National Indian Health Board

Health Reporter

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Advance Appropriations for Indian Health Service – A Critical Need For Our People

NIHB Chairperson Cathy Abramson (second from right) and Tim Schuerch (far right), President/CEO of the Maniilaq Association, testify before Congress on the need for advance appropriations for the Indian Health Service.

On July 15, National Indian Health Board Chairperson Cathy Abramson testified before the House Natural Resources Subcommittee on Indian and Alaska Native Affairs in support of H.R. 3229 – the Indian Health Service Advance Appropriations Act. This legislation would require Congress to determine the Indian Health Service (IHS) budget a year in advance to prevent IHS and Tribal facilities from waiting on Congress until the end of the fiscal year to receive funding. In the last 16 years, Congress has only enacted IHS funding before the beginning of the fiscal year once.

Ms. Abramson testified: "Enacting advance appropriations for IHS would allow IHS, Tribal, and Urban [Indian] health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for American Indians and Alaska Natives."

Also testifying on the bill was Tim Schuerch, President/ CEO of the Maniilaq Association. Mr. Schuerch testified that, "When we have interruptions in our funding process, it causes all kinds of problems…It is so difficult to hire doctors, dentists, nurses, and other health professionals…They have to know that they're going to get a paycheck."

Continued on page 3

Five Days, Five Communities: Affordable Care Act Training on the Navajo Nation

Who is an IHS employee? Audience members raise their hands during the ACA training in Window Rock, AZ on July 28, 2014.

For five days the National Indian Health Board's (NIHB) Tribal Health Reform Team and representatives from the Navajo Nation Division of Health (NDOH) and the Navajo Area Indian Health Service (NAIHS) traveled across the Navajo Nation reaching out and educating Tribal members and Tribal health program staff about their benefits through the Affordable Care Act (ACA).

Continued on page 6

INSIDE THIS ISSUE

National Indian Health Board
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From the Chairperson

Dear Indian Country Friends and Advocates,

As the summer draws to a close, we are grateful to our Member organizations, Tribes and our American Indian and Alaska Native Peoples who help keep the National Indian Health Board (NIHB) effective. We will be seeing many of you at the NIHB Annual Consumer Conference in Albuquerque, New Mexico from September 8-11. The conference is a great time for Tribes concerned with our Peoples' health from across Indian Country to gather to make change, share our stories about the most important needs affecting our communities as well as share knowledge and successes about policies, programs and advocacy that impact Native health. This year's theme, "Advancing Health Care through Consultation, Technology and Tradition," acknowledges three important pillars of the Indian health system and we look forward to seeing you there.

This summer, NIHB has been on the road conducting Tribal Education and Outreach seminars about the Affordable Care Act (ACA). Our team has traveled to ten states, trained over 1,000 people held enrollment events wherever we have gone and listened and learned about Tribal concerns. We thank the Tribes for welcoming our team into their communities and we will continue our trainings for the rest of the year and into 2015. The ACA represents a historic opportunity for Indian health and NIHB is committed to ensuring that all of Indian Country knows the benefits of this important law and has enough information to take full advantage of it.

In the last several months we have worked successfully on several legislative efforts and made significant progress on Capitol Hill. On March 31, Congress passed a 1-year renewal of the Special Diabetes Program for Indians (SDPI), which now expires in September 2015. While this is an election year and Hill actions have slowed to a crawl, we must continue keeping multiple-year, or permanent, SDPI renewal as a top priority. NIHB also has made recent progress in our quest to achieve advance appropriations for the Indian Health Service. There were two legislative hearings held on this legislation – one in the Senate Committee on Indian Affairs (April 4) and one in the House Natural Resources Subcommittee for Indian and Alaska Native Affairs (July 15). In June, we successfully achieved the introduction of the NATIVE CARE Act, a bill that would make Indian Health

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.

Service referred care dollars (formerly Contract Health Service) go much further. If passed, this legislation could truly be a game-changer for access to care in Indian Country because it would mean that IHS could purchase care outside of the system at much cheaper rates – the rates already paid by other federal health providers.

The Public Health Programs and Policy Department had a very busy summer as well working out in the community. In June, NIHB hosted the Tribal Public Health Accreditation Advisory Board meeting and developed some new insights and recommendations to support Tribal accreditation efforts. And in July NIHB staff had the honor of facilitating Tribal visits for the Centers for Disease Control and Prevention (CDC) staff to the Northern Arapaho and Eastern Shoshone Tribes on the Wind River Indian Reservation. The visits focused on nutrition, fitness, diabetes, methamphetamine and suicide prevention programming. NIHB has also boosted its training repertoire by piloting two new training products in August: Tribal public health law in Traverse City, Michigan and sustainability planning in Tulsa, Oklahoma. Staff also facilitated the meeting of the Tribal Public Health Workgroup as well as attended the CDC Tribal Advisory Committee (TAC) meeting in Traverse City in order to continue to ensure a strong Tribal voice in CDC decision-making. We also continue to provide support to grantees for the Methamphetamine Prevention Suicide Initiative and HIV prevention – which you can read about in this issue.

NIHB relies greatly on your support and advocacy to mobilize the Affordable Care Act campaign and advance the legislative agenda on Indian health. We always look forward to working with you to help restore healthy Native communities. We encourage you to provide input on this publication and all issues concerning the health and wellness of our people. NIHB is here to serve you.

Yours in Health,

Cathy Abramson

Cathy Abramson, *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.

Continued from page 1

Advance Appropriations for Indian Health Service – A Critical Need For Our People

Unreliable funding distributions create unnecessary work and additional expenses. When Congress cannot agree on a budget by the end of the fiscal year, a "continuing resolution" (or "CR") is passed to keep federal funding flowing for a short time. The length of a CR can vary significantly from just a few weeks to several months. As a result, Tribal health programs are left to make long-term decisions with only short-term money guaranteed.

The Veterans' Health Administration (VHA), which also provides direct care to patients as a result of contractual obligations made by the federal government, has received advance appropriations since FY 2010. Patients on Medicaid and Medicare do not have to worry on September 30 if they will have access to care on October 1. Even the Public Broadcasting Corporation receives advance appropriations. The First People of this country should not be funded after Big Bird.

To convince Congress to pass appropriations, NIHB needs your help! NIHB has started the "AdvanceIHS" campaign. You can help in several ways:

1. Distribute "AdvanceIHS" postcards and have individuals fill out their name and address, as well as their Representative and Senators.
2. Tweet at key leaders "@_____be responsible about the trust responsibility due to American Indians and Alaska Natives. #AdvanceIHS"
3. Share your experience of how delays in funding, or short term funding by Congress has hurt health delivery or hindered long term planning at your facility.
4. Pass a Tribal resolution on Advance Appropriations.

To obtain postcards, view sample letters and resolutions, please visit: www.nihb.org/legislative/advance_appropriations.php ■

Special Diabetes Program for Indians is Saving Lives and Transforming Communities – Act Now!

"The Healthy Heart Program has given us a new confidence in our overall health."
– Buddy and Les Hoptowit (brothers), Yakama Indian Health Center Healthy Heart Project

An alarming 14.8% of the adult population served by the Yakama Indian Health Service (IHS) on the Confederated Tribes and Bands of the Yakama Nation Reservation have Type 2 Diabetes compared to 7.4% state-wide. This disparity speaks to an urgent need to elevate both the level and access to preventative and treatment services. Thanks to the Special Diabetes Program for Indians, the Yakama Indian Health Service has adopted an innovative pharmacist case management system to engage IHS pharmacists in the disease monitoring and treatment of their adult patients. Staff pharmacists manage blood pressure, glycemic control and cholesterol by conducting periodic tests and ordering, adjusting or stopping medication regimens, order specific lab work, conduct limited exams, provide referrals, provide health education, and set health-related goals with patients. The pharmacist case management system allows patients easier access to care, ensures consistency, and improves health plan adherence as pharmacists schedule appointments with patients when the patients come to refill their regular prescriptions. Currently, two full time equivalent (FTE) Yakama IHS pharmacists manage approximately 400 participants and 800 patients are serviced between eight FTE medical providers. The program is displaying remarkable results in the areas of medication adherence and medication utilization.

The Yakama Healthy Heart Program strives to meet community needs as well as further the mission to provide prevention services. The program hosts at least one to two community events each month to provide participants and the general population with opportunities for physical activity and education. Many events are culturally and traditionally centered with activities such as traditional food gathering (root digging and huckleberry picking), Dance Away Diabetes (a Pow Wow dance style exercise class) and Bison Distribution, to name a few.

But unless Congress acts next year, successes like this one could all go away.

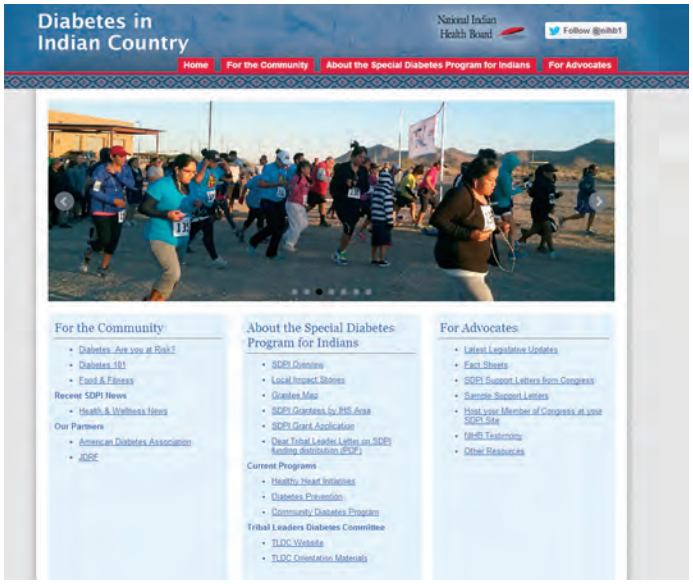
The Special Diabetes Program for Indians (SDPI) is critical to ending the epidemic of Type II Diabetes in Indian Country. In 1997, Congress established SDPI for Indians to address the growing epidemic of Type II Diabetes in American Indian and Alaska Native (AI/AN) communities. SDPI has successfully become the nation's most strategic and comprehensive effort to combat diabetes. SDPI is transforming lives and changing the diabetes landscape in America.

Today, SDPI is funded at a level of $150 million per year and supports 404 diabetes treatment and prevention programs in 35 states. With funding for this critical program set to expire on September 30, 2015, NIHB is urging everyone to become involved in this critical renewal effort. Now is the time to lay the important groundwork with your Senators and Representatives in support of this program.

SDPI is usually renewed as part of a piece of legislation known as the "SGR Fix" or "DocFix" which governs the rates that providers are paid by Medicare. Due to the controversy over the high cost this larger piece of legislation incurs, Congress has chosen only to enact short-term fixes, and thus, SDPI has only been renewed on a short term basis. Sadly, SDPI has not seen an increase since 2001 – which really represents a 23 percent decrease when considering inflation.

NIHB and Tribes are requesting that Congress renew this critical program for $200 million for five years. By having multi-year funding, SDPI programs can recruit and retain more staff, and be able to strategically plan program activity to ensure the best long-term impact on the health of communities.

We are urging you to take up the call to action with us! Please invite your Member of Congress to visit your SDPI program or arrange a meeting telling them about the importance of a long-term renewal next year. For tools and resources about Congressional outreach, please visit www.nihb.org/sdpi. ■



Stay up-to-date on the latest in SDPI news – VIST **www.nihb.org/sdpi** !

Conflicting Courts of Appeals Decisions Could Mean Big Impacts for Health Reform Law

On July 22, 2014, two United States Courts of Appeals had conflicting decisions regarding the Affordable Care Act (ACA). In both cases, the issue was the same, namely, whether the ACA permits the Internal Revenue Service (IRS) to provide tax credits for insurance purchased through federal Exchanges (now called Marketplaces). The federal tax credits are for low and middle income Americans to offset the cost of insurance policies purchased through the Marketplaces. The Marketplaces advance an individual's eligible tax credit dollars directly to health insurance providers as a means of reducing the upfront cost of plans to consumers. Marketplaces also determine which health plans satisfy federal and state standards.

The ACA delegates primary responsibility for establishing the Marketplaces to individual states; however, if a state does not set up its own Marketplace, it is up to the Secretary of Health and Human Services (HHS) to establish and operate the Marketplace within the state. As of the date of both decisions, 14 states and the District of Columbia established Marketplaces. The federal government through HHS established Marketplaces in the remaining 36 states.

In *Halbig v. Burwell*, the United States Court of Appeals for the District of Columbia Circuit (DC Cir.) found that the ACA unambiguously restricts the tax credits to insurance purchased in the Marketplace established by the state, not Marketplaces established by HHS. In *King v. Burwell*, the United States Court of Appeals for the Fourth Circuit (4th Cir.) found that the statutory language was ambiguous and subject to multiple interpretations. According to the Court, the IRS crafted a rule that provides the credits shall be available to anyone enrolled in one or more qualified health plans through a Marketplace regardless of whether the Marketplace was established and operated by a state or by HHS.

We have two conflicting decisions in two Courts of Appeals. In order to resolve the conflict an appeal to the United States Supreme Court would be in order. Until further action by the court or Congress the two decisions will not affect the tax credits being offered nor does it affect the special Tribal provisions for cost sharing reductions and monthly enrollment periods. ■

Reenrollment Under the Affordable Care Act: What You Need to Know

The Affordable Care Act open reenrollment period is right around the corner and there are certain issues that American Indians and Alaskan Natives (AI/ANs) need to be made aware of. Starting on January 1, 2015, insurance companies can make changes to the plans they offer in the Marketplace. This may mean an increase or decrease in monthly premiums, a change in the provider network, and certain plans may no longer be offered. Most AI/ANs are enrolled in "bronze" level coverage with either zero cost sharing or limited cost sharing plans and will want to stay in those plans. Enrollees can expect a letter from their insurance provider informing them of any changes to the plan they are enrolled in. There are a number of things AI/ANs can do to ensure that they have the best coverage possible.

Members of federally recognized Tribes have a unique benefit and can change their insurance plan at any time during the year and are not restricted to the open enrollment period, however they need to enroll by the 15th of the month in order to be eligible for coverage starting on the 1st of the following month. If an enrollee is receiving tax credits to help pay for their premium, they can use the open enrollment period between November 15, 2014 and February 15, 2015 to get a new determination on their tax credit amount for 2015. The tax credit helps individuals pay for their premiums. It is based on age, family size, income, and the cost of insurance at the "silver" level. If any of those things change, their tax credit will change as well. If an enrollee's tax credit is not updated, they will likely have a lower tax credit than what they are entitled to.

Enrollees wishing to make changes to their plans or those looking for a redetermination of their 2015 tax credit, can do so by going to www.healthcare.gov or calling 1-800-318-2596. At any time they can change their plan to include one that has their Indian health provider, covers any necessary medicines, and relevant medical specialists or local hospitals. Every plan offered in the Marketplace has special zero cost sharing and limited cost sharing plans for members of federally recognized Tribes. By being aware of these changes and keeping their insurance information up to date, AI/ANs can protect themselves from higher health care costs. Please feel free to contact the National Indian Health Board for more information. ■

Continued from page 1

Five Days, Five Communities: Affordable Care Act Training on the Navajo Nation

"We understand that there are a lot of misconceptions and misinformation in Indian Country about the Affordable Care Act. It is our job to bring the correct information and offer technical assistance to Tribes and Tribal communities," said Dawn Coley, Tribal Health Reform Outreach and Education Program Manager with NIHB. "We were excited and very thankful to have partnered with the Navajo Nation to provide education on the ACA to their communities. As the largest direct service Tribe, the Navajo Nation has done great work in educating their Tribal members. We are pleased with this collaboration."

The Team's schedule was ambitious. They started their ACA training journey on July 28, 2014 in Window Rock AZ and ended in Tuba City, AZ on August 1, 2014. In between, they provided training in Crownpoint, NM on July 29; Nenahnezad, NM on July 30; and Chinle, AZ on July 31.

April Hale, NIHB's Tribal Health Reform Outreach and Education Communications Coordinator, provided several presentations throughout the week, including an overview on the Affordable Care Act, strategies to increase American Indian and Alaska Native (AI/AN) enrollment in the Health Insurance Marketplace and ACA messaging and media outreach. Some strategies included partnering with Tribal Colleges or Universities to host enrollment events, inviting local radio stations to broadcast remotely from an event and partner with faith-based groups and churches to maximize the outreach to Tribal communities.

"I found the enrollment strategies presentation most beneficial. More examples of enrollment events and social media and marketing from Indian Country would be helpful," said an attendee from the Window Rock, AZ training.

Ms. Coley gave presentations on the basics of health insurance, the AI/AN exemption waiver and the ACA and Medicare for Native Elders. She showcased NIHB's ACA Elders Toolkit, which includes posters, brochures, an activity meal placemat and a bingo game – all on how the ACA strengthens Medicare and general ACA information that Elders may share with their loved ones. Laura Bird, Legislative Associate with the National Congress of American Indians also provided a presentation on the Large Employer Mandate at the training in Nenahnezad.

"It was good coverage on the Affordable Care Act. I'm beginning to understand it better now," said an attendee from the training in Tuba City, AZ.

Representatives from the Purchased Referred Care (PRC) department (formerly known as Contract Health Service) at the Navajo Area Indian Health Service and the Navajo Nation Employee Benefits Program were invited to join the training team for the week to provide presentations on their respective areas. Eulanda Ciccarello, Insurance Claims Analyst with the Navajo Nation Employee Benefits Program shared great insight throughout the week on the ACA implementation within the Navajo Nation's health plan for compliance.

"By having these workshops available, we were able to include information about the Navajo Nation Employee Benefit Plan which extends employer-offered health insurance coverage to eligible participants of the Navajo Nation and its recognized Enterprises," said Ms. Ciccarello. "As an employer-offered health plan, the community became aware of how the Navajo Nation Government is impacted by the ACA with its plan provisions. The audience consisted of health plan participants whether they were employees, spouse, or even children insured under the Plan, and they seemed pleased to know that the ACA enhanced the employee benefit health plan offered through the Navajo Nation. Communication to our vast rural area of Dine Nation must continue to ensure understanding of the ACA and the impacts to individuals."

The most common questions during the trainings were about the AI/AN exemption waiver: *Do I have to apply for an exemption if I use Indian Health Service? When should I apply for an exemption? What happens after I apply for an exemption?* One audience member brought her exemption response letter to the training, because she was concerned that she received three letters with two different exemption numbers. Ms. Coley was able to answer her questions, and K Dempsey from NAIHS assisted her with calling the Marketplace Call Center to resolve the issue.

An attendee from the Tuba City, AZ training said, "Everything covered was very informative, especially the importance of filling out the exemption form regardless if we have insurance or not."

In Chinle, representatives from the New Mexico and Arizona Exchange/Marketplace and state Medicaid department presented on two separate panels, respectively. On the "Overview of State Medicaid Program and Medicaid Expansion," Kari Armijo, Health Care Reform Manger for New Mexico Assistance Division, stated that Native Americans in New Mexico's Centennial Care can go to any IHS, Tribal 638, or Urban Indian health center (I/T/U and choose their I/T/U to be their primary care provider. Thomas Betlach, Director of the Arizona Health Care Cost Containment System (AHCCCS), presented on Medicaid Expansion in Arizona and how AHCCCS provides coverage for over 150,000 American Indians in the state. It was stated that the Navajo Tribe has the highest Medicaid Expansion enrollment among other Tribes in both New Mexico and Arizona.

On the "Health Insurance Exchange/Marketplace" panel, Scott Atole, Native American Coordinator for the New Mexico Health Insurance Exchange and Byron Lewis, Health Benefits Navigator with North Country Healthcare both spoke about their respective state's Marketplace and American Indian enrollment. Mr. Lewis, a Marketplace Navigator, said that Arizona ranks at #10 of the greatest number of uninsured people in the country. But, as of April 2014, approximately 120,071 people in Arizona have enrolled in a Marketplace plan through the ACA; about 17,591 of that number are in rural areas.

A training participant who attended the Chinle session said, "All the information presented was a great collection to take back to the family and community members – both in New Mexico and Arizona sides of the reservation. I would like to see more information on the exemption for Native Americans addressed in future trainings."

Each training was well attended. The largest audience was in Window Rock with nearly 140 people in attendance. In Crownpoint, 66 people showed up to the Navajo Technical University site for the training. At Nenahnezad Chapter House, 27 people attended the training. At the Navajo Department of Behavioral Health Services Outpatient Treatment Center in

Chinle, 86 people gathered in the facility's gymnasium. At the To'anees'dizi Chapter House in Tuba City, 46 people attended. Most were Indian Health Service, Tribal 638 and urban Indian health program staff as well as Tribal community members.

"I would like to thank all the presenters. This is the type of training we need. The more we all know, the more effective the message to the communities," said an attendee from the Crownpoint, NM training.

There were several questions about why Tribal members should enroll in a Marketplace plan and where they can get assistance through the application process. Selena Simmons, a Certified Application Counselor with the Tuba City Regional Health Care Corporation expressed to the audience that she and her staff – other Certified Application Counselors – are available with assistance in enrolling in the Marketing and filing for an exemption.

"The Affordable Care Act is an opportunity for our Native people to be covered – whether it's through the Marketplace or Medicaid Expansion. Our young families, students, adults and Elders should all know that they have health insurance options – and those options are affordable," said Ms. Coley.

For more information about ACA training for your Tribe or region, contact Dawn Coley at dcoley@nihb.org or April Hale at ahale@nihb.org, or by calling 202-507-4070. Also, visit www.nihb.org/tribalhealthreform for ACA events, news and updates.

NIHB extends sincere gratitude to the Navajo Nation Division of Health, including Larry Curley, Roselyn Begay, Sylvia Etsitty-Haskie, Hank Haskie, Belle Lynch, Carmelita James and Arthur Ledesma. NIHB also thanks the Navajo Area Indian Health Service, including Genevieve Notah and K Dempsey. ■

ACA Training participants in Tuba City, AZ review the AI/AN exemption waiver during a presentation on August 1, 2014.

HHS Gets a New Secretary

Sylvia Mathews Burwell is the new Secretary of the Department of Health & Human Services (HHS). She was sworn in on June 9, 2014. She has extensive experience overseeing and managing federal and private agencies. Burwell is a graduate of Harvard University and Oxford University, where she was a Rhodes Scholar. She has served on the boards of the Council on Foreign Relations, MetLife and the University of Washington Medical Center, as well as other organizations. In 1993, she joined the Clinton Administration where she served as Staff Director of the National Economic Council, Chief of Staff to the Secretary of Treasury, Deputy Chief of Staff to the President, and Deputy Director of Office of Management and Budget (OMB) in 1998.

She has served as President of the Global Development Program at the Bill & Melinda Gates Foundation. In 2012, Burwell served as President of the Walmart Foundation in Bentonville, Arkansas, where she spearheaded efforts to combat hunger in America. Burwell then joined the Obama Administration where she oversaw the President's Second-Term Management Agenda and served as Director of OMB in 2013.

Secretary Burwell has three guiding tenets for HHS: to deliver results on a wide range of complex issues; to strengthen the relationships that drive progress; and to build strong teams with the talent and focus needed to deliver impact for the American people. She will oversee more than 77,000 employees as Secretary. In September 2014, Tribal leaders from across Indian Country will be meeting with her for the first time as part of the Secretary's Tribal Advisory Committee to discuss issues of critical importance to American Indians and Alaska Natives. ■

Avoid the Tax Penalty: Apply for the Indian Exemption Today!

Dawn Coley (left), NIHB Tribal Health Reform Outreach and Education Program Manager, is explaining the American Indian/Alaska Native Exemption Form to an Association of American Indian Physicians Conference attendee in July 2014 in Denver, CO.

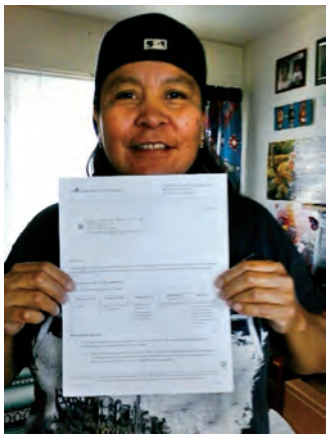
The National Indian Health Board's Tribal Health Reform Team traveled across Indian Country this summer providing Affordable Care Act training. Questions and concerns about the American Indian/Alaska Native Exemption Waiver were a common factor among all the trainings. So, what is the Indian Exemption and why should Tribal members care about it?

First some background information: Under the Affordable Care Act (ACA) all Americans, including American Indians and Alaska Natives, are required to have health coverage that meets minimum essential benefits. This is also known as the "individual responsibility requirement." Those who do not have health coverage may have to pay a tax penalty. However, the Centers for Medicare and Medicaid Services (CMS) issued a rule to allow American Indians and Alaska Natives (AI/AN) to receive an exemption from the shared responsibility under the ACA.

This means that AI/ANs – and those eligible to receive service through an Indian Health Service provider – can apply for an exemption ensuring they will not have to pay a tax penalty fee. Exemptions are granted by the Health Insurance Marketplace at any time or by the Internal Revenue Service (IRS) through the tax filing process.

Navajo Nation Tribal member, Sherri Hale, filed her exemption form in June and received her exemption number within a month. With limited income and the Indian Health Service as her primary health care provider, Ms. Hale said it was important to file for an exemption to avoid paying the tax penalty. "I could use the tax penalty fee for something else, like buying food for my family or gas for my car. It just makes sense to file for the exemption," added Ms. Hale.

The exemption form is available online at www.marketplace.gov, but can only be submitted by mail. An online submission process is not yet available. Once someone files for the exemption they will receive a response from the Marketplace with an Exemption Certificate Number (ECN). This is number should be used when filing federal taxes in 2015.



Sherri Hale, member of the Navajo Nation, shows her AI/AN exemption waiver response letter.

In Denver at the Association of American Indian Physicians Annual Conference in July, NIHB Tribal Health Reform Outreach and Education Program Manager Dawn Coley helped a young woman through the exemption application process. She is a college student currently without health insurance and uses the Indian Health Service as her provider. She was unaware that applying for an exemption was an option.

"There are many questions that surround the exemption waiver. The message here is that all American Indians and Alaska Natives – whether they have job-based or private insurance or are on a federal health program – should apply for an exemption. It is security. It is peace of mind," said Ms. Coley.

The exemptions are not tied to households. Each person in the family should apply for an exemption, including children and infants. Dependents may have a parent, guardian, or family member apply on their behalf. These exemptions are retroactive and prospective. This exemption continues indefinitely, therefore there are no future penalties. ■

National Indian Health Board and Tribal Communities Working Together to Gather Information on the Health Insurance Marketplace Experiences

Through funding provided by the Centers for Medicare and Medicaid Services, the National Indian Health Board is partnering with both rural and urban tribal communities to learn more about best practices regarding the Health Insurance Marketplace and American Indians/Alaskan Native (AI/AN) beneficiaries. The Tribal partners and NIHB will talk with community members and Tribal health care enrollment staff about their experiences with the Marketplace. The knowledge gained through these conversations will be combined with other available data to provide important insight into how to increase AI/AN access to quality health care. NIHB staff is meeting with Tribal partners this fall to plan out the details for each project site. Information will be gathered throughout the fall, winter, and spring. The analysis of the results is anticipated to be complete by the end of summer 2015. ■

Capping PRC Payment Rates Could Save Millions for the IHS

Sadly, it is often said in Indian Country, "Don't get sick after June 1." This is because that is often when funding for Purchased/ Referred Care (PRC) (formerly Contract Health Services) programs at the Indian Health Service (IHS) runs out. IHS is drastically underfunded at only 59 percent of need, and PRC funding is even worse off with an estimated $760 million shortfall FY 2013.

Yet in many cases, IHS and Tribal health providers are paying too much for PRC. PRC programs routinely pay full-billed charges for non-hospital services, including physician services. On average this is up to 70 percent more than would be paid by Medicare, and other federal and private payers. As a result, the PRC program continues to run out of funds each year, with 147,000 services denied last year.

When services are denied, IHS patients suffer. Because PRC is only treating the most desperate of cases at current funding levels, any shortfall in the program correlates to increased death rates for communities in Indian Country. Failure to pay PRC claims also means that patients are often given only symptomatic treatment, leading to long-term pain management, worse health outcomes and increased costs to the Indian health delivery system.

The House draft of the FY 2015 appropriations bill has PRC funded at $929 million, which is $51 million above the FY 2014 level and the Senate draft bill funds PRC at only $2.5 million above the FY 2014 level. Clearly, it will be hard to get the PRC dollars IHS and Tribal health providers need if they rely solely on the federal appropriations process.

That's why NIHB and its partners are calling on Congress to enact H.R. 4843 – the Native CARE Act which would extend the Medicare-like rate cap on payments made by PRC programs at the IHS and Tribal levels to all Medicare participating providers and suppliers. Hospitals are already paying Medicare rates to IHS due to the Medicare Prescription Drug, Improvement, and Modernization Act passed by Congress in 2003. Yet, non-hospital services are still bought at significantly higher rates. In 2013, the Government Accountability Office found that this small change could save IHS millions and provide about 253,000 additional patient visits a year without any additional appropriation by Congress.

Please contact your Members of Congress and urge them to co-sponsor H.R. 4843 today!

You can learn more about this issue by visiting: www.nihb.org/legislative/medicare_like_rates_for_ihs.php ■

Benefits of Public Health Accreditation for Tribes

Public health accreditation is the process of measuring health department performance against a set of standards. Public health departments that meet or exceed these standards are then recognized by being accredited for a specified amount of time. The goal of the voluntary national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. The Public Health Accreditation Board (PHAB) has been charged with establishing the accrediting standards, employing volunteers to work with public health departments to measure their performance, and ultimately grant accredited status to those public health departments that satisfactorily complete the process.

Federally recognized Tribal health departments are eligible to seek accreditation as entities that have jurisdictional authority to provide public health services. The most obvious benefit to Tribes is the commitment to ensure quality of existing services and continuously improve services. Health departments will be able to identify strengths and weaknesses, improve management, enhance systems and programs, and create a greater sense of accountability and transparency, however there are other benefits:

- **Avenue for Tribes to exercise Tribal sovereignty**: Through the accreditation process, Tribal health departments have the opportunity to showcase Tribally-specific models and programs and demonstrate how their effectiveness may differ from those of state or county health departments.
- **Unifying impact on the public health department staff**: Gathering information from existing staff to use their expertise to redesign systems, documents and protocols, can improve morale, increase understanding of management decisions, ensure all staff understand policies and procedures, and increase staff buy-in.
- **Increases appeal to funders**: If health departments can demonstrate their level of performance and existing services are held up against a set of standards, then it is possible that funders may favor them for a grant over a health department that is not accredited. While this is not a funding criteria yet, it stands to reason that it could become a component of eligibility in the future.
- **Better staff recruitment**: When applicants are searching for jobs, knowing that a Tribe has been accredited communicates to applicants a high level of performance, national connectedness, willingness to internally engage in quality improvement, and establishes a high level of expectation for applicants.

NIHB would like to ensure that Tribes have all of the information and resources that they need in order to make a well-informed decision if accreditation is the right path for them to pursue, and then feel supported on that journey. We do believe that there is inherent value in exploring that decision at the Tribal level, and examining internal processes even if it doesn't lead to PHAB accreditation. We all have an interest in providing high-quality services, and what is more important than the health and well-being of our communities? ■

Navajo Nation Special Diabetes Project

Forty hikers from Tuba City area hiked down Bitatakin Navajo Monument trail during summer.

MISSION STATEMENT

To provide diabetes prevention/intervention services by promoting healthy lifestyle changes to reduce and prevent diabetes.

VISION STATEMENT

The Navajo Nation Special Diabetes Project envisions a life filled with beauty, harmony and happiness through diabetes prevention, education and wellness.

The Navajo Nation Special Diabetes Project (NNSDP) is located in Window Rock, Arizona with seven sub-offices serving the population of over 300,000 on the 28,000 square-miles of the Navajo Nation in the states of Arizona, New Mexico and Utah. NNSDP utilizes the Diabetes Prevention Best Practice for its target population of Native Americans ages 5-55 residing on or near the Navajo reservation. Its main goal is to reduce the incidence rate of diabetes among the Navajo population through community-directed activities during and/or after working hours.

SPDI Grantee Project Summary

As a grant recipient, the Navajo Special Diabetes Project's initiative is to prevent diabetes on the Navajo Nation by promoting healthy life-styles and physical activities. With the help of all those who learned about diabetes, its prevention, and changing lifestyles with daily physical activities, and by continually working together with all health providers, clinics and health programs, NNSDP's efforts is to stop diabetes for future generations.

The staff members at the seven Service Areas located in Chinle, Dilkon, Fort Defiance, Kayenta, and Tuba City, Arizona as well as in Crownpoint and Shiprock, New Mexico are engaged in the communities by providing diabetes education and physical activities events on a daily basis utilizing Native Lifestyle Balance and Food for Life curriculums as well as SPARKS, PAK, TRAILS, and other game activities to keep people active. There are weekly community walks and runs, half-marathons, and weight loss challenges being utilized by the staff to encourage people to exercise 150 minutes or more per week. Some of the Service Areas have inter-governmental challenges between different government offices for most distance walks and runs on a weekly basis. Kayenta Service Area for example does a 20,000 minutes challenge between different offices where five-member teams compete against one another for 20,000 minutes to see which teams loses the most weight or improves their Body Mass Index. The winners receive nice incentives sponsored by the local township. The staff also work with community schools where they make presentations on diabetes prevention to school children and provide physical activities during the school year. A couple of Service Areas have extended their work with schools into the summer months where children are involved with gardening projects to learn traditional methods of growing crops and learning about eating healthy home-grown food.

NNSDP previously used the Aberdeen Software to collect client data, but due to the large number of clients, it did not meet specific needs. As a result, NNSDP worked with Real Time Solutions, a web-site designer, to develop a customized software to collect data. The Web-Based Data Collection and Management System kicked off on June 3, 2014, and so far over 8,000 entries have been made. The system has basic client information, records their BMI and weight when they register, and then follow-ups are made every three months to record progress. The staff is able to review with each client the charts and graphs and whether they have reached their weight loss goals and objectives. If a client reaches a goal, a new goal may be set for the coming months. Each staff member has a computer tablet to record and transmit information about their clients. Even though there are empty spots or zones for internet service on the reservation, they are able to save the information until they have internet service. The new system has enabled the Central Office Administration to

Runners approach finish line in Twin Arrows, Arizona completing 400 mile relay run in Running in Beauty for a Stronger and Healthier Navajo Nation on August 2, 2014.

IHS Acting Director Dr. Yvette Roubideaux addresses walkers and runners in Towoac, Colorado at the beginning of Running in Beauty for a Stronger and Healthier Navajo Nation on July 27, 2014.

Bernice Sage, Health Education Technician talks to Navajo elderly in Pueblo Pintado, New Mexico during health fair at the local school.

obtain queries for necessary reports without having to travel to each Service Area or to have the Service Areas submit information separately.

Fourth Annual Running in Beauty for a Stronger and Healthier Navajo Nation

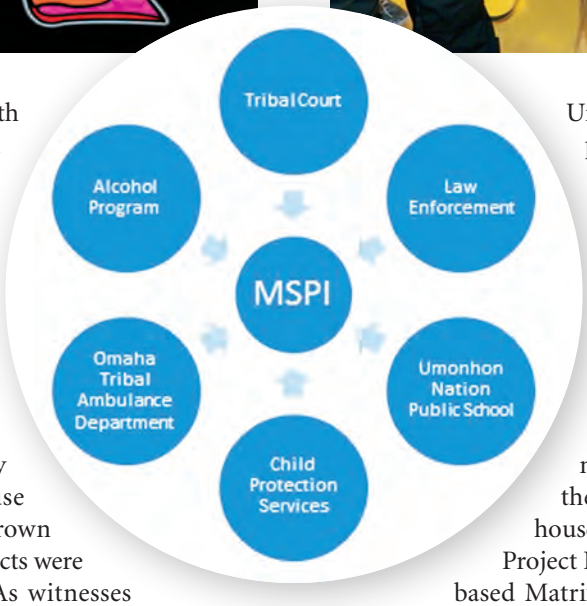
NNSDP recently completed the Fourth Annual Running in Beauty for a Stronger and Healthier Navajo Nation from July 27 – August 2, 2014, in collaboration with the Office of the President and Vice President of the Navajo Nation. The relay run covered 400 miles across deserts, canyons, mountains, and high plateaus to encourage communities across the Ute, Hopi and Navajo Nations that it is time to change lifestyles by returning to tribal traditions of running. 558 runners participated in the run along with 1,121 walkers in 19 communities. Nearly 2,500 people attended the health fairs that were held in conjunction with the run.

Runners and walkers participated in the run at the following communities from Towoac Recreation Center, Utah communities of Aneth, Montezuma Creek, Bluff, Mexican Hat, and Monument Valley; Kayenta, Chilchinbeto, Rough Rock, Tachee, Blue Gap, Whippoorwill, Smoke Signals, Low Mountain, Keams Canyon, Jeddito, White Cone, Indian Wells, Dilkon, Teesto, Tolani Lake, Birdsprings, Luepp, and Twin Arrows Resort and Casino in Arizona. The run was initiated by Navajo Nation Vice President Rex Lee Jim in 2011 to bring attention to the health of the people and the increase of childhood obesity and diabetes across Indian Country.

"The goal is to improve the quality of health for our people, and hopefully reduce health-care costs associated with obesity, diabetes, cancer, substance abuse, and mental health issues," Jim said. "We are a strong people and have endured through many trials, but in looking at the future, we want our people to be stronger and healthier. We have many strong runners on the Navajo Nation, but we want people of all ages participating in this run to improve their health.

The National Indian Health Board would like to thank the Navajo Nation Special Diabetes project who contributed this report. ■

Fighting Against Meth Everyday



Project F.A.M.E. (Fighting Against Meth Everyday) is a program that has been designed by the behavioral health team at the Carl T. Curtis Health Education Center of the Omaha Tribe of Nebraska to address the rising issue of methamphetamine use. The Center decided to use their resources in a new way to address an issue in their community that had formally not seen as much attention.

An assessment of the community by the project staff found that the use of methamphetamine had not only grown among the adult population, but the effects were entering the lives of many children. As witnesses within the community, the Behavioral Health Department Guidance and Development center put their plans in action to heal the community as a whole. Project F.A.M.E. approaches the issue in two phases: educating the community on the realities of methamphetamine addiction; and providing intensive outpatient program services to support people returning home from a treatment facility.

Project F.A.M.E. has been remarkably successful in engaging the community, especially the youth. The Meth Awareness Assembly hosted by Project F.A.M.E. is a prime example of an activity that captured the attention of many local junior high and high school students. The assembly included cultural presentations, participation of the Drug Enforcement Agency (DEA), an appearance from the Omaha National Law Enforcement K-9 unit (who brought two police dogs in to meet the students), and a comedian who shared his experiences as a recovering meth addict through a humorous message that resonated with the youth.

Project F.A.M.E. has designed their programming to engage a variety of resources throughout the community. This model of community collaboration is also key in Project F.A.M.E.'s approach. Partners include Tribal courts, law enforcement, Umonhon Nation public school, child protection services, Omaha Tribal Ambulance Department, and alcohol programs. This model builds a sustainability framework for this project. It is also important to gain buy-in from the Tribal Council and support from Elders.

Two key collaborators in the project's efforts have been the Behavioral Health Specialists, Inc. resident treatment center in Norfolk, Nebraska, and the Umonhon Alcohol Program halfway house. In structuring this aftercare program, Project F.A.M.E. has implemented the evidence-based Matrix Model for Meth Treatment. Though the program was originally a year, Project F.A.M.E. adapted to reflect 16 weeks of structured outpatient care and programing and an additional 16 weeks of continuing care with patients and families.

Key staff include a Behavioral Health Specialist, the Behavioral Health Tech, and the Meth Prevention Tech, who all work together to provide the wide array of prevention and therapeutic services. The Behavioral Health Specialist focuses on the educational and therapeutic components of the aftercare program, and the Meth Prevention Tech is integral in reaching out to build awareness in the community.

So far, Project F.A.M.E. is seeing an increasing interest in their aftercare services and has successfully cared for a number of individuals. The team is looking toward continuing this work by engaging and healing the community as whole.

Rosalie Two Bulls, Project F.A.M.E. Program Director, and Siva Pula, Guidance and Development program associate with Project F.A.M.E., contributed to this article. For more information or any questions about Carl T. Curtis Health Education Center's Project F.A.M.E. programing, please contact Two Bulls, Rosalie at Rosalie.TwoBulls@ihs.gov, or Siva Pula at siva.pula@ihs.gov. ■

Second Annual Rez Condom Tour

By: Keioshiah Peter (Diné), National Native Youth Council-HIV

Native youth on the Navajo Reservations share messages on sexual health to cars passing by.

Recent college graduates and students on summer break are usually taking classes, working, or enjoying the summer heat; but that was not the case for those who organized the 2nd Annual Rez Condom Tour on the Navajo Nation. Instead, they decided to give back to the Native community through youth-led community organization and mobilization.

The Rez Condom Tour is the original brainchild of Matthew Skeets (Diné) who organized the first event in 2013 through the Sovereign Bodies Project (SOBOPRO [which should not be confused with the Sovereign Bodies that focuses on Indigenous women's health]). SOBOPRO provided free condoms to Diné youth. Within two hours, Skeets and his volunteers gave out 2,000 condoms, provided by the New Mexico Department of Health, in Gallup, New Mexico and Tse Bonito, New Mexico. Thus, the Rez Condom Tour promotes healthy sexual activity by increasing access to condoms and providing sexual health education for Diné youth and communities. In addition, the tour provides free rapid HIV testing to increase the number of people who know their HIV status.

This past summer, the SOBOPRO partnered with Rising Native Youth, Tested I Am I Kno, and the Native Youth Sexual Health Network to re-launch the 2nd Annual Rez Condom Tour. Given that the Navajo Nation is geographically the largest reservation with a population to match, funding for food, gas, lodging, supplies, giveaways, and promotional t-shirts was scarce for the college-age students who were leading this effort. To fund the effort, $221 was raised via a GoFundMe campaign. Along with additional donations, they traveled to various communities on the Navajo Nation, which included Window Rock, Chinle, Tuba City, and Shiprock. They racked up more than 924 miles, and set up booths at flea markets and chapter houses.

The group passed out 3,318 male condoms, 178 female condoms, and 102 dental dams and performed countless demonstrations – of course providing plenty of laughs along the way. After visiting one of the booths, the Tuba City Community Health Representative (CHR) program requested 1,000 condoms to distribute during CHR home visits. The youth were also invited to present and set up a booth at the Survival of the First Voices Festival in Farmington, New Mexico, July 30th – August 1st, where they passed out 500 more condoms.

Organizers of the Condom Tour and youth activists want to remind Native people that there is "a need to reclaim and take control of our sovereign bodies. By reminding Native people that Sex is Ceremony, we begin to de-stigmatize the topic of sex in our communities and protect our people from HIV infections. By opening the conversation about sexual health and education in our Native communities, we are creating new pathways that Indigenous youth and students can affect positive change on the grassroots levels through hard work and collaboration."

To learn more information about our partners or learn more about the Rez Condom Tour, please visit the Sovereign Bodies Project Facebook page at www.facebook.com/sovereignbodies. ■

Meaningful Use for Electronic Health Records – One Year Left to Keep Getting Incentives

The National Indian Health Board recently received a one year No Cost Extension on the Office of National Coordinator's (ONC) Regional Extension Center (REC) program. That means the only National REC serving Indian Country is still operational, still able to help providers in IHS/Tribal/Urban health facilities achieve Meaningful Use of an Electronic Health Record (EHR), and help in the application for incentive payments from Medicare or Medicaid. The incredible REC program will remain with NIHB until April 5, 2015 and services from our four partners; Alaska Native Tribal Health Consortium (ANTHC), California Rural Indian Health Board (CRIHB), Northwest Portland Area Indian Health Board (NPAIHB), and United South and Eastern Tribes (USET) will continue to be funded from NIHB through the REC grant.

So what does the future of Meaningful Use hold for Indian Country? As of right now, some limited resources may be available after April 2015 and NIHB is currently building an online Resource Library that will house all of the information gathered from the REC program over its five year history. This Resource Library will be open and available to anyone that has a desire or need to learn more about Meaningful Use. All five partners are continually pursing grants and other funding sources that help make future Meaningful Use work possible.

But there is still work to be done now. Many providers in Indian Country have not yet achieved Meaningful Use. Let's all take advantage of the free REC services while they are still available. If you or anyone in your health facility need help, please reach out to the National Indian Health Board or one of the regional partners.

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What You Need to Know About Electronic Health Records

EHR - Electronic Health Record is a collection of health information about an individual patient in digital format that is capable of being shared.

HITECH - Health Information Technology for Economic and Clinical Health Act was enacted under the American Recovery and Reinvestment Act (ARRA) in 2009. Under the act, the Department of Health and Human Services is promoting and expanding the adoption of Health Information Technology.

MU - Meaningful Use is the use of a certified Electronic Health Record in accordance with specific standards set forth by the Centers for Medicare & Medicaid Services (CMS). Upon achieving Meaningful Use, providers can be eligible to avoid penalties and even receive incentive payments from CMS.

ONC - Office of the National Coordinator for Health Information Technology is a division within the Department of Health and Human Services that leads the national Health IT efforts in the implementation and use of Electronic Health Records and the exchange of health information.

REC - Regional Extension Center's were formed under a grant program from the Office of National Coordinator. There are 62 REC's across the nation that offer technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of Electronic Health Records. ■

Upcoming Events

September

SEPTEMBER 17-18, 2014:
HHS STAC MEETING
Washington, DC

SEPTEMBER 23-24, 2014:
SELF-GOVERNANCE STRATEGY SESSION
Ocean Shores, WA

SEPTEMBER 30-OCTOBER 2, 2014:
NIHB BOARD RETREAT
Location, TBD

October

OCTOBER 7-9, 2014:
DOI & IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE MEETING
Washington, DC

OCTOBER 13-14, 2014:
INDIAN HEALTH BUDGET SUMMIT
Washington, DC

OCTOBER 21-23, 2014:
NPAIHB BOARD MEETING
Worley, ID

OCTOBER 23-25, 2014:
ALASKA FEDERATION OF NATIVE CONFERENCE
Anchorage, AK

OCTOBER 26-31, 2014:
NCAI ANNUAL CONVENTION & MARKETPLACE
Atlanta, GA

November

NOVEMBER 18, 2014:
MMPC F2F
Washington, DC

NOVEMBER 19-20, 2014:
TTAG F2F
Washington, DC

December

DECEMBER 4-5, 2014:
HHS STAC MEETING
Washington, DC

SEPTEMBER 21-24, 2015

National Indian Health Board

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