passed a year ahead of time. Across the Board Sequestration cuts are also possible in FY 2016 – two bills have been introduced – S. 1771 and H.R. 3063 – exempt Indian programs from sequestration, which devastated many Indian health programs in FY 2013.

Here is a summary of what we know so far:

- **Indian Health Service Appropriations:** The House Interior, Environment and Related Agencies Appropriations Bill legislation (H.R. 2822) funds the IHS at \$4.787 billion, (3% above FY 2015) and the Senate’s version funds IHS at \$4.779 billion. Tribes requested \$5.4 billion for IHS in FY 2016. Most of the programs in the Interior bill were either cut or flat funded.
- **Contract Support Costs:** Both bills contain language on Contract Support Costs (CSC). Tribes and President Obama have requested that Congress enact “mandatory” appropriations (meaning that it would not be in the annual appropriations process, but automatically funded each year) for CSC, but it looks like Congress will not take that approach this year. In both the House and Senate FY 2016 bills, the Appropriations Committees provided \$717.97 million for CSC (which is the same as the President’s Request for FY 2016). The House included language that would create “X-year” funding for CSC and language noting that CSC is not paid from services funds. In the Senate, Appropriators create a separate appropriation line for CSC, breaking out of the “services” budget entirely. This would also mean that funds



NIHB Executive Director Stacy Bohlen testifies on behalf of Indian Health priorities before the House Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee in April 2015.

- cannot be use from “services” to pay CSC, even if a shortfall occurs.
- **Definition of Indian in the Affordable Care Act:** Language is included in the report that accompanies the House Appropriations bills that would encourage the Administration to write regulations to ensure that “establish a consistent definition of an “Indian” for purposes of providing health benefits.” The definitions included in several provisions of the Affordable Care Act are not consistent with those that IHS and the Centers for Medicare and Medicaid Services (CMS) use to determine eligibility.
- **Tribal Behavioral Health Grants:** The House Labor, Health and Human Services, Education Appropriations bill (Labor H) funds Tribal behavioral health grants at \$15 million, (an increase of \$10 million) and includes report language that would include require the agency to provide better coordination between Tribal behavioral health programs.
- **Tribal Epidemiology Centers:** Tribal Epidemiology Centers (TECs) are critical to studying disease prevalence and prevention in Indian Country, but are severely underfunded. The House Labor H bill includes report language that would require the Centers for Disease Control and Prevention (CDC) to “to conduct a review and develop an action plan, in consultation with Indian Country...on actions CDC can undertake to address improved surveillance and measurable public health impacts in tribal communities.” This report could form the basis of establishing more funding for TECs in the future.

As noted above, much remains in flux for FY 2016 appropriations. But, Indian health programs have some important provisions in the current draft proposals that could make big impacts on Indian health, if enacted.



¹ Federal Spending caps are set out in the Budget Control Act (P.L. 112-25)

Tribes Continue to Ask for Relief from the Employer Mandate under the Affordable Care Act

► The Employer Shared Responsibility Rule, otherwise known as the “Employer Mandate,” states that all employers with 50 or more employees must offer health insurance to their employees or pay a penalty. Tribal governments are currently counted as large employers for application of this rule. This a problem for some Tribal governments because they do not have the resources to provide their employees with insurance. The penalty is roughly \$2,000 penalty per employee for failing to provide them with insurance.

American Indians and Alaska Natives (AI/AN) are exempt from the Individual Mandate to purchase health insurance. This is in recognition of the fact that AI/ANs should not be forced to purchase healthcare that is obligated by the federal government’s trust responsibility and which is delivered through the Indian Health Service (IHS). Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself.

Many Tribes have told NIHB that they will cut services or lay off employees in order to comply with this requirement. Tribal governmental funding is a zero sum game, and any funding used to either comply with the mandate or pay the penalties will necessarily come from coffers used to provide what may be the only constituent services for hundreds of miles.

Furthermore, the employer mandate undercuts other provisions in the ACA. The mere offer of insurance to Tribal employees negates any premium tax credits that members of federally recognized Tribes are entitled to receive through the ACA and actively discourages enrollment in the Marketplace, which is often a more affordable option for Tribal members than employer-sponsored insurance. It is clear that the lack of Tribal consultation on this piece of the ACA has resulted in unintended consequences that will drastically impact some Tribes.

The National Indian Health Board is working to advocate for a Tribal exemption to this mandate with both Congress and the Administration. In February, NIHB and partner organization, United South and Eastern Tribes (USET) sent a letter to the White House asking for a meeting to discuss a regulatory exemption for Tribes from the Employer Mandate. When no response was received, a second letter, signed by NIHB, USET, National Congress of American Indians, The Tribal Self-Governance Advisory Committee, the Direct Service Tribes Advisory Committee and the Rocky Mountain Tribal Leaders Council was sent in June 2015.

On September 10, a delegation of Tribal leaders, Tribal organizations and their representatives met at the White House to discuss this issue with representatives from the White House, Indian Health Services

and the Department of Health and Human Services. The meeting served as an important starting point for White House officials to learn about how the Employer Mandate will negatively impact Tribes. The Tribes asked for the Administration to initiate Tribal consultation on this issue and have participation from the White House, the Department of Health and Human Services, and the Department of Treasury. NIHB and its partners will continue to press the Administration for Tribal employer relief from the employer mandate.

In July, “Tribal Employment and Jobs Protection Act” (S.1771 and H.R. 3080) was introduced by Senator Steve Daines (R-MT) and Representative Kristi Noem (R-SD), which would exempt Tribal employers from the Employer Mandate under the Affordable Care Act (ACA). NIHB worked closely with Senator Daines’ and Congresswoman Noem’s offices for several months in order to ensure that the language included in the legislation would truly help Tribal employers. With perpetual gridlock in Congress, enacting these bills will certainly be an uphill battle, but if enacted, will ensure that the statute reflects the unique trust responsibility that Tribal governments enjoy when it comes to health care.

For more information on how you can be involved in this effort you can contact Devin Delrow, Director of Federal Relations (ddelrow@nihb.org) or Caitrin McCarron Shuy, Director of Congressional Relations (cshuy@nihb.org) at (202) 507-4070. 📞



Tribes and Tribal organizations meet at the White House on September 10, 2015 to advocate for a Tribal Exemption to the Employer Mandate.

Indian Health Care Providers Must List Themselves as Essential Community Providers

► A qualified health plan (QHP) is a major medical health insurance plan that covers all the mandatory benefits of the Affordable Care Act (ACA or “Obamacare”). Qualified Health Plan (QHP) Issuers are required to include within their network, “Essential Community Providers” (ECPs) that serve their members.

Under the Affordable Care Act, QHP issuers are required to contract with at least 30 percent of the available ECPs in their service area. The Department of Health and Human Services (HHS) has compiled a non-exhaustive list of available ECPs, based on data it and other federal agencies maintain and is available at <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>.

CMS plans to open the Essential Community Providers Provider Petition for the 2017 Benefit Year. All Indian Health Care Providers (IHCPs), even those that already appear on the 2016/Draft 2017 HHS ECP List, are required to provide any missing information in order to remain on the list for benefit year 2017.

The National Indian Health Board has heard from Tribes across the country that IHCPs are not being offered contracts by QHP issuers. Ensuring the IHCPs are listed properly as ECPs list is one critical step towards correcting this wrong. In order to ensure that IHCPs are correctly accounted for and offered contracts by QHP issuers, all IHCPs complete and submit the ECP petition in order to be added to the HHS ECP list or to address missing information if they are already listed. <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10561.html>

IHCPs seeking to correct their information or be added to the HHS ECP List prior to October 23, 2015, can e-mail CMS at essentialcommunityproviders@cms.hhs.gov. These IHCPs also should contact the federal agency responsible for initially supplying their information to CMS for inclusion on the HHS IHCP List (i.e., the Indian Health Service) and request to update their information. 📧

► Continued from page 1 — ACA TRAINING ON THE ROAD

the Denver Coliseum and attracts thousands of dancers, drummers and spectators each year. Nearly 400 people stopped by the booth to learn more about the ACA, ask questions about their current coverage or get information to share with their families.

In addition to the DIHFS staff, Navigators from Connect for Health Colorado and private insurance brokers volunteered their time at the booth to help PowWow goers check out their options on the Marketplace or to find out if they're eligible for Medicaid or CHIP.

“This was a great chance to meet with Tribal members and talk to them about how we can help them get the healthcare they need and improve their financial security through affordable health insurance,” said Gabriela Aguilar, Outreach Manager with Connect for Health Colorado.

Nearly a month later the NIHOE National Partners were back on the road to Albuquerque, New Mexico for an ACA training and enrollment event held at the Indian Pueblo Cultural Center on April 22, 2015. About 45 people were in attendance.

Amber Carrillo, ACA Coordinator with the Albuquerque Area Indian Health Service

provided an update on the ACA outreach in the Albuquerque Area, which covers New Mexico and Colorado. Scott Atole, Native American Coordinator and Consultant with the New Mexico Health Insurance Exchange (NMHIX) gave attendees a glimpse of how the NMHIX is working to increase the number of insured Tribal members throughout the state.

According to NMHIX statistics and as of April 2015, approximately 5,947 American Indians enrolled in Medicaid and 1,575 enrolled in a Marketplace plan. Mr. Atole also encouraged those working as Tribal health program CEOs, directors, Community Health Representatives and Patient Benefits Coordinator to attend and participate in the NMHIX Native American Advisory Council monthly meetings.

Representatives from Molina, Presbyterian, Blue Cross Blue Shield, United Health Care, the Navajo Nation and the Native American Professional Parent Resources (NAPPR) were onsite to help with enrollment and provide health coverage information. The day before the training, NAPPR – a Navigator entity in New Mexico – helped a young Navajo man apply for a Marketplace plan after he suffered a health problem.

Derrick Smith, Navajo/Apache, had a pain in stomach one day in April that sent him to the emergency room. It was gall stones. Derrick, 37 and living in Albuquerque, is not on Medicaid because he makes too much money and did not have private health insurance. He needed some kind of coverage for the surgery to remove the stones. He and his wife visited Renaldo, a Navigator with NAPPR, and Derrick was able to get on a Bronze Plan paying \$100 a month. Also, Purchased/Referred Care through the Indian Health Service covered his emergency room expenses. Derrick is now recovering from the surgery and is back to work.

“I was in a lot of pain but I didn't want to go to the hospital because I knew I would have a huge bill. My wife convinced me that my life and good health was more important, so we went to the emergency room. Once I was able to move around, we went to NAPPR to get assistance with the insurance application. We'd seen NAPPR set up at events around the Pueblos. Renaldo really helped us out. I'm glad I now have health insurance. I feel a lot better about my health care now,” Derrick said.

To find a Navigator or enrollment assister in your area visit: www.healthcare.gov/. 📧

Gearing Up for Open Enrollment 3: What Your Tribe Can Do to Boost Enrollment

➤ Outreach is extremely important when it comes to enrollment – and education – of the Affordable Care Act. There are several ways you, your Tribe and the Tribal clinic can help boost enrollment for Tribal citizens in the Health Insurance Marketplace. Host an enrollment event, place informational ads in the Tribal media or set up an exhibit booth at the local pow wow or community event. The more Tribal citizens are informed about the benefits through the Affordable Care Act (ACA), the better they will understand their insurance coverage options.

This year’s Open Enrollment Period for the Health Insurance Marketplace and all other private coverage for individuals and families begins on November 1, 2015 and ends on January 31, 2015. Though members of federally recognized Tribes can enroll in a Marketplace plan on a monthly basis, the open enrollment period is a prime time to get the word out about the benefits for American Indians and Alaska Natives (AI/AN).

Take an active role to get out in the community and start educating individuals on their health insurance options through the Marketplace or Medicaid or the Children’s Health Insurance Program (CHIP). Start by hosting an enrollment event. This can take place at a Tribal facility, like a community center, chapter house or even a Tribal college. When hosting an enrollment event, it’s best to connect with stakeholders, such as the Indian Health Service or a Tribal or urban health facility for assistance with consumers. Partnering with regional or national organizations, like the NIHB offers additional resources.

Hosting an enrollment event is a great way to educate the AI/AN population on the ACA, and to encourage and assist them in the Marketplace. ACA continues to be a hot topic in the media. So, hosting an enrollment event may:

- Bring attention from the local media;
- Showcase community involvement;
- Encourage others in the community to look into their own insurance options through the Marketplace or Medicaid or CHIP; and
- Opens up opportunities for folks to volunteer.

Messaging is also key when educating Tribal members about the ACA. First, it’s important to know your target audience before starting a messaging plan. Older adults may respond differently to message about having “peace of mind” or “security” with having insurance coverage than young adults. No matter who your target audience is – all people



Jason Curley, Tribal Health Care Reform Program Coordinator, conducts outreach and education on the Affordable Care Act (ACA) during the 2015 National Congress of the American Indian (NCAI) Mid-Year Conference in St Paul, MN.

Tribal Health Care Reform Team partners with ACA navigators in March 2015, in Denver, CO to encourage enrollment in the Marketplaces.



will respond to messages about saving money and affordability. Other key messages are:

- It’s important that people know that have options;
- Plans are affordable;
- In-person assistance is available; and
- AI/AN benefits, like the special monthly enrollment status.

You know your community well. You can relate to the community members better than any outside entity. This makes you a valuable asset in not only educating Tribal members on ACA, but helping them understand how it will benefit them and seeing them through the enrollment process.

Also, there are many opportunities in Indian Country to set up an information booth at local and regional events, such as pow wows, health fairs, Tribal fairs, seasonal community events and faith-based events, like revivals.

NIHB and the Centers for Medicare and Medicaid Services (CMS) offer accurate and comprehensive educational materials and resources on the ACA. For more information, visit: www.nihb.org/tribalhealthreform. 

NIHB Brings Tribes Together to Comment on New Medicaid Managed Care Proposed Rule

► On July 27, 2015, the National Indian Health Board, after weeks of input from Tribal representatives and Technical advisors submitted its comment on the new Centers for Medicare and Medicaid Services (CMS) proposed rule on Medicaid Managed Care. According to CMS, “Managed Care” is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month payment for these services.

This is the first time in more than a decade that CMS has updated its managed care regulations. Taking into account that it might be another decade before they are updated again, NIHB, through its Medicaid, Medicare, and Health Care Reform Policy Committee (MMPC) carefully constructed its 28-page comment.

Through MMPC, Tribal Technical Advisors from across the Country volunteered to break the more than 600 page rule into separate pieces for analysis and comment. At the end, each piece was put together and edited into a single comment. A draft template was also submitted to Tribes so that they could internalize and submit their own comments.

In the comment, NIHB asked CMS to ensure that the American Recovery and Reinvestment Act of 2009 (ARRA) Medicaid Managed Care protections are meaningfully implemented in the proposed rule for those American Indian and Alaska Natives (AI/ANs).

The comment also provided numerous examples and reasons why Medicaid managed care typically does not work in Indian Country. For example, Managed Care Entities typically require Indian Health Care Providers (IHCPs) to have contracts in place for the AI/AN beneficiaries to have access to services provided by their managed care entity network providers. This often results in AI/ANs having no meaningful access to specialty care services managed by those managed care entities. In addition, managed care entities



typically auto-assign beneficiaries to particular plans and particular providers in a manner inconsistent with the right of Tribal Medicaid enrollees to choose an IHCP as their primary health care provider. In our comment, NIHB asks CMS to recognize these difficulties and impose protections in the regulation that prevents AI/ANs from being mandated into managed care. We asked that those AI/ANs who voluntarily elect to enroll in managed care, that their protections under ARRA also be protected and not waived.

The Comment included a Tribal redline of the new proposed regulations as well as an Indian Managed Care Addendum that we propose all Managed Care Entities include when offering network agreements to all Indian Health Care Providers in their Service Area. We also asked that the rule be implemented as an Interim rule only, in order to provide Tribes with further opportunity to provide comments and ensure minimal interference and administrative burden caused by a State’s decision to rely on managed care. NIHB would like to thank all the Tribal representatives and Technical Advisors that contributed to the creation of the comment.

To view NIHB’s comments, please go here: <http://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/07/NIHB-Comment-on-CMS-2390-P.pdf>.

Please contact Devin Delrow, Director of Federal Relations at ddelrow@nihb.org, if you are interested in learning more about becoming involved in MMPC and the Regulations Workgroup. 📧

SDPI Spotlight: Yavapai-Apachi Community-Directed Grant Program

► After 19 years, Tribes and Tribal organizations are embarking on a new era of the Special Diabetes Program for Indians (SDPI). SDPI has provided funding for diabetes treatment and prevention activities and services in American Indian and Alaska Native (AI/AN) communities since 1998.

Changes announced this year by Indian Health Service (IHS) Principal Deputy Director, Mr. Robert McSwain, will take effect on October 1, 2015 for fiscal year 2016. These changes include:

- The SDPI set-aside funds formerly assigned to the Center for Disease Control and Prevention’s (CDC) Native Diabetes Wellness Program will now be assigned to the SDPI Community-Directed (C-D) grant program.
- The IHS will utilize a new and competing continuation FOA, allowing ALL federally recognized Tribes to apply for funding.
- More recent data (FY 2012) will be used in the funding formula to address changes in AI/AN user population and diabetes prevalence that have occurred over the past decade.
- The SDPI Diabetes Prevention and Healthy Heart (DP/HH) Initiative program will be merged into the SDPI C-D grant program.

In response to these significant changes to the program, some grantees are taking the opportunity to revamp their own treatment and prevention efforts. The Yavapai-Apache Nation Community-Directed grant program is one of the many programs who is doing exactly that. Ms. Cindy Nahee, the Yavapai-Apache Nation’s SDPI Diabetes Program Coordinator, sat down with us to discuss the shift in purpose and programming the Yavapai-Apache SDPI program is currently working on.

The Yavapai-Apache Nation has received an SDPI grant since the beginning of the program – shortly after Congress established the SDPI funding to address the growing epidemic of diabetes in AI/AN communities in 1997 as part of the Balanced Budget Act.

Until recently, the program was housed in the Tribe's Community Health Representative Program. The program is now located in and operates as a function of the health clinic located on the Tribe's reservation in Camp Verde, Arizona. This change is indicative of a shift from primarily funding prevention activities, to now encompassing both prevention activities for the community and youth, as well as treatment and transportation for Tribal members already living with Type 2 diabetes.

In the past, the Community-Directed funds have supported various health and wellness activities aimed at preventing diabetes and creating healthier lifestyles for Yavapai-Apache Tribal members. Like many SDPI programs across Indian Country, these activities incorporate the culture, language and history of the Tribe and their ancestors. The program funds a community garden that provides a dozen community members and their families with traditional foods and fresh vegetables. The program also hosts an annual health fair that draws a crowd of over 100 people, and has purchased and maintains equipment and instructors for two fitness facilities that all Tribal members can access.

The program has contracted a horticulturist to assist with the community garden, but irrigating and maintaining the plots throughout the season is still challenging for Ms. Nahee and her participants as the irrigation system is manual and time consuming. A unique purchase of the program, is the vehicle that was purchased to transport pre-diabetic and diabetic patients to and from the health clinic for treatments and check-ups. Ms. Nahee commented on the benefit of having the van available, especially now that the SDPI program and team members are housed right at the clinic where patients have their appointments.

Although not outlined in sent out by Principal Deputy Director McSwain, there are programmatic changes that will be occurring to SDPI as result of the changes to the national funding distribution and formula. One change that will significantly impact grantees and their programming, is the change in SDPI Diabetes Best Practices put out by the Division of Diabetes Treatment and Prevention. As part of their required activities, SDPI Community-Directed grantees will implement one SDPI



Diabetes Best Practice (also referred to as "Best Practice"). The Best Practices are focused areas for improvement of diabetes prevention and treatment outcomes in communities and clinics.

The most recent best practices that the Yavapai-Apache Nation's program has focused on include nutrition and screening diabetes patients for depression. Ms. Nahee expressed how challenging the depression screenings can be as the funding is no longer enough to support having a full-time behavioral health specialist on staff for the diabetes program. Tribal members have the option to be treated at other facilities which makes it difficult for the SDPI team to follow-up due to patient/provider confidentiality. Ms. Nahee and her team are currently working on writing their grant proposal for FY 2016, and they will be incorporating Best Practices that focus on both prevention activities and treatment or related programming for Tribal members with Type 2 diabetes.

IMPORTANT LINKS

SDPI Funding Distribution Dear Tribal Leader Letter:
www.ihs.gov/newsroom/triballeaderletters/

SDPI Funding Distribution Urban Indian Organization Letter:
www.ihs.gov/newsroom/urbanleaderletters/

IHS Division of Diabetes Treatment and Prevention (DDTP):
www.ihs.gov/MedicalPrograms/Diabetes/

SDPI Diabetes Best Practices
www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBP_New

NIHB Updates on SDPI and Diabetes:
www.nihb.org/sdpi

After meeting Cindy and Chairman Thomas Beauty, the Phoenix Area TLDC Representative and Chairman of the Yavapai-Apache Nation, it was clear that the Tribe is taking the new FY 2016 funding cycle of SDPI as an opportunity to make changes and improvements to their Community Directed grant program. The Tribe will be taking steps to better integrate both prevention activities for the community and treatment for current diabetes patients in order to improve overall outcomes of the program. 🌟



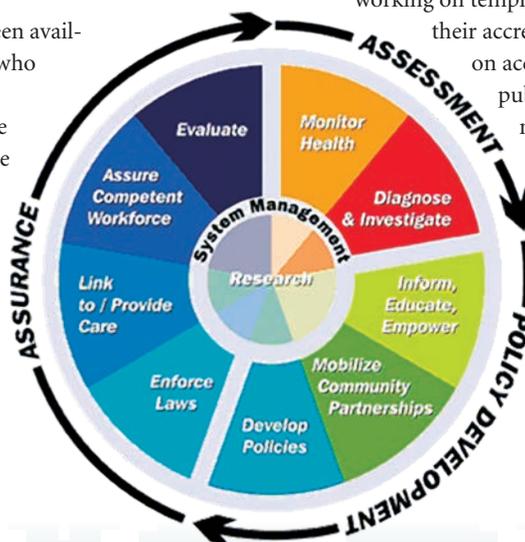
NIHB Builds Upon the Success of the Tribal ASI Program

► In the winter of 2014, the National Indian Health Board (NIHB) launched a pilot project with the support of the Centers for Disease Control and Prevention (CDC) titled the Tribal Accreditation Support Initiative (Tribal ASI). The project was designed to provide Tribes interested in pursuing public health accreditation fiscal support and tailored technical assistance. Through the Tribal ASI, NIHB has committed to elevating Tribal accreditation stories, facilitating the sharing of Tribal examples and resources and supporting capacity building in Tribal public health systems.

Five Tribes were awarded Tribal ASI funds from February through June 2015 and completed public health accreditation activities such as the development of Tribal health department strategic plans and workforce development plans. Each Tribe highlighted their projects during monthly Tribal Accreditation Learning Community (TALC) webinars, hosted by NIHB. These webinars and as well as a repository of templates, accreditation resources, and technical assistance materials have all been housed on NIHB's new Tribal ASI webpage.

Lessons Learned

National public health accreditation has only been available since 2011 and to date, there are no Tribes who have been accredited through the Public Health Accreditation Board (PHAB), although a few are getting close. With limited resources and unique health organizational structures, the first Tribes to move through the accreditation process are creating a path through new terrain and the lessons they have learned will be invaluable



NIHB staff meets with Keweenaw Bay Indian Community Health and Human Services Staff to discuss their public health accreditation plan.

to Tribes that will follow. One of the most critical lessons learned by Tribes is having a well-thought out, realistic plan. The public health accreditation process is lengthy and can require significant coordination among existing programs and services. In addition, effectively engaging the community and sustaining leadership support can be subject to the ebb and flow of Tribal natural and organizational systems. Thinking through the steps, mapping out goals against a realistic timeframe, and planning for challenges can lay the groundwork for accreditation success.

Second Cycle of Tribal ASI Funding

NIHB and the CDC are pleased to move Tribal ASI into its second year of funding and support. NIHB is able to fund more sites in the next cycle, as CDC increased its financial support for the project. The Tribal ASI will fund 6-10 Tribes at amounts ranging from \$5,000 to \$10,500 to work on specific components related to strengthening the Tribal health department and working towards public health accreditation as defined by the Public Health Accreditation Board. NIHB will be continuing its monthly TALC webinars and will be spending time in the coming year working on templates for strategic plans that Tribes can use for their accreditation efforts, holding Tribal “think tanks” on accreditation, and increase the presence of Tribal public health accreditation-related topics at national conferences.

If you have any questions about the funding opportunity, as well as the resources available to Tribes please contact the Program Manager, Karrie Joseph at kjoseph@nihb.org. 📧

SAMHSA & NIHB Work Together on the Tribal Behavioral Health Agenda

The State of Behavioral Health in Indian Country

Behavioral health refers to a person's mental and emotional (and could include spiritual well-being as this is often intimately related to mental and emotional wholeness). Behavioral includes a wide array of issues facing people from diagnosable disorders to daily life challenges, and includes substance abuse. Behavioral health in Indian Country – as in the much of the U.S. – is an openly acknowledged problem but too few resources assigned to address it and the community seemingly too paralyzed to mobilize.

Research continues to point out that American Indians and Alaska Natives (AI/ANs) have the highest rate of substance dependence or abuse compared with other racial groups,¹ and American Indians and Alaska Natives are also at higher risk for suicide.² However, recent publications add new depth to this issue – painting a starker picture of behavioral health disparities than previous thought. Beals et al. state that in study of two American Indian Tribes that “the most common lifetime diagnoses in the American Indian populations were alcohol dependence, posttraumatic stress disorder (PTSD), and major depressive episode.... [L]ifetime PTSD rates were higher in all American Indian samples, lifetime alcohol dependence rates were higher for all but Southwest women, and lifetime major depressive episode rates were lower for Northern Plains men and women.”³ The results suggest that these American Indian populations had generally greater mental and behavioral health service needs than the general population. According to a Substance Abuse and Mental Health Services Administration (SAMHSA) data report published in 2015 on the Treatment Episode Data Set (TEDS), there were more than 1.7 million substance abuse treatment admissions in 2012. Of these, 2.5 percent were American Indian or Alaska Native (AI/AN). Additionally, a higher percentage of AI/AN admissions than other

admissions began using alcohol or drugs at age 11 or younger.⁴

These statistics point us to serious concerns around the programs designed to prevent and address the mental health of the community. There are gaps in the behavioral health service delivery infrastructure, clinical treatment processes, prevention and education programs, and program evaluation. “As a consequence, the mental health needs of these communities have ... outpaced and overwhelmed” the systems established to serve AI/AN populations.⁵

Context of the TBHA

Addressing these issues is going to take a multidisciplinary and collaborative approach that will examine the nature of service delivery, the scope of treatment and prevention approaches (including traditional and cultural practices), the state of Tribal policies addressing behavioral health, the role and state of the workforce, and the role of the stakeholders. In order to develop a unified response to the behavioral health crisis facing Indian Country, SAMHSA has launched an unprecedented effort to advance a Tribal Behavioral Health Agenda (TBHA). SAMHSA began the process by connecting with AI/AN people, national AI/AN organizations and AI/AN-serving organizations to get a grasp on the scope of the problem and suggested courses of action.

The aim is to develop something grounded in the experiences and realities of people who are either experiencing this crisis firsthand through personal and/or professional experience. To this end, SAMHSA collaborating with other federal agencies (like Indian Health Service), and partners like the National Indian Health Board (NIHB) and the National Council of Urban Indian Health (NCUIH) to a systemic information gathering phase.

The TBHA at the ACC

The information collected is now being synthesized with the help of NIHB into a draft “agenda” that can be presented to Tribal leaders and health professionals to garner feedback, and insure that the process is moving in the right direction. To that end, NIHB and SAMHSA will be partnering during the Annual Consumer Conference (ACC), September 21-24 in Washington, DC to host targeted listening sessions on the draft agenda. These sessions will be jointly facilitated by SAMHSA and NIHB staff and will present components of the agenda for discussion so that the agenda can be further refined.

This process will not only lead to a final product, but also evolve the Tribal-federal partnership, and set the stage for real collaborative and responsive action to address behavioral health. If you are attending the Annual Consumer Conference, please make plans to attend one of the SAMHS TBHA session – your feedback and input is vital to the success of this effort. For more information on the ACC sessions, please consult the published conference agenda, or contact Robert Foley (rfoley@nihb.org). 📧

(Endnotes)

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For Some American Indians, Cost of Hepatitis C Drugs Put Treatment Out of Reach

BY MALLORY BLACK / NATIVE HEALTH NEWS ALLIANCE

► SAN DIEGO – Public health advocates say hepatitis C is too often left out of the conversation of health in Indian Country, pointing to rising HCV-related mortality rates among American Indians.

The virus, which attacks the liver causing inflammation, is more prevalent in American Indians than in all other racial and ethnic groups, according to Hepatitis Foundation International. Between 2011 and 2012, acute hepatitis C rates increased more than 86 percent for American Indians and Alaska Natives, according to the Centers for Disease Control and Prevention.

“For American Indians, there is a high prevalence of hepatitis C among baby boomers who contracted it years ago, but also in younger people who inject drugs,” says Jessica Leston, Clinical Programs Manager at the Northwest Portland Area Indian Health Board. “Clinicians are seeing it now all the time.”

Nationally, about one third of injection drug users under 30 are infected with HCV, according to the most recent surveys by the CDC.

The CDC also reports 75 percent of older, former injection drug users have chronic HCV, but don’t realize they’re infected because symptoms can take decades to develop.

A HIGH PRICE FOR A CURABLE DISEASE

An advocate for Native health, Leston assists tribal clinics in the Northwest and Great Plains regions by helping build community awareness around hepatitis C as well as by providing access to medical specialists who can diagnose and treat the disease.

She says local clinicians know hepatitis C is an issue and want to do something about it, especially now that there’s a potential cure. With the introduction of new antiviral drugs, clinicians could presumably manage treatment.

However, that potential cure comes at a cost – over \$1,000 per daily dose, or \$96,000 for a full 12-week treatment.

Clinical studies of one of the drugs called Harvoni, approved by the U.S. Food and Drug Administration last year, have shown 9 out of 10 HCV patients were cured after 12 weeks of treatment, according to the drug’s manufacturer Gilead Sciences.

Hannabah Blue (Navajo), a project manager at the American Indian Public Health Resource Center at North Dakota State University, says many Native people need HCV treatment, yet the high price often puts the cure out of reach.

About 2.7 million Americans live with chronic hepatitis C.

– ACCORDING TO THE CDC



Hep C Health advocates say injection drug use and sharing needles are some of the leading risk factors for hepatitis C. (Courtesy: Centers for Disease Control and Prevention)

Financial assistance programs are available for patients to help lower the cost of the antiviral drugs. More information about patient assistance and eligibility can be found through the American Liver Foundation.

Left untreated, chronic hepatitis C can progress into liver failure and liver cancer. In Indian Country, chronic liver disease is the fifth leading cause of death.

American Indians are more likely to die from hepatitis C than other races and ethnicities, making it one of the most deadly diseases for Native people, according to Hepatitis Foundation International.

HEPATITIS C: WHO IS AT RISK IN NATIVE COMMUNITIES



**BABY
BOOMERS
BORN
BETWEEN
1945 TO
1965**



**YOUNG
ADULTS
WHO
INJECT
DRUGS**

**PIERCINGS OR
TATTOOS +
UNSTERILE
NEEDLES**



**BORN TO A
MOTHER WHO
HAS HEPATITIS C**



**BLOOD
TRANSFUSION OR
ORGAN
TRANSPLANT
BEFORE 1992**



**HIGH-RISK
SEXUAL BEHAVIOR**



(Source: Centers for Disease Control and Prevention, Mayo Clinic)

RISK FACTORS FOR HEPATITIS C

The foundation’s chief executive officer, Ivonne Cameron, says the epidemic of type 2 diabetes and alcohol abuse in Native communities often propels the progression of HCV infection.

“If you consume alcohol at a significant rate, that will further damage the liver and lead to faster progression of hepatitis C-related diseases like cirrhosis, liver cancer, and ultimately cause death,” Cameron says. “These risk factors contribute to the progression of the mortality of the disease.”

Currently there is no vaccine to prevent hepatitis C. An added challenge to combatting the spread of HCV is that many people haven’t been diagnosed, a problem not exclusive to Indian Country.

About 2.7 million Americans live with chronic hepatitis C, according to the CDC. However, citing statistics on the number of American Indians living with the disease is difficult because of the lack of accurate, comprehensive data.

THE STIGMA ATTACHED TO HEPATITIS C

Health advocates agree that what has obscured the perception of HCV is its association with HIV, or human immunodeficiency virus, and its tie to injection drug use.

Both HCV and HIV are blood-borne viruses with similar risk factors, but Blue says HCV is much more transmission-resilient, surviving on “surfaces, needles and other equipment used for injection drugs for days.”

Transmission of HCV commonly occurs through sharing or reusing needles to inject drugs. Homemade tattoos and using unsterilized tools for body piercings are also risk factors.

Because of occupational exposures such as needle sticks, medical workers can be at increased risk for hepatitis C. Some patients were exposed to HCV via transfusion or other medical procedures that were done prior to 1992, the year a blood test for HCV was approved.

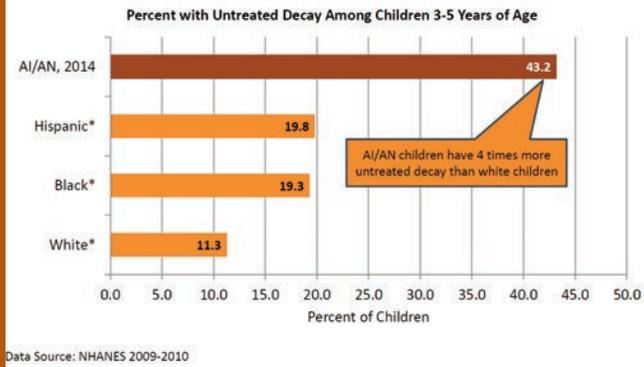
For most patients, the source to the virus is unknown.

“We shouldn’t have to wait for an outbreak of hepatitis C to work on preventing it,” Blue says. “Getting tested doesn’t seem urgent, but it is.”

© Native Health News Alliance This is the first in a series of hepatitis C stories produced by the Native Health News Alliance (NHNA), a partnership of the Native American Journalists Association (NAJA).



FINDING # 2 (CONT.): AI/AN CHILDREN HAVE MORE TOOTH DECAY THAN OTHER POPULATIONS



Dr. Rachael Hogan, Swinomish DHAT supervising dentist, observes Savannah Bonorden, a DHAT in Sitka, Alaska.

Tribes in the Pacific Northwest Announce Plan to Improve Oral Health Care in their Community by Expanding the Dental Team

➤ In June 2015, the Swinomish Indian Tribal Community announced an innovative new program to better address the oral health crisis in Indian country and to help bring Tribal oral health into the 21st century. The Tribe announced a plan to bring Dental Health Aide Therapists or “DHATs” as part of their dental team. DHATs work as mid-level dental providers who perform routine and preventive dental services like education, exams, fillings, x-rays, and simple extractions, all under the supervision of a dentist.

Over a decade ago, the Alaska Native Tribal Health Consortium (ANTHC) spearheaded an effort to bring DHATs to the United States (DHATs have been practicing in around the world since the 1920s). ANTHC was sued by the American Dental Association and its allies on the grounds that DHATs were operating outside of the state’s licensing regulations. However, Tribal sovereignty prevailed and today, 40,000 Alaska Native people have access to quality, consistent oral health care via a DHAT. Furthermore, 95% of those surveyed reported that they were satisfied by the care provided to them by a DHAT.

Despite the legal victory in Alaska, language was added into the Indian Health Care Improvement Act (P.L. 111-148) that prevented the use of DHATs outside of Alaska by the Indian Health Service (IHS) within the Community Health Aide Program unless agreed upon by the state legislature. After working for years on a bill to authorize DHATs in Washington State, the Swinomish have decided to use their authority as a sovereign nation to train one of their Tribal members as a DHAT to help increase access to care in their community.

“Oral health is essential to overall health,” said Brian Cladoosby, Chairman of the Swinomish Indian Tribal Community. “We cannot have healthy communities without access to reliable, high quality and culturally competent dental care.” Cladoosby continued: “We as Indians have

long faced an oral health crisis, and the crisis is only growing, but there just aren’t enough dentists in Indian country to address this crisis. The Swinomish dental clinic sees more than twice the number of patients per provider as the national average.”

The National Indian Health Board is thrilled to encourage Swinomish as they begin this important journey. Hopefully, it will serve as a model for many Tribes in the lower 48 who seek to improve oral health care in their communities.

The Northwest Portland Area Indian Health Board (NPAIHB) is also working with several Tribes in Oregon to expand the DHAT model under state-authorized “Dental Pilot Projects” which are designed to encourage the development of innovative practices in oral health care delivery systems. The NPAIHB is working in partnership with three Oregon Tribal communities to prepare an application for a Dental Pilot Project to be submitted to the Oregon Health Authority this fall.

American Indians and Alaska Natives suffer disproportionately from oral health disease. In fact, American Indian and Alaska Native children ages 2-5 years have an average of 6 decayed teeth, while the same age group in the U.S. population has only one decayed tooth. In 2014, more than 2.4 million Native Americans lived in counties with dental care shortage areas, and half of all Native American children lived in a shortage area.

According to the Indian Health Service (IHS), 90 Percent of Dental Services provided fall into “basic dental care” category, meaning DHATs could serve as a viable solution to expanding oral health access in Indian Country.

For more information on the projects in the Pacific Northwest visit: http://www.npaihb.org/programs/oral_health_project. ❄️

Demanding Results to End Native Youth Suicides

During the hearing addressing the suicide crisis, the witnesses included: then Acting Director for the Indian Health Service (IHS) Robert McSwain, Oglala Sioux Tribe Councilman Collins “C.J.” Clifford, Red Lake Band of Chippewa Indians Chairman Darrell G. Seki, Sr., and Stanford Professor Dr. Teresa D. LaFromboise.

Testimonies focused on the unstable nature of “patchwork funding” and the lack of mental health professionals on Indian Reservations. When funding for positive suicide prevention programs run out, communities are back where they started and the gains they have made disappear. As one Tribal leader recently told NIH: “It’s as if funds are awarded when rates spike, but return to complacency with alarming rates when rates fall somewhat. Programs cannot be sustained with uncertainty over funding from year to year.” Committee Vice Chairman John Tester (D-MT) agreed and said, “We cannot continue to airdrop in resources erratically when suicides spike in Indian communities and then turnaround and abandon those communities when patchwork funding runs out. We need stability, we need consistency in mental health programs...”

Committee Chairman John Barrasso noted his desire to hold Indian Health Service accountable for effective mental health programming. He said: “[The] Committee will do whatever it takes legislatively and in its oversight capacity to support results.”

All witnesses noted that tribal health care facilities and schools are severely understaffed when it comes to Mental Health Professionals. Council Member Clifford asked for counselors to be staffed at high schools on the Pine Ridge Reservation in South Dakota while at

Red Lake, Chairman Seki noted that there is *one counsellor for every 290 students.*

Dr. LaFromboise spoke of several successful suicide prevention programs and strategies for all ages from elementary school up to young adults. She stressed that we have strategies that work, but lack the staffing power of counselors and mental health therapists.

Senator Heidi Heitkamp (D-ND) called Native Youth Suicide a “Systemic problem for Indian People” and noted how trauma has such a wide reach within native communities. Senator Franken (D-MN) articulated “We can’t depend on children to solve these problems like suicide, we’re supposed to be the adults. We’re the Indian Affairs Committee, we’re here to fight for funding for you.”

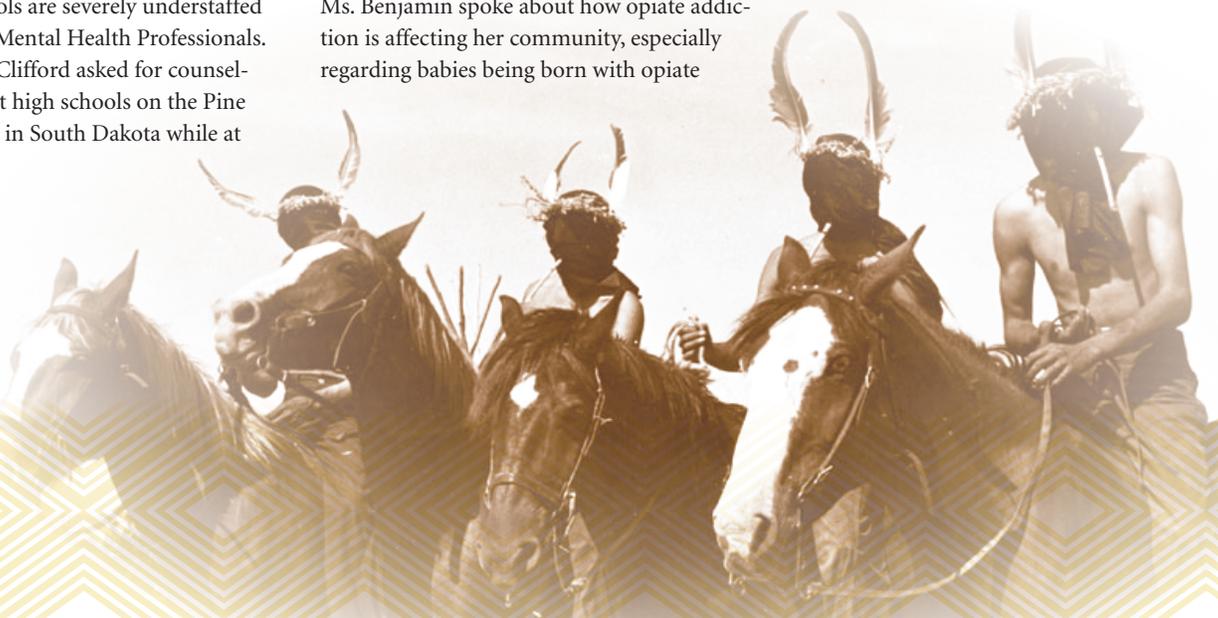
The True Costs of Alcohol and Drug Abuse in Native Communities

A month later, the Committee convened a separate hearing on alcohol and drug abuse in Indian Country. Chairman Barrasso sought to find realistic solutions to prevent and treat alcohol and substance abuse in Indian Country. Witnesses included Principal Deputy Director Robert McSwain from the Indian Health Service, Mirtha Beadle the Director of Office of Tribal Affairs and Policy for Substance Abuse and Mental Health Services Administration, Melanie Benjamin the Chief Executive of the Mille Lacs Band of Ojibwe, John P. Walters the Chief Operating Officer of the Hudson Institute and Sunny Goggles, the Director of the White Buffalo Recovery Program for the Arapaho Tribe of the Wind River Reservation.

Ms. Benjamin spoke about how opiate addiction is affecting her community, especially regarding babies being born with opiate

addictions. She suggested the Committee to provide more funding for research on this issue, culturally appropriate treatment and, enforce severe consequences for physicians who over prescribe opiates to Native Americans. John Walters urged the Committee to consider this problem as an epidemic to bring more resources and attention by government agencies to the problem and said “the system is failing” our communities. Sunny Goggles from The Wind River Reservation spoke about the successes of the White Buffalo Recovery Program. She noted the huge costs of alcohol and substance use to the community while explaining that these issues are preventable.

Senator Lisa Murkowski (R-AK) voiced her concern that “we have been operating on a triage basis” when it comes to combating drugs in Indian Country. Senator Heitkamp stated “Indian Health has been unrelentingly unable to address healthcare crisis in Indian Country” and was disappointed to say “we don’t have a strategy, we just have a series of events.” Senator Franken from Minnesota urged his colleagues on the Committee when he said “We need to be ambassadors to the rest of Senate and tell them the scale of the problems in Indian Country.” The National Indian Health Board continues to work with the Senate Committee on Indian Affairs and other Members of Congress to address these critical issues. If you have any information to share about how these issues are effecting your community, please contact Caitrin Shuy, Director of Congressional Relations at cshuy@nihb.org. You can read testimonies and watch videos of the hearings at www.indian.senate.gov. 



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