Health News & Notes

Our Mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

A Publication of the Northwest Portland Area Indian Health Board

HEALTH REFORM AND BEHAVIORAL HEALTH SERVICES

by Jim Roberts, Policy Analyst

The recent passage of health care reform law makes it an appropriate time to focus this edition of the Board's newsletter on behavioral health issues. The new law provides an opportunity for Tribes to address behavioral health needs in tribal communities. In the Portland Area behavioral health has consistency ranked as one of the highest health priority areas for Northwest Tribes. It is broadly understood that American Indian and Alaska Natives (AI/AN) are at a higher risk for mental health disorders than other racial and ethnic groups in the United States. Indian Health Service (IHS) utilization data validate that at least one-third of the demand for services in IHS and tribally operated facilities is related to behavioral health issues. The high prevalence of substance abuse, depression, anxiety, violence, and suicide has invoked Tribal leaders to respond and command that these issues are addressed in Tribal communities.

During the reauthorization of the Indian Health Care Improvement Act the National Steering Committee placed a high priority on rewriting and modernizing the IHS behavioral health programs. Tribal leaders supported a comprehensive behavioral health program to reflect tribal values and emphasize collaboration among alcohol and substance abuse programs, social service programs and mental health programs. The recent health care reform bill passed by Congress may now provide Tribal leaders with the necessary tools to begin to address these crucial issues in their communities.

The Patient Protection and Affordable Care Act (P.L. 111-148, or Affordable Care Act) is a comprehensive health reform bill that includes amendments to reauthorize the Indian Health Care Improvement Act (IHCIA). Taken together, the Affordable Care Act and IHCIA will make many positive improvements to improve access to health services for AI/AN people. This is especially true for those individuals—many who are AI/AN---that may require behavioral health services. For example, the Affordable Care Act will allow many low-income and other uninsured people to purchase health insurance. Health reform will also expand the Medicaid program to cover individuals up to 133% of the federal poverty level. These new options will have a positive effect and increase the opportunity for Indian people to gain access to health care and behavioral health services.

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In This Issue.....

Our Behavioral Health Issue Contains:

THE ROLE OF REGIONAL REFERRAL SPECIALTY CARE CENTERS

by Joe Finkbonner, Executive Director

In 2005, all twelve of the Indian Health Service Area (IHS) Offices completed a comprehensive master planning process. The master plans serve as a guidance document to plan and develop future health facilities in each of the IHS Areas. The plans identify facility and service needs for all Tribes in each Area. The new facilities construction priority system makes it a requirement that in order for a construction project to be evaluated and ranked it must be included in the master planning process. Otherwise, the project may not be considered for funding (with exception for the joint-venture and small ambulatory programs).

The Portland Area does not have an inpatient or specialty care center, which makes NW Tribes very reliant on the Contract Health Service (CHS) program. Those IHS Areas that have inpatient and specialty care can internalize the costs of delivering care normally provided through CHS programs. This results in more health services being available in those Areas that have hospitals, while CHS dependent areas like Bemidji, California, Portland and Nashville must often reduce the levels of care due to underfunding in the CHS program. Those Areas with hospitals can also bill Medicare and Medicaid to generate third party revenue, which allows them to provide more services. The CHS Areas are at a disadvantage for generating additional resources and developing regional referral specialty care health center would increase access to health care and result in better health outcomes.

The Portland Area master plan included a concept proposing three regional referral specialty care centers and one Area-wide inpatient facility that have generated a great deal of discussion and debate among Portland Area Tribes. The master plan proposes developing regional referral specialty care centers in northwest Washington, another in northeast Washington or western Idaho, and one in Oregon. While the master plan includes an Area-wide inpatient facility, it was proposed in the event a funding opportunity would present itself, and the construction of a hospital could be explored. Recent discussions around regional centers have validated that construction of an inpatient hospital is not a viable option for the Portland Area and will no longer be explored.

Discussions around regional referral specialty care centers suggest that there is confusion about the types of services these facilities will provide and their role in the Portland Area health care delivery system.

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HEALTH REFORM AND BEHAVIORAL HEALTH SERVICES

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IHCIA Behavioral Health Programs

The Affordable Care Act amendments expand the mental health services authorized under the IHCIA to create comprehensive behavioral health and treatment programs. The IHCIA amendments (Title VII of the Act) build on existing programs to encompass the broader focus of behavioral health as compared with current law's more narrow focus on substance abuse. It authorizes both prevention and treatment programs for Indian children, youth, women and elders. The new programs emphasize a systems approach and interconnectedness of services related to alcohol and substance abuse, child welfare, suicide prevention and social services. In addition, it requires the IHS to establish new programs for youth suicide prevention and develop inpatient mental health care facilities in each of the IHS Areas.

This includes a new program to award grants to Tribes and tribal organizations (Ts and TOs) to carry-out demonstration projects using tele-health technology to provide youth suicide prevention and treatment services. To accomplish this, the IHCIA authorizes appropriations of $1.5 million over three fiscal years for the new program.

The IHCIA amendments include requirements for the IHS and the Department of the Interior to assess the need for comprehensive alcohol and substance abuse prevention and treatment services in order to provide community education programs. The bill also authorizes training and community education programs, demonstration projects to establish substance abuse counseling education curricula at tribally operated community colleges, and grants for preventing, treating, and diagnosing fetal alcohol syndrome (FAS) and fetal alcohol effects.

Additional programs are authorized for Indian youth, Indian women, those affected by fetal alcohol disorder in Indian communities, and both the victims and perpetrators of child sexual abuse in Indian households. In addition to a comprehensive approach to addressing behavioral health services, the reauthorized IHCIA recognizes and affirms the importance of providing care within the context of an individual's family, community and particular tribal culture, such as is used by the systems of care model.

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Northwest Portland Area Indian Health Board

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Affordable Care Act & Behavioral Health

The Affordable Care Act will provide new options for AI/ANs to gain access to health care and behavioral health services by purchasing health insurance or providing health coverage under Medicaid. It is anticipated that many Tribal health programs, either through their Contract Health Service programs, or through tribal contributions will facilitate providing health coverage for eligible tribal members. The health reform law will requires health plans and Medicaid to meet certain standards and cover mental health and substance abuse services.

It is estimated that approximately 90% of people in need of behavioral health services are unemployed or are not covered by federal programs like Medicare or Medicaid. This means they do not have an employer-based health insurance plan. If they try to purchase their own insurance, they find many barriers. Insurers can refuse to sell or renew policies based on a person's health or mental health conditions, deny coverage for any pre-existing conditions (thereby failing to pay for ongoing mental health treatment), or issue a policy with limits on the length of covered treatment. Even when such policies can be found, they are often extremely expensive and do not provide good coverage. The Affordable Care Act will change this and correct these problems so that insurance companies can no longer continue this practice. It will improve access to health and mental health care for people with behavioral health needs.

The Affordable Care Act will also expand the Medicaid program to cover individuals up to 133% FPL. It is estimated that this will provide coverage to an additional 16-18 million new Medicaid enrollees. It is estimated that approximately 250,000 of these new enrollees will include AI/ANs, many who will be users of the Indian health system. This means that IHS and Tribal health programs that are currently providing behavioral health care can now rely on the insurance exchange or Medicaid programs to cover the costs of providing this care. This will allow IHS and Tribes to provide additional types of health services to other beneficiaries.

The new health reform law and amendments to the IHCIA will greatly improve access to quality health care and to behavioral health services for most AI/AN people. Hopefully it will provide Tribal leaders and health programs with the tools to assist to address behavioral health issues in our communities.

Joe Finkbonner, NPAIHB Executive Director, Elaine Dado, NPAIHB Executive Administrative Assistant, and Pearl Capoeman-Baller, Quinault Nation Delegate, Lisa Griggs NPAIHB Assistant at NCAI Just Move It Walk, Albuquerque, NM

Jefferson Keel , Chicksaw Nation and NCAI President leading Just Move It activities.

THE ROLE OF REGIONAL REFERRAL SPECIALTY CARE CENTERS

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Regional referral specialty care centers are direct service outpatient healthcare facilities that will offer the services of physician specialists (i.e., cardiology, oncology, day surgery). The complete level of services has not been determined for each site and will be developed in consultation with the Tribes that will be served by that facility. Inpatient services will not be provided at the regional centers.

Regional referral specialty care centers are a means to address Contract Health Services (CHS) dependency problem of Portland Area tribes by providing a certain level of specialty care services for Tribes in that region. These are services that the Tribe is already purchasing care and likely paying transportation costs for through its CHS program. Offering these services through a regional referral specialty care center operated by Tribes will alleviate the drain on CHS budgets and the demand for services at the local level. It will benefit tribes by allowing tribal clinics and health programs to stretch their CHS budgets. Many of these services will be reimbursable under Medicare or Medicaid and will generate third party resources that can be used to provide expand care.

In the course of discussion around regional centers, it's been speculated that regional centers affect current workload and budget of existing IHS or tribal health programs. Because the centers would be funded with new money they will not impact current IHS or Tribal health budgets. In fact, the expanded availability of services provided at a regional center will enhance IHS and Tribal programs without affecting current workload and will save tribes money. The current services that Tribes are purchasing through the private sector could now be referred to the regional center and save valuable CHS funding. This practice is in place already at the Phoenix Indian Medical Center (PIMC) although many within the IHS system may not acknowledge that PIMC is a regional referral center. A study on the PIMC user population will reveal that IHS and tribal health programs throughout the southwest refer patients to PIMC.

The regional referral model is also in place in the Alaska Native health system. The Alaska Native Medical Center (ANMC) is an acute, specialty, primary and behavioral healthcare provider that provides comprehensive medical services to Alaska Native and American Indian people living within the state. The Center serves as a statewide (regional) referral center for other regional health centers located throughout Alaska. The model used in Alaska has many similarities to that proposed in the Portland Area. The fact that regional centers are in place in Arizona and in Alaska validate that these health care delivery systems have a place in the Indian health care delivery system. Tribes are willing to pay the costs of transportation in order to realize the cost savings in CHS and health program budgets in order to access care provided at regional centers.

As positive as regional referral specialty care centers may seem, there is still a long way to go before this concept becomes a reality in the Portland Area. Funding to construct and staff the proposed centers is the most critical issue. It is anticipated that the cost of one regional health center could cost between $50 to $100 million depending on the size and level of services that will be available. Each of the Tribes in the respective regions to be served by a regional center will need to decide for themselves if they would like to become a partner in the development of regional centers. Then the ownership and governance structure of the regional facilities would have to be worked out. This process would have to be determined with each of the Tribes participating in the respective regions. All of this will be very complex and take time to work out. It's likely that a regional center will not see construction funding for at least five to ten years-if not longer.

SEASONAL INFLUENZA UPDATE

by Thomas M. Weiser, MD, MPH, Medical Epidemiologist

Seasonal Influenza Update

The 2010-2011 influenza season is beginning in the Northern hemisphere with increases in reported cases in both North America and Europe. There are important differences between the two regions, however, in that in the U.S. and Canada, the pandemic strain from last year (Influenza A (H1N1)) makes up a small percentage (7.9%) of the total number of influenza viruses identified as of the end of Week 51 (**Tables 1 and 2**). In Europe, the Influenza A (H1N1) strain has been the predominant strain reported.

All three influenza strains currently in circulation in North America, Influenza A (H1N1), Influenza A (H3N2) and Influenza B, are included in this season's influenza vaccine. According to World Health Organization (WHO), those infections that have been caused by Influenza A (H1N1) in Great Britain are more frequent and more severe in those who are younger, as was the case last year. The frequency of infections caused by other strains of circulating influenza viruses (Influenza A (H3N2) and Influenza B) is more evenly distributed and the severity of infection is greater among the elderly, as is typically seen with seasonal influenza.

Table 1. Week 51 Influenza Virologic Surveillance*

Positive specimens by type/subtype	Total (%)	% of Influenza A specimens
Influenza A	479 (69.5%)	na
A (2009 H1N1)	15 (2.2%)	3.1%
A (no subtype)	277 (40.2%)	57.8%
A (H3)	187 (27.1%)	39.0%
Influenza B	210 (30.5%)	na

* Total number of specimens tested, Week 51: 3,284;
Total specimens positive for any influenza, Week 51: 689 (21%)

Table 2. Cumulative Influenza Virologic Surveillance, Week 40-51

Positive specimens by type/subtype	Total (%)	% of Influenza A specimens
Influenza A	2903 (59.7%)	na
A (2009 H1N1)	228 (4.7%)	7.9%
A (no subtype)	1341 (27.6%)	46.2%
A (H3)	1334 (27.6%)	46.0%
Influenza B	1961 (40.3%)	na

Source: CDC, http://www.cdc.gov/flu/weekly/summary.htm

In the Portland Area, current influenza surveillance updates are available for both Oregon (http://www.oregon.gov/DHS/ph/acd/flu/surveil.shtml) and Washington (http://www.doh.wa.gov/EHSPHL/Epidemiology/CD/fluupdate.pdf). These data show only sporadic or local influenza activity so far. Data from the IHS Influenza Awareness System (IIAS), both nationally and in the Northwest show influenza-like illness (ILI) patterns to be similar to those reported by CDC. The NW ILI-rate is 3.1% (range: 2% – 10%) and has been increasing for each of the past 3 weeks. Influenza vaccination rates are also tracked by this system and show that as of 12/27/2010, 13,125 patients or approximately 25.6% (range: 11.5% – 35.4%) of the active clinical

SEASONAL INFLUENZA UPDATE

population from NW reporting sites had received at least one dose of the current influenza vaccine.

Vaccine Hesitancy: Anecdotally, it has seemed that a lot of people refuse the influenza vaccine. But it may be that this year, many more people are being offered a flu shot than ever previously. At one site, in which approximately 30% of patients were vaccinated, the vaccine refusal rate was actually about 10%. Providers at this site commented that this was lower than what they thought it actually was.

Table 3. Influenza Immunization Coverage, by Age, Portland Area IHS Influenza Awareness System, (12/27/2010)*

Flu FAQs:

Q: Is it too late to get my flu shot?

A: No. The sooner you get your flu shot, the sooner it can start protecting you and those around you from the effect of flu. Although it may take 4-6 weeks for full immunity to develop, the flu shot can lessen the severity of infection within 2 weeks of administration.

Q: I got my H1N1 shot last year, do I need to get a flu shot this year, too?

A: Yes. Even though you may have some protection from H1N1, the Influenza A H3N2 and Influenza B strains are much more common this year and were not part of either the seasonal flu shot or the H1N1 flu shots offered last year.

Q: My doctor told me I had H1N1 disease last year, do I need to get a flu shot this year?

A: Yes. For much the same reason as above. Previous infection with H1N1 does not offer any protection against the other strains that are most commonly expected this year, Influenza A H3N2 and Influenza B.

For more information about the flu, contact your local public health nurse, county medical officer or Portland Area Medical Epidemiologist, Tom Weiser, MD, MPH (tweiser@npaihb.org; 503-416-3298)

Age Group	Active Clinical User Population	User Popultation	Seasonal flu (1dose)	% Seasonal flu (1dose) [user pop]	% Seasonal Flu (1dose) [user pop]	At least 1 dose H1N1 [active pop]	% At least 1 dose H1N1 [active pop]	% At least 1 dose H1n1 [user pop]
0-5 months	145	259	---	---	---	---	---	----
6 months - 4 yrs	3868	5351	1300	33.6	24.3	1	0	0
5-9	4173	6507	872	20.9	13.4	---	---	---
10-18	7536	12620	1587	21.1	12.6	1	0	0
19-24	5335	9283	809	15.2	8.7	---	---	---
25-64	26005	40131	6879	26.5	17.1	---	---	---
65+	4262	6112	1678	39.4	27.5	---	---	---
TOTAL	51324	80263	13125	25.6	16.4	2	0	0

NORTHWEST TRIBAL SUBSTANCE ABUSE ACTION PLAN

by Colbie Caughlan, Suicide Prevention Project Coordinator

At the request of the Portland Area Indian Health Service, the Northwest Portland Area Indian Health Board (NPAIHB) began a collaborative planning process in early 2010 to develop an intertribal *Substance Abuse Action Plan* for the NW tribes. To guide the development of the plan, NPAIHB staff met with NW tribes and regional partners throughout the year to identify priority issues and concerns related to substance abuse prevention and treatment, particularly related to alcohol, tobacco, and other drugs (ATOD).

The planning process involved multiple phases, beginning with a review of substance abuse rates and risk and protective factors for American Indians and Alaska Natives (AI/AN) living in the region. NPAIHB then gathered additional information about available and needed substance abuse services, and assessed the capacity of the region's tribes to address substance abuse at the community level. Questions adapted from the *Community Readiness Model* were discussed at length with regional partners, exploring a broad array of topics, including prevention activities, treatment services, and perceptions about community knowledge, action, climate, and concern.

This information was then shared with NW tribes and regional partners, and used to collaboratively select and design intervention strategies that would be most responsive to the current level of community capacity and readiness within the Northwest tribes. The resultant plan spans a five year period, and includes the 43 federally-recognized tribes located in Idaho, Oregon and Washington.

A draft of the *Northwest Tribal Substance Abuse Action Plan* was completed in November 2010, and has been circulated among partners for critical review and feedback. A brief overview of the plan follows:

Tribal Action Plan Mission:

Reduce substance abuse among American Indians and Alaska Natives living in the Pacific Northwest by increasing tribal capacity to prevent and treat substance abuse, and by improving regional services and collaborations.

Primary Goals for 2011-2015:

Goal 1: Increase the capacity of Tribal health programs to prevent, screen for, and treat substance abuse in culturally-appropriate ways.

Goal 2: Increase knowledge and awareness about substance abuse among NW tribal community members, and in doing so, take steps to address the *acceptance* of substance abuse and the *stigma* that surrounds behavioral health programs, preventing community members from using available prevention and treatment services.

Goal 3: Improve tribal policies and procedures surrounding the availability, abuse, screening, referral, and treatment of substances, and the enforcement of those policies.

Goal 4: Improve intertribal and interagency communication about substance abuse prevention, referral, and treatment in order to improve outcomes for individual patients, and share and maximize limited resources.

Please Provide Feedback: We welcome your review and comment on the *Northwest Tribal Substance Abuse Action Plan.* For a copy of the plan, please contact Colbie Caughlan at ccaughlan@npaihb.org or (503) 416-3284.

Once complete, the plan will be reviewed by the delegates of the Northwest Portland Area Indian Health Board and the Behavioral Health Committee, and a resolution supporting the plan's implementation will be submitted for consideration.

HIV CARE AND TREATMENT PROGRAM

by Christy Myers, MSW
Grants Coordinator HIV Care and Treatment Program, Oregon Health Authority

All states receive federal funding through the Ryan White Treatment Modernization Act to provide health care coverage or financial resources for those diagnosed with HIV/AIDS disease. Although Ryan White funds are to be used as payer of last resort, individuals who identify as American Indian or Alaska Native can receive Ryan White services even if they are eligible for care from other sources (through Indian Health Services for example).

The Oregon HIV Care and Treatment Program is a Ryan White grantee, providing high quality, cost effective services that promote access to and ongoing success in HIV treatment for people living with HIV/AIDS (PLWH/A) in Oregon. Through successful case management, access to important supportive services and assistance through Oregon's AIDS Drug Assistance Program, CAREAssist, PLWH/A are empowered to effectively manage their HIV disease and improve their overall health and quality of life. *If you have a patient with an HIV diagnosis, please ensure they are aware of the following services.*

CAREAssist (Oregon's ADAP) assists eligible HIV positive Oregonians by paying for health insurance, prescription medication and medical service co-payments and deductibles. The program has higher income limits than most social service programs so most individuals are eligible. Additional information and applications can be found at the program's website www.healthoregon.org/careassist or by calling 1-800-805-2313.

Individuals who are uninsured or are not enrolled in CAREAssist may be eligible for up to a 90-day emergency supply of prescription medications related to their HIV care through the Bridge Program. This program can also assist with medical visits and lab work necessary to determine appropriate HIV treatment regimens. Coverage is available to Primary Care Providers establishing the client's ongoing medical needs. The Bridge Program Application must be completed by a physician and can be found at the program's website.

Finally, the HIV Care and Treatment Program contracts with county health departments and community based organizations around the state to provide HIV case management services to persons living with HIV and their families. HIV Case Managers help PLWH/A with a variety of supportive services, including emergency housing and utility assistance, food and nutrition assistance, medical transportation assistance, substance use treatment, mental health treatment, translation services, dental care, home health care, and assistance applying to other mainstream benefit programs. Furthermore Registered Nurses are available to provide coordination of care through intensive medical case management to clients who need support managing their disease, including adherence counseling. Please visit the program's website www.healthoregon.org/hiv to find the HIV case management service nearest you, or call the program at 1.800.805.2313.

For additional information on HIV, please visit the Oregon AIDS hotline at http://www.oregonaidshotline.com/ or call (800) 777-2437.

NEWS FROM PROJECT RED TALON

Project Red Talon Announces Three New Multimedia Health Projects

For over 22 years, Project Red Talon has worked with the NW tribes to promote sexual health and reduce the prevalence of STDs, HIV/AIDS, and teen pregnancy in the region. This quarter, Project Red Talon is kicking off three exciting new initiatives to better meet the needs of Native teens and young adults: Native VOICES, It's Your Game (IYG), and a Multimedia Health Project.

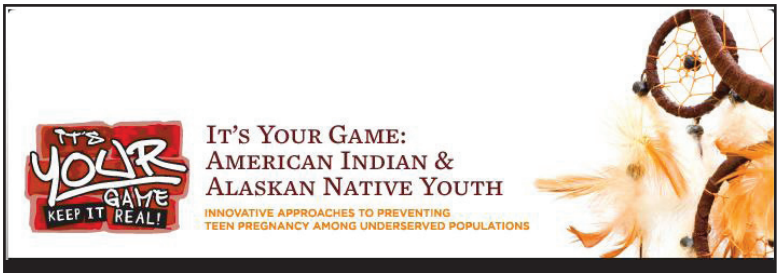
Together, these projects will help fulfill Project Red Talon's multimedia strategic plan – creating user-friendly sexual health resources made by and for Native youth. All components of the project will be designed to promote the health of adolescents, support positive youth development, delay sexual initiation, reduce sexual risk-taking, reduce STD/HIV infections and disparities, and achieve a more coordinated national and NW tribal response to STDs/HIV.

Native VOICES Adaptation

The Native VOICES project will develop an innovative evidence-based sexual health video for the NW tribes that will provide young people with accurate risk information, correct misconceptions, and demonstrate culturally-specific strategies for encouraging condom use and enhancing partner communication. The project is supported by a three-year grant from the Indian Health Service, issued through their Native American Research Centers for Health (NARCH) program.

NPAIHB will work closely with tribal and Indian Health Service partners to adapt a CDC-recognized intervention, *Video Opportunities for Innovative Condom Education and Safer Sex* (*VOICES*), and evaluate its effectiveness as an HIV/STD prevention resource for American Indian and Alaska Native (AI/AN) teens and young adults 15-29 years old.

To maximize the cultural appropriateness of the Native VOICES video and supplementary materials, Project Red Talon will collaborate with I/T/U partners to hold focus group talking circles, individual interviews, and community feedback sessions that will capture the varied experiences of AI/AN teens and young adults in Washington, Idaho, and Oregon. Project staff will also seek input from I/T/U clinicians on the feasibility of the intervention, and ways to successfully integrate the video into the flow of community health services.



It's Your Game (IYG) Adaptation

New funds have also been secured by Project Red Talon to adapt a multimedia sexual health program

NEWS FROM PROJECT RED TALON

for AI/AN youth 12-14 years old, *Its Your Game…Keep it Real* (IYG). The IYG Adaptation Project is a multi-site research endeavor that will be carried out in partnership with the Alaska Native Tribal Health Consortium, Intertribal Council of Arizona, Indian Health Service, the Bureau of Indian Education, Tribal Boys and Girls Clubs, University of Texas Prevention Research Center, and Oregon Health and Sciences University. Funding for the three-year project was provided by the Centers for Disease Control and Prevention.

Project Red Talon will work with NW tribes to culturally adapt the Internet-based HIV, STI, and pregnancy prevention program for Native youth. This will involve recruiting 30 youth in March 2011 to test and provide feedback on the program's online interface, ease of use, credibility, motivational appeal, and personal applicability. In consultation with the NW tribes, the program will then be adapted during the second year of the project. In the third year, we will recruit 400 NW Native youth (12-14 years old) to test the effectiveness of program.

Multimedia Health Project

Additionally, Project Red Talon has secured funds to develop several state-of-the-art multimedia health resources for Native teens and young adults that will promote holistic health and positive identity and development.

The website, funded by the President's National HIV/AIDS Strategy and the Indian Health Service's National HIV/AIDS Program, will specifically target American Indian and Alaska Native teens and young adults. The site will address health and social issues important to Native youth, and will integrate other social marketing strategies like MySpace©, Facebook©, Twitter©, and text messaging.

NW Native youth will also be sought to assist in the construction of the website, by becoming authors of blogs, directors of videos, graphic design artists, and much more. Supporting this effort, a text messaging service will be designed to send out periodic health tips, provide subscribers with updates on related contests and social service opportunities, and challenge youth to take a more active role in their own health and wellbeing. Both services will be launched in 2011.

Please contact NPAIHB if you or your tribe is interested in participating in any of these projects:

Stephanie Craig Rushing, *Project Director*, scraig@npaihb.org or 503-416-3290

Wendee Gardner, *Native VOICES Project Coordinator*, wgardner@npaihb.org or 503-416-3275

Jessica Leston, *Multimedia Project Coordinator*, jleston@npaihb.org or 907-244-3888

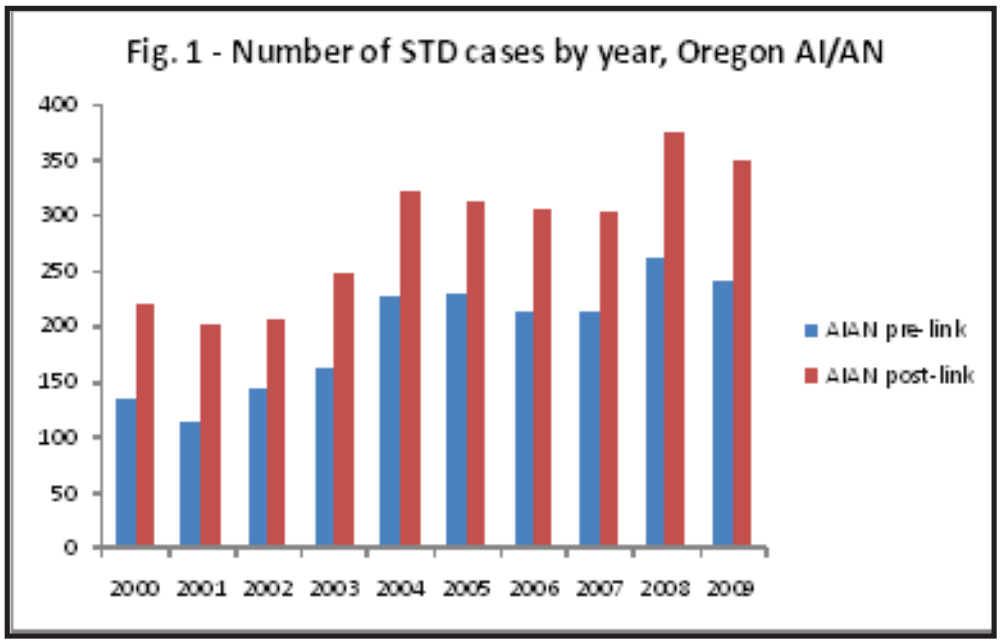
David Stephens, *Multimedia Project Specialist*, dstephens@npaihb.org or 503-416-3307

IMPROVED OREGON STD & HIV DATA OBTAINED THROUGH RECORD LINKAGE

by Megan Hoopes, MPH; Project Director, IDEA-NW & Northwest Tribal Registry

Sexually transmitted diseases (STDs) are common among teens of all races and ethnicities. One out of every 4 sexually active teens will get an STD this year, and 1 in 10 sexually active teens has chlamydia. American Indians and Alaska Natives also experience high rates of sexually transmitted diseases, but the true burden may be under-estimated when race information isn't correctly reported in state data systems. The "Improving Data & Enhancing Access" Project (IDEA-NW, or Registry Project) recently completed a data linkage between the Northwest Tribal Registry database and Oregon's STD/HIV surveillance system. The linkage was intended to improve the coding of race for AI/AN cases, and to provide more accurate estimates of STD rates for this population.

The linkage identified over 950 AI/AN cases that were miscoded or missing race in the state's data, a misclassification prevalence of 32.3%. As a result of the linkage, case ascertainment of STDs increased almost 47%, and HIV cases increased by 71% among AI/AN. As seen in **Figure 1**, the number of STD cases would be substantially under-estimated each year if race hadn't been corrected. Between 2000 and 2009, there were an average of 284 new STD cases per year among AI/AN. Approximately 55% of these occurred in young people ages 15-21, which follows the national pattern of the highest rates of chlamydia and gonorrhea occurring in teens and young adults. An average of 12 cases of HIV were reported per year among AI/AN in Oregon.



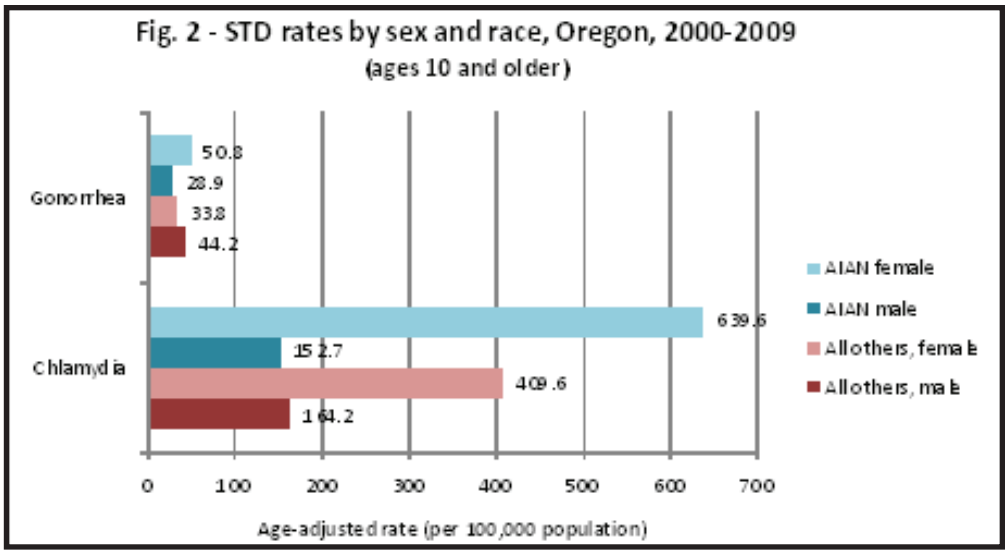


Table 1. HIV case counts (%) in Oregon by race and sex, 2000-2009

	Male	Female	Total*
AI/AN	81 (65.9)	42 (34.1)	123
All other races	6035 (78.6)	1461 (19.0)	7679

*Totals may not equal due to missing sex data

IMPROVED STD & HIV DATA OBTAINED THROUGH RECORD LINKAGE

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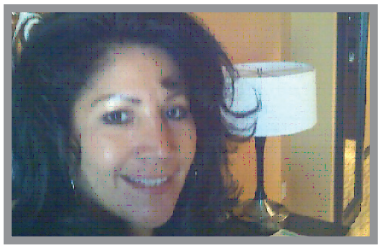
AI/AN females had significantly higher rates of both chlamydia and gonorrhea than females of other races/ethnicities, but for males the rates were approximately the same. Female AI/AN also comprised a larger burden of HIV cases compared to other races (34% of HIV cases among AI/AN were female, vs. 19% for other races combined). Rate estimates for selected STDs are presented in **Figure 2**, and HIV case counts in **Table 1**. These results are similar to other STD estimates across Indian Country and nationally.

Without accurate data for AI/AN, important public health concerns may not receive the attention they deserve. Improved data such as the STD statistics presented here can be used to inform tribal health priorities, ensure that limited health resources are appropriately distributed, and help plan and target prevention and intervention programs.

For culturally-appropriate STD/HIV prevention and outreach resources, please contact Project Red Talon or visit: www.npaihb.org/epicenter/project/project_red_talon/.

Note **-** The IDEA-NW Project can provide health data for your community, and is available for data partnerships with northwest tribes. Please contact Megan Hoopes at mhoopes@npaihb.org or 503-416-3261 for more information.

MONITORING THE ABUSE OF DRUGS



by Julie Taylor, Monitoring the Abuse of Drugs Project Director

In an effort to assist Northwest Tribes, NPAIHB has partnered with the National Institute on Drug Abuse as well as the Native American Research Centers for Health, to develop the capacity to collect and use health data to improve health status and reduce health disparities related to substance use. The Monitoring the Abuse of Drugs project will sponsor capacity development work in four separate American Indian communities in the Pacific Northwest. Currently, we have one Tribe in Oregon, one Tribe in Idaho, and recruitment is ongoing for two other Tribes. We also have the capacity to hire 4 local research assistants that will work within the community.

Utilizing community based participatory research methods; this four-year project will assist tribes in the following three areas:

(a) developing a drug problem index that monitors and tracks community impacts related to the use of drugs and alcohol in the community;

(b) assessing current capacity for treating drug and alcohol disorders in the community and implementing quality improvement interventions; and

(c) interviewing in-treatment and out-of-treatment drug users to estimate the level of drug and alcohol disorders present in the community.

In addition, this project seeks to identify and understand the unique experiences that American Indian communities face with regard to substance use and to assist communities in building upon skills to address these experiences.

If you have any questions please feel free to contact us.

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TRIBAL INJURY PREVENTION COALITION RECRUITMENT

The Northwest Portland Area Indian Health Board (NPAIHB) Injury Prevention Project is seeking **Tribal participation in a new Injury Prevention Coalition.** NPAIHB's Injury Prevention Program is focused on sharing evidence-based effective strategies for prevention of injuries, especially those related to motor vehicle crashes and elder falls.

We welcome input, ideas and participation from Tribal Leaders and members, Tribal/Urban/non-profit Indian organizations, injury prevention specialists, law enforcement, tribal courts, grant writers, state and federal IP advocates, physicians, public health nurses, pharmacists, physical therapists, dietitians, optometrists, social workers, clergy, businesspeople, senior centers, health promotion/disease prevention staff, community health representatives (CHRs), home health aides, environmental health experts, elders, youth and other key stakeholders, to share resources and expertise, and to work to address injuries within tribal communities.

If you or your tribe is interested in participating in the coalition, please complete the attached form and return to Luella Azule by no later than February 4, 2011.

Coalition members are expected to attend monthly conference calls and participate in at least one quarterly face to face meeting; to collaborate in the planning, implementation and evaluation of projects; and to contribute to a Five Year Strategic Injury Prevention Plan for Northwest Tribes.

Over the last few decades, there has been a significant disparity between the rates of injury death among American Indians and Alaska Natives (AI/AN) and the general population. Nationwide, unintentional injury (UI) is the **leading cause of death** for AI/AN ages 1-44, and is the **third leading cause of death for Northwest AI/AN of all ages**, according to the Centers for Disease Control and Prevention (CDC).

Motor vehicle-related injuries kill more children and young adults than any other single cause in the United States and are the **leading cause of death from injury** for people of all ages, according to the CDC. **Unintentional fall injuries** are a leading cause of hospitalizations in AI/AN communities, and reduce independence and quality of life for elders.

NPAIHB was one of **23 new sites** awarded a $65,000 **Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) grant from the Indian Health Service**. Luella Azule (Yakama Nation/Umatilla) was hired by NPAIHB on November 15, 2010 as the IP Project Coordinator. From May 2002 to May 2007, Ms. Azule was the Portland area IHS representative for the Tribal Steering Committee on Injury Prevention. She has completed Levels I and II Injury Prevention courses offered by the Indian Health Service.

SAVE THE DATE: Upcoming IHS Level 1 Injury Prevention trainings on May 24-26, 2011 in Portland, OR and March 15-18, 2011 in Sacramento, CA.

For More information Contact:
Luella Azule, Injury Prevention Project Coordinator
lazule@npaihb.org
2121 SW Broadway, Suite 300
Portland, OR 97201
Phone: 503-416-3263
Fax: 503-228-8182

Injury Prevention Coalition Contact Information:

First Name:

Last Name:

Title:

Tribe

Name of Program:

Mailing Address:

City:

State:

Zip:

Telephone:

Fax:

Email:

What is your injury prevention interest?

Do have any injury prevention experience?

NEW FACES AT THE BOARD

David Stephens, is the Multimedia Project Specialist for Project Red Talon at the Northwest Tribal Epidemiology Center. He is responsible for providing assistance with the development and implementation of PRT's new multimedia campaign as well as the adaptation of the teen pregnancy prevention program *It's Your Game(IYG)...Keep It Real*. Beginning as an intern with Project Red Talon in the Fall of 2008, Stephens was an integral part of the 2009 Native Youth Media survey that has given Project Red Talon an understanding of how NW Native youth use media technologies. Stephens graduated from Lewis and Clark College with a B.A. in psychology.

Shiix patch'way, my name is **Carrie Sampson** and I am the Native Nutrition and Physical Fitness Project Coordinator at NPAIHB and enrolled member of the Confederated Tribes of the Umatilla Indian Reservation.

continued on page 16

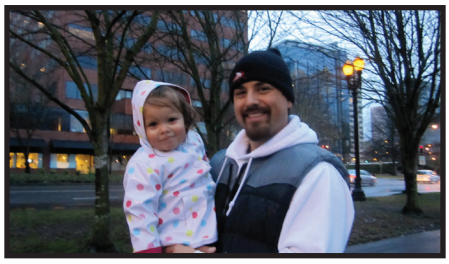
NEW FACES AT THE BOARD

continued from page 15

Carrie is currently a senior pursuing a bachelor's degree in Community Health Education at Portland State University. With this degree I plan to dedicate my career to the health and perseverance of Native people.

I have prior work experience as a nurse in Obstetrics & Gynecology, Family Practice and Long-term care and previously worked on the Prevention of Toddler Overweight and Tooth Decay Study as Project Assistant at NPAIHB and Site Coordinator at Yellowhawk Tribal Health Center, Pendleton, OR. I am very excited to return to the Board and jump back into the field of research, health promotion and disease prevention. I feel blessed to have the opportunity to serve the 43 Northwest member tribes and aim to serve the people of Indian country with the utmost dignity and respect.

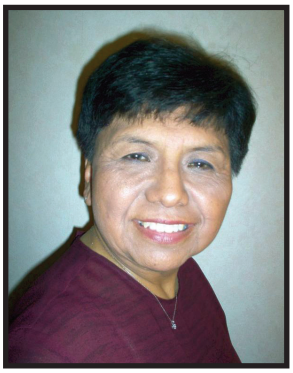
On a personal note, I am the daughter of the late Curtis Sampson and granddaughter of Chief Carl Sampson of the Walla Walla. I was raised in Missouri and returned to my Northwest roots in early 2006. I dedicate my spare time to my studies, 3 year old daughter Avery, working out and frequent visits back home to Pendleton when I need relief from the city. I also enjoy cooking, traveling, outdoors, rodeos and experiencing other cultures.



Erik Kakuska, (Zuni Pueblo) was born on the Zuni Reservation in New Mexico. He is an enrolled tribal member of the Zuni Pueblo. Mr. Kakuska arrived in the NW in '08 as the Project Specialist for the Access to American Indian Recovery (AAIR) program.

Currently, Mr. Kakuska has accepted a new position at the NPAIHB as the Project Coordinator for the IDEA-NW project. The Project Coordinator's primary responsibility is to assist the Project Director with all aspects of implementing the Improving Data and Enhancing Access – Northwest (IDEA-NW) Project. IDEA-NW is a three-year project funded by the Agency for Healthcare Research and Quality (AHRQ), which aims to: (1) use record linkage methods to assess and improve race data quality for American Indians and Alaska Natives (AI/AN) in a range of health-related data systems; and (2) provide high quality, locally-useful health status data obtained through state partnerships to the NPAIHB's 43 member tribes.

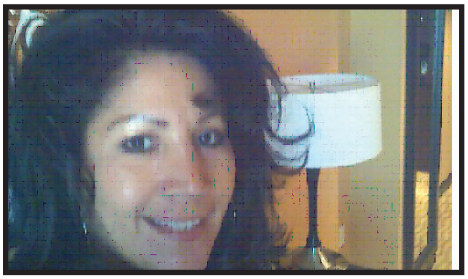
Jessica Leston has worked for tribal health services for 7 years. Currently, she is employed by Project Red Talon at the Northwest Portland Area Indian Health Board (NPAIHB). Prior to working at the NPAIHB, she was employed for 6 years by the Alaska Native Tribal Health Consortium STD Program. Jessica has managed and contributed to a variety of trainings, technical assistance projects and quantitative and qualitative research projects. She graduated from the University of Alaska with an MPH in Community Health.



Luella Azule, BS, (Yakama Nation/Umatilla) returned to NPAIHB as the Injury Prevention Project Coordinator in November 2010. Funded under a cooperative agreement with Indian Health Service (IHS), Ms. Azule will form and coordinate a Northwest Tribal Injury Prevention Coalition. They will develop a 5-year Injury

NEW FACES AT THE BOARD

Prevention Plan with emphasis on motor vehicle safety and elder falls prevention. Additionally, she will implement an effective injury prevention and education strategies that maximize the impact of limited resources across the 43 Northwest Tribes. Additionally, she will contribute to the collection, analysis and interpretation of injury data; participate in IHS Tribal IPP meetings, site visits and conference calls. From September 2000 to February 2002 she worked at the board as the Project Assistant/ Specialist for the Northwest Tribal Cancer Coalition Project. From March 2002 until September 2009, she was the Project Coordinator for the Native American Research Center for Health. She received her Bachelor of Social Science degree from Oregon College of Education where she majored in economics and minored in business administration, physical science and mathematics. She has more than 19 years experience working with American Indians and Alaska Natives in both urban and reservation settings.



Julie Taylor, (Umatilla, Walla, Cayuse), BS is the current Project Director of the Monitoring the Abuse of Drugs (MAD) project. She also served as a community liaison for a Community of Substance Abuse Project. Ms. Taylor came to the NPAIHB as an extern from Indian Health Service in 2008 and worked with Western Tribal Diabetes Project, Northwest Tribal Comprehensive Cancer Program, and Women's Health Program. She formerly worked for the Confederated Tribes of Umatilla Indian Reservation and served for as the Youth Services and Recreation Manager. Julie holds a BS in Social Science from Portland State University and is currently in her 2nd Advanced year at Portland State University working towards her Master's Degree in Social Work.

Greetings, I am **Ronda Metcalf.** It is a pleasure to be working for the Northwest Portland Area Indian Health Board. I am the Project Coordinator for the Sexual Assault Prevention Program. This is exciting for me as it allows me to use my skills and experiences to assist the Portland Area Tribes in developing sexual assault prevention programs. I am a member of the Sauk-Suiattle Indian Tribe. I graduated from the University of Nebraska at Kearney with a BSW in Social Work and a MSE with a specialization in Community Counseling. I have worked for the last 10 years for tribes in the area of Health and Social Services. I am a U.S. Army Veteran, I served from August, 1979-October, 1988, and I was a 91B Combat Medic. My greatest accomplishment in life is being the mother of 8 wonderful children and Grandmother to 7 wonderful grandchildren, with 2 more to be added in February and July. Portland is my home so it is great to be home with my family and friends.

Wendee Gardner, a member of the Stockbridge-Munsee Band of Mohican Indians, has been hired by the NPAIHB as the Native VOICES Project Coordinator. Wendee comes to Project Red Talon after working as an ORISE fellow at the Centers for Disease Control and Prevention (CDC), Division of STD Prevention. At CDC Wendee collaborated with colleagues at Indian Health Services, Music Television Network (MTV), Kaiser Family Foundation and Planned Parenthood to outreach to AI/AN youth through the *GYT: Get Yourself Tested Campaign*. Wendee received her Masters of Public Health at Emory University, where she concentrated on HIV, STDs, and international community health and development.

NATIONAL HEALTH OBSERVANCES & UPCOMING EVENTS

JANUARY

Cervical Health Awareness Month
Tobacco-Free Awareness Week

January 31 – February 3
ATNI 2011 Winter Conference
North Bend, OR

FEBRUARY

National Children's Dental Health Month

Through with Chew Week & Great American Spit Out

February 2
Idaho State DHW Meeting
Boise, ID

February 8
Human Health Risk Assessment Training
Kirkland, WA

February 11
AIHC Meeting
Location: TBD

February 28 - March 2
NCAI Executive Council Winter Session
Washington, DC

MARCH

National Colorectal Cancer Awareness Month

National Nutrition Month

National Native American HIV/ AIDS Awareness Day
March 20th

March 3-4
13th National HHS Budget Formulation Consultation
Washington, DC

March 4 - March 6
4th International Meeting on Indigenous Child Health
Vancouver, British Columbia, Canada

March 25
Contemporary Northwest Tribal Health Conference
Portland, OR

APRIL

National STD Awareness Month

National Cancer Control Month

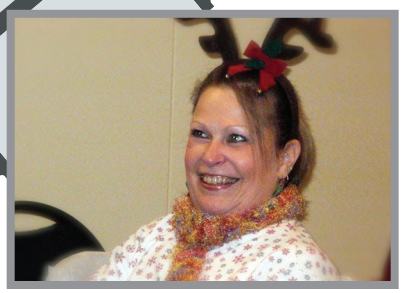
National Infant Immunization Week

Sexual Assault Prevention Awareness Month

Child Abuse Prevention Awareness Month

April 26 - April 28
NPAIHB Quarterly Board Meeting
Ocean Shores, WA

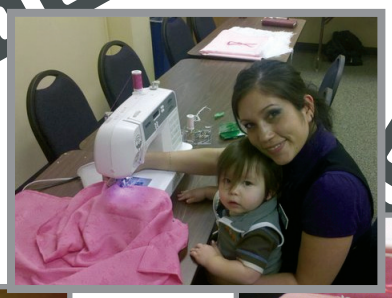
THE BOARD SCRAPBOOK



Debi Creech in her holiday spirit

The Board welcomes its newest member, Finley Rushing. Little Miss Finley Rushing arrived January 12, 2010 at 4:20 PM. 8 lbs. 21 in. Congratulations Stephanie, Ryan and Finley!

Julie Taylor and Ronda Metcalf enjoy the Board Holiday Party



Casandra Frutos and family made Pink Shawls for the NARA New Years Eve Powwow. A Pink Shawl Honor dance was done for Breast Cancer Survivors and to promote early screening.

Wendee Gardner posing with her "White Elephant" gift

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S OCTOBER 2010 RESOLUTIONS

RESOLUTION #11-01-02
Recommendation to Appoint Tribal Leaders to a Search Committee to Assist Recruit, Interview, and Select the Next Area Director for the Portland Area Office

RESOLUTION #11-01-04
Recommendation to Adopt a Uniform Definition of "Indian" for the Affordable Care Act

RESOLUTION #11-01-05
Supporting Tribal Representation to the VISN 20 Advisory Council

RESOLUTION #10-04-05
Support for the Submission of a Grant to the Centers for Disease Control and Prevention (CDC) for Funding for the Northwest Tribal Cancer Policy Program