Health News & Notes

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

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January 2014

Behavioral Health Issue

FY 2014 NEAR FINAL: APPROPRIATIONS DOES LITTLE TO RESTORE SEQUESTER OR FUND CURRENT SERVICES

Jim Roberts, Policy Analyst

On January 16th, the President signed a short-term bill to fund the federal government through Saturday, January 18th, in order to give Congress time to pass the long-term FY 2014 omnibus budget bill. This was needed since the pending continuing resolution (CR) expired at midnight January 15th. The short-term CR provides $45 billion for continued government operations, while the larger omnibus bill will provide $1.012 trillion in discretionary spending for defense and non-defense programs. This is an increase from last year's discretionary amount of $986 billion.

On Wednesday, January 15th, the full House passed the $1.012 trillion omnibus bill with overwhelming support to fund the government through the end of the fiscal year (September 30, 2014). At this writing, the Senate has yet to take action of the omnibus package. The bill passed the House easily, supported by a vote of 359-67, with sixty-four Republicans and three Democrats voting against it. The three Democrats were Reps. Raul Grijalva (AZ), Rush Holt (NJ), and Mike McIntyre (NC). The bill--totals over 1,500 pages with supporting amendments--and provides appropriations for 12 different spending bills, including the Indian Health Service

Putting the IHS Budget into Context

It is challenging to put what is to become the final IHS FY 2014 appropriation into context is a bit challenging given the various baselines that could be used for comparisons and analysis. The comparisons could be made to the FY 2012, the FY 2013 enacted, or the FY 2013 post-sequestration budget marks. It is not fiscally prudent for Indian Country to use the final 2013 operating budget for any types of budget comparisons. The simple fact that the IHS budget has lost over $175 million since FY 2012 dictates that analysis should use the FY 2012 enacted budget marks (pre-sequester) for any type of comparative analysis. Otherwise the true budget picture

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Northwest Portland Area Indian Health Board

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Pearl Capoeman-Baller, *Vice Chair*
Quinault Nation
Shawna Gavin, *Treasurer*
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Spokane Tribe
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Confedrated Tribes of Grand Ronde

Delegates

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Dan Gleason, Chehalis Tribe
Leta Campbell Coeur d'Alene Tribe
Andy Joseph Jr., Colville Tribe
Vicki Faciane, Coos, Lower Umpqua & Siuslaw Tribes
Eric Metcalf, Coquille Tribe
Sharon Stanphill, Cow Creek Tribe
Cassandra Sellards-Reck, Cowlitz Tribe
Cheryle Kennedy, Grand Ronde Tribe
Lisa Garcia, Hoh Tribe
Brent Simcosky, Jamestown S'Klallam Tribe
Darren Holmes, Kalispel Tribe
Leroy Jackson, Klamath Tribe
Velma Bahe, Kootenai Tribe
Frances Charles, Lower Elwha S'Klallam Tribe
Cheryl Sanders, Lummi Nation
Nathan Tyler, Makah Tribe
Maria Starr, Muckleshoot Tribe
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Shawna Gavin, Umatilla Tribe
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Janice Clements, Warm Springs Tribe
Vivian George, Yakama Nation

CHAIRMAN'S NOTE

Andy Joseph, Jr., NPAIHB Chair, Confederated Tribes of Colville Tribe

This edition of our newsletter continues a focus on behavioral health issues. This is a very important issue for us at Colville because of some many suicides that we have had in the past years. I know it is very important for other tribes too. Our Tribe and the Board was represented very well at the recent Senate Committee on Indian Affairs listening session on the impact of sequestration in Indian Country. In that hearing I provided testimony on the effect that funding is having on behavioral health programs and the ability of Tribes to respond to mental health crisis in our communities. I believe suicides can be prevented with intervention and resources are needed to help our people. I hope our Board can continue to help our Tribes address the on-going suicide epidemic in our communities. We should never have to lose one of our youth to suicide.

You have heard me at Board meetings explain that I am worried for our Tribal warriors who are returning from Afghanistan and Iraq and our past veterans. As a veteran that served in the Army, I know firsthand the needs of our young men and women returning from the Middle East. I am very proud of the fact that I served our Country, but not proud of the way our Indian warriors get treated (or not treated) when they return. We need to do more to help our Indian people that served in the military. It's not just physical care we need to provide, but also their emotional and spiritual well-being. I hope the on-going budget debate is not used as an excuse to fund the needs of our Indian veterans.

The holiday season is always a good time to reflect on our accomplishments and take time to enjoy our families, friends, and tribal communities. I hope you all had a chance to do this with your loved ones. It's important and in our work we often get too busy to take time to do this. I also want to wish each of our delegates, their families, and members of their Tribal community a very happy New Year! I hope it holds great promise and is your best year ever.

I am pleased to state that travel has slowed down a little since our last Board meeting. Given the budget constraints and the continuing resolution many meetings have been moved to be teleconferences and webinars. In November, I participated with Jim Roberts our Policy Analyst in the White House Tribal Nations preparation meeting hosted by NCAI. Following the meeting Jim and I made several hill visits calling on Congressional members to talk about the looming budget, reauthorization of the

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and needs of Indian health programs and our people are misrepresented.

Here are the simple facts about the recent trends in the IHS budget. If the FY 2013 enacted level (pre-sequester) amount is considered, then it could be reasoned that IHS received a slight increase of $49.7 million (1.2%) over FY 2012 levels. However the Administration and Office of Management and Budget interpreted that IHS should be subject to a full sequestration and rescission (with limitations on SDPI and staffing increases), which negated this small increase. Therefore, the FY 20 13 final operating plan for IHS had $175 million (4.1%) less than it did in FY 2012. No justice is done for Indian Country by making budget comparisons to an operating plan that was reduced by over 4% from the previous year's amount. Thus, the Board's comparisons for the FY 2014 request and with the final enacted budget will be made to the FY 2013 pre-sequester or FY 2012 amounts.

FY 2014 IHS Budget

Let's be clear that the FY 2013 budget is the worst budget in the history of the IHS appropriation and the FY 2014 omnibus is not much better. The bill provides a slight increase of $77.9 million over last year's enacted amount for the IHS budget. This may seem like a favorable increase given last year's sequester and rescission and the difficult budget climate. However if the staffing needs of approximately $50 are factored in, it leaves only $27.9 million for over 560 Indian health programs to divide and cover current service needs (inflation and population growth). The past two years' budgets will result in many IHS, tribal and urban programs cutting health services in order to absorb the costs. Effects of the 2013 and 2014 budgets will be felt for many years by Indian Country.

Specific details about the budget amounts are not available at this writing and the amounts reported in this article are subject to change. Preliminary details indicate the omnibus bill adopts all of the recommended funding amounts proposed in the President's FY 2014 request for IHS. The omnibus bill provides $3.4 million more than the President's request and most of the funding differences are in the facilities accounts. Important for Northwest Tribes is that the bill provides $875.6 million for the Contract Health Service line item, which has been renamed Purchased/Referred Care (PRC) to avoid confusion with the Contract Support Cost line item. This represents a $33.6 (4%) increase over the 2013 pre-sequester budget and also earmarks $51.5 million for the Indian Health Care Improvement Fund. The Hospitals and Clinics line item receives a slight increase of $21 million (1.2%). Most other increases to the budget are trivial, ranging from zero to 1%.

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IHS is required to submit an operating plan on funding allocations to the appropriations committees within 30 days of the bill's enactment. Only then can we analyze completely the effect of the past two years budgets on Indian health programs.

Contract Support Costs

The most important detail about the IHS budget is contained in an explanatory statement accompanying the bill. In the bill language Congress rejects the Administration's proposal to cap Contract Support Cost (CSC) on a contract-by-contract basis. The language calls on the Administration to work with Congress and Tribes on a long-term solution. The bill also eliminates the CSC cap limits, which means there is no limitation on what IHS can spend on CSCs. This means that CSC may be paid completely out of each agency's lump-sum appropriation.

The Joint Explanatory Statement explains the basis for Congress' decision to reject the Administration's proposal to cap costs by contract and to remove the aggregate cap language. Congress makes clear that IHS must determine how much CSC is to pay from their discretionary appropriated funds—but underpayments would subject the Government to contract liability under Cherokee case. Congress goes on to explain that, "the underlying contradictions in current law;" must be addressed by Congress.

The committees instruct IHS to consult with Tribes and work with Congress "to formulate long-term accounting, budget, and legislative strategies to address the situation." IHS is required within 120 days of enactment of the bill to develop a work plan and announce consultation with Tribes.

FY 2014 NEAR FINAL: DOES LITTLE TO RESTORE SEQUESTER OR FUND CURRENT SERVICES

Indian Health Service FY 2014 Budget

Comparing Enacted FY 2012, FY 2013, and FY 2014 Budgets

Prepared by: NW Portland Area Indian Health Board - 1/15/2014

Sub-Sub Activity	FY 2012 Enactd	FY 2013 Full Year CR	FY 2013 Operating Plan	President's Request			Consolidated Appropriations Act		
				President's FY 2014 Request	Change Over Full Yr CR	Pct of Change	H.R. 3547	Change Over Full Yr CR	Pct of Change
SERVICES									
Hospitals & Health Clinics	$ 1,810,966	$ 1,844,397	$ 1,749,072	$ 1,865,630	$ 21,233	1.2%	$ 1,865,630	$ 21,233	1.2%
Dental Services	$ 159,440	$ 165,191	$ 156,653	$ 168,225	$ 3,034	1.8%	$ 168,225	$ 3,034	1.9%
Mental Health	$ 75,589	$ 78,171	$ 74,131	$ 79,873	$ 1,702	2.2%	$ 79,873	$ 1,702	2.3%
Alcohol & Substance Abuse	$ 194,297	$ 195,245	$ 185,154	$ 196,405	$ 1,160	0.6%	$ 196,405	$ 1,160	0.6%
Contract Health Services	$ 843,575	$ 844,927	$ 801,258	$ 878,575	$ 33,648	4.0%	$ 878,575	$ 33,648	4.0%
Subotal, Clinical Services	*$ 3,083,867*	*$ 3,127,931*	*$ 2,966,268*	*$ 3,188,708*	*$ 60,777*	*1.9%*	*$ 3,188,708*	*$ 104,841*	*3.4%*
Public Health Nursing	$ 66,632	$ 69,894	$ 66,282	$ 71,194	$ 1,300	1.9%	$ 71,194	$ 1,300	2.0%
Health Education	$ 17,057	$ 17,454	$ 16,552	$ 17,677	$ 223	1.3%	$ 17,677	$ 223	1.3%
Comm. Health Reps	$ 61,407	$ 61,482	$ 58,304	$ 61,661	$ 179	0.3%	$ 61,661	$ 179	0.3%
Immunization AK	$ 1,927	$ 1,925	$ 1,826	$ 1,931	$ 6	0.3%	$ 1,931	$ 6	0.3%
Subtotal, Preventive Health	*$ 147,022*	*$ 150,755*	*$ 142,964*	*$ 152,463*	*$ 1,708*	1.1%	*$ 152,463*	$ 5,441	3.7%
Urban Health	$ 42,984	$ 42,949	$ 40,729	$ 43,049	$ 100	0.2%	$ 43,049	$ 100	0.2%
Indian Health Professions	$ 40,596	$ 40,563	$ 38,467	$ 40,602	$ 39	0.1%	$ 40,602	$ 39	0.1%
Tribal Management	$ 2,577	$ 2,575	$ 2,442	$ 2,577	$ 2	0.1%	$ 2,577	$ 2	0.1%
Direct Operations	$ 71,653	$ 71,594	$ 67,894	$ 71,845	$ 251	0.4%	$ 71,845	$ 251	0.4%
Self-Governance	$ 6,044	$ 6,039	$ 5,727	$ 6,049	$ 10	0.2%	$ 6,049	$ 10	0.2%
Subtotal, Other Services	*$ 163,854*	*$ 163,720*	*$ 155,259*	*$ 164,122*	*$ 402*	0.2%	*$ 164,122*	*$ 402*	*0.2%*
TOTAL, SERVICES	$ 3,394,744	$ 3,442,406	$ 3,264,491	$ 3,505,293	$ 62,887	1.8%	*$ 3,505,293*	*$ 62,887*	*1.9%*
CONTRACT SUPPORT COST									
Contract Support Cost	$ 471,437	*$ 472,193*	$ 447,788	$ 477,205	$ 5,012	1.1%	$ 477,205	$ 5,012	1.1%
FACILITIES									
Maintenance & Improvement	$ 53,721	$ 53,721	$ 50,919	$ 53,721	$ -	0.0%	$ 53,614	$ (107)	-0.2%
Sanitation Facilities Constr.	$ 79,582	$ 79,582	$ 75,431	$ 79,582	$ -	0.0%	$ 79,423	$ (159)	-0.2%
Health Care Fac. Constr.	$ 85,048	$ 81,489	$ 77,238	$ 85,048	$ 3,559	4.4%	$ 85,048	$ 3,559	4.2%
Facil. & Envir. Hlth Supp.	$ 199,413	$ 204,231	$ 193,578	$ 207,206	$ 2,975	1.5%	$ 211,051	$ 6,820	3.4%
Equipment	$ 22,582	$ 22,582	$ 21,404	$ 22,582	$ -	0.0%	$ 22,537	$ (45)	-0.2%
Total, Facilities	*$ 440,346*	*$ 441,605*	*$ 418,570*	*$ 448,139*	*$ 6,534*	1.5%	$ 451,673	$ 10,068	2.3%
TOTAL, IHS	**$ 4,306,528**	**$ 4,356,204**	**$ 4,130,849**	**$ 4,430,637**	**$ 74,433**	1.7%	**$ 4,434,171**	**$ 77,967**	**1.8%**

IHS CONTRACT SUPPORT COST WORKGROUP RECONVENED

Jim Roberts, Policy Analyst

For the first time in over two years, the IHS Director, Dr. Yvette Roubideaux, reconvened the Tribal Contract Support Cost Work Group (CSCWG) to meet in Rockville, Maryland on January 7-8, 2014. The role of the CSCWG is to provide advice and guidance to IHS Director on key policy issues associated with Contract Support Cost (CSC) obligations to Tribes. The CSCWG was finally reconvened amid controversy and tribal discontent over the Administration's proposal to cap CSC payments by contract in the appropriations process and the outstanding CSC claims owed by IHS to Tribes.

The Portland Area representatives on the CSCWG are Andy Joseph, NPAIHB Chair and Colville Tribal Council Member, and Fawn Sharp, President of the Quinault Nation. Chairperson Joseph serves as one of the co-chairs for the CSCWG, along with Arlen Melendez, Chairman of the Reno Sparks Indian Community. There is also a federal co-chair, Randy Grinnell, who serves as the IHS Deputy Director for Field Operations.

The IHS Director, opened the meeting with a report and overview of what IHS hoped would be the CSCWG objectives for the meeting. The Director reported that the Supreme Court's *Ramah* decision has raised several new CSC issues including settlement of past claims and future funding in the appropriations process. The later statement regarding spending contract caps is in the appropriations process, Dr. Roubideaux explained that the Administration had "heard" the objections from tribes and that the proposal for line-item caps is not supported. Although recent action by Congress has rejected the Administration's proposal, the Director stated that the proposal is still under consideration by Congress and that she does not know what the final outcome will be. She also stressed that the CSCWG would not be discussing appropriations.

The Director requested the CSCWG to focus on how the tribes and the agency should negotiate an estimate of contract support costs in the pre-award contract negotiation phase. It's important to note that following the *Ramah* decision, IHS and Tribal attorneys agreed to contract language to use in funding agreements. The language consists of three simple paragraphs acknowledging CSC commitments by the Agency and expected by Tribes. The first proviso of this language requires the parties to "set forth an estimate of the tribal contractor's full CSC need for the year." Unfortunately this has been difficult since IHS unfairly scrutinizes tribal finances to minimize this requirement. Thus, IHS and tribal contractors have not been able to agree on what is prescribed under this requirement.

Following the report from Dr. Roubideaux, the CSCWG convened their work to hear presentations from Max Tahsuda, IHS Agency Lead Negotiator, reviewing factors affecting the calculation of CSC need for purposes of estimating CSC need for the year as described above. The factors Mr. Tahsuda explained were based largely on the statutory language defining CSC as reasonable, necessary, allowable, and non-duplicative amounts for activities that must be carried out to ensure prudent management and compliance of contracts. The CSCWG worked to develop recommendations to the IHS on these issues and are included in the meeting record.

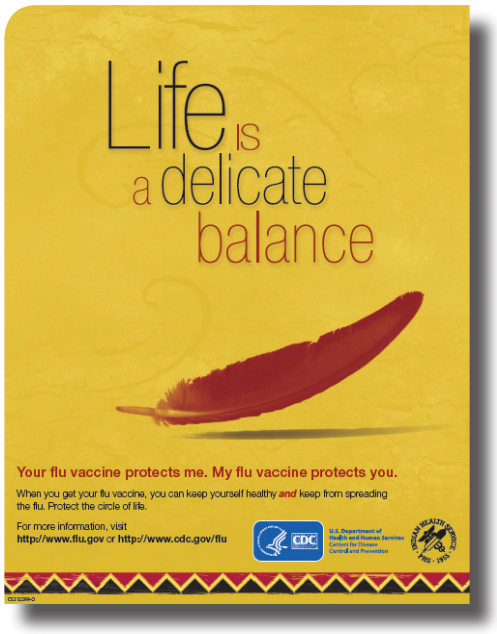
The Workgroup concluded their meeting by presenting their recommendations to the IHS Director. The CSCWG explained that the recommendations were still preliminary and not final and that they planned to meet again to continue discussions. Dr. Roubideaux explained she plans to update the Office of Management and Budget about the CSCWG progress, and that she would emphasize their efforts are ongoing and that its recommendations will be subject to tribal consultation once finalized. The CSCWG has proposed February 24-25, 2014 for their next meeting. For a detailed copy of these recommendations contact Jim Roberts, Policy Analyst, at jroberts@npaihb.org or by phone at 503.416.3276.

2013-2014 INFLUENZA VACCINE INFORMATION -- WHICH FLU SHOT SHOULD I GET?

Which Flu Shot is Right for Me?

This year there are some new choices when it comes to getting a flu shot. All the same flu shots that were available last year are available for this year's flu season, too. But there are three new types of flu shots that you should know about:

- Quadrivalent Vaccines
- Cell-based Vaccines
- Recombinant Vaccines

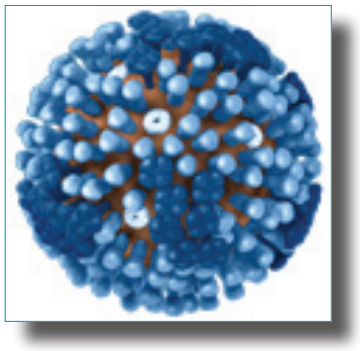


These new influenza vaccines were made to provide additional protection (quadrivalent vaccines) or use new techniques (cell-based and recombinant vaccines). Based on the most recent information, these new vaccines provide just as much protection as previous flu shots. Some flu shots are only recommended for certain age groups. So far, no single flu shot is recommended over any other flu shot.

Trivalent or Quadrivalent?

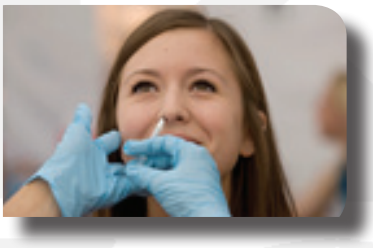
Until this year, all flu shots were called "trivalent" which just means they gave protection against three strains of flu–two types of influenza A virus and one type of influenza B virus. The new "quadrivalent" vaccines provide protection against four flu strains - the same as the trivalent plus an additional influenza B strain.

Egg-based, Cell-based or Recombinant?



Traditional flu vaccines are made by growing influenza virus in incubators using chicken eggs. Vaccines made this way may use "live" viruses that are changed so they don't cause disease or they may use dead viruses. Both types help your body to create antibodies which fight off natural infection by the flu. This year's new vaccines use two new methods in addition to the traditional method. The cell-based vaccine uses cells from mosquitoes to grow the viruses. The viruses are then either changed so they don't cause disease (but are still live viruses) or they are killed. Recombinant vaccines use pieces of the virus' DNA to stimulate the body's immune system. The recombinant flu vaccine does not have any "live" viruses and no egg components.

Needle or Nose?



Any flu vaccines containing dead viruses are given as a shot. Most flu shots are given in the muscle but one vaccine, introduced last year, is given in the skin. The nasal mist vaccine contains

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2013-2014 INFLUENZA VACCINE INFORMATION -- WHICH FLU SHOT SHOULD I GET?

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live virus particles that are inhaled - no needles! The nasal mist vaccine is best for healthy people from 2—49 years of age.

High Dose?

The High Dose flu vaccine is recommended for those 65 and older. This vaccine has a higher dose of vaccine and has been shown to be more effective than the standard dose for preventing severe illness and hospitalization in elders.

Ask your Doctor

The best flu vaccine is the one you actually get. The best choice for flu vaccine may depend on your age and health status, so ask you health care provider.

CHAIR'S REPORT

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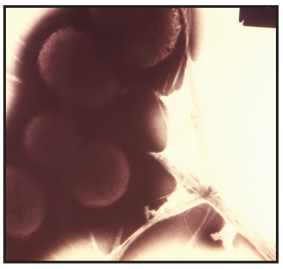
Special Diabetes Program for Indians, and expanding Medicare –like rates to non-hospital based services. I also attended the National Indian Health Board quarterly board meeting in held in Washington, D.C. And recently, I attended the IHS Contract Support Cost Workgroup meeting in Rockville, Maryland. While you can see that the holidays gave a little break, the work continues on.

Looking ahead, we need to get ready for the President's budget to be release soon and preparing for Tribal consultation on a number of issues. HHS is preparing to have its Regional sessions, we have ATNI Winter meeting, and also have the NCAI Winter sessions coming up.

I hope you enjoy this edition of the newsletter and look forward to our work in the New Year!

GONORRHEA OUTBREAK IN THE PACIFIC NORTHWEST

You may have seen reports in the news or on social media that gonorrhea is on the rise. This is true in Washington, Oregon, and in many areas across the nation. Counties in central and northeast Washington have been especially hard hit, Tribal areas included. Public health officials are calling this an outbreak, since case counts are so much higher than usual. While teens and young adults usually show the highest rates, this recent outbreak has hit an older crowd. And though we're in a new year, early reports from 2014 show that new cases continue to occur.



Why is this alarming? It is true, gonorrhea is a common sexually transmitted disease (STD). It is estimated to affect about 800,000 people in the U.S. each year.[1] But people who have it often show no symptoms, and they can spread the infection to their partners without knowing. Plus, gonorrhea can cause serious health problems, especially if left untreated. The worst cases can lead to serious infections of the blood and joints and cause infertility.

Luckily, gonorrhea is treatable, and can be cured with the right treatment. This usually involves taking two antibiotics. However, a person cannot be treated unless they have been tested and know their status. Knowing your status is as easy as peeing in a cup, for both males and females. It is important to spread the message: get tested, learn your status, and get treated if you are infected.

Gonorrhea is also preventable. Practicing safe sex, including proper use of a condom, reduces the risk of getting gonorrhea. The best way to avoid transmission is to have sex with only one partner, who has been tested and is not infected, and who is only having sex with you.

With Valentine's Day right around the corner, now is the perfect time to talk about STD prevention. It is important we include all community members in this conversation. We highlight some key steps you can take to promote sexual health and wellbeing in your community. *Know the facts: educate, motivate, and mobilize!*

1. Start talking about sexual health issues with friends and family.
2. Increase community awareness about sexual health topics. Host meetings and participate in community outreach events.
3. Support a resolution documenting your Tribe's commitment to sexual health.
4. Work with your Tribe's clinic to update its HIV/STD screening and treatment policies and practices.
5. Form a workgroup to create a local action plan to address HIV/STDs in your community.
6. Help reduce stigma surrounding these issues by reaching out to those who are affected.
7. Learn how to protect yourself against HIV and STDs.
8. Get tested—and encourage others to do the same. Simple blood, urine, and saliva tests are available for different STDs. Most infections can be treated or cured!

More information can be found on the Project Red Talon website. Here, you can also find a link to the *Tribal HIV/STD Advocacy Kit & Policy Guide*, developed by IHS.
http://www.npaihb.org/epicenter/project/project_red_talon

Other helpful links include:
http://www.ihs.gov/epi/index.cfm?module=epi_std_main

http://www.cdc.gov/std/Gonorrhea/

1. Estimate from the Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/std/gonorrhea/STDFact-Gonorrhea.htm

SUICIDE & BULLYING

Colbie Caughlan, MPH – Suicide Prevention Manager, THRIVE

We all know it's true – bullying can be linked to suicidal thoughts, attempts, and completions. Although there are currently no good reports that show the rates of bullying in Indian Country, it is something that has been plaguing Native teens, whether they be in rural and urban settings. With media (cell phones, computers, tablets, etc.) being such a huge part of our lives now, another form of bullying has surfaced: cyber-bullying. Now people can be bullied twenty-four hours a day! It is not as though a teen can leave school or get off the school bus and think, "one more day down, and now I can just relax at home." Once they turn on their computer to search the internet for a school report or check their cell phone, they are seeing additional forms of bullying through hurtful texts, untrue Facebook posts, and even forwarded private photos of themselves. Nothing is private anymore and it is something that kids and teens need to be educated about. From this article I hope you can learn something new and bring it to your community to help combat youth bullying and in turn decrease suicidal thoughts, attempts, and even completions.

In addition to suicide, bullying has been linked to other negative outcomes including substance use and mental health. Those who have been bullied may "feel" the effects in physical, emotional, or mental ways. They may: feel depressed or anxious; have a drop in grades at school; not want to attend school or other events; or report other health complaints due to the bullying. Those being bullied are not the only ones suffering though; the bullies themselves are also subtly asking for help. Bullies are more likely to abuse alcohol, engage in risky behaviors such as vandalizing property or early sexual activity, and even be abusive in their relationships.

Bullying in the U.S.:

- In the 2007-2008 school year 32% of U.S. students 12-18 years old reported that they were bullied.
  - 7% reported daily bullying
  - 10% reported being bullied 1-2 times per week
  - 21% reported being bullied 1-2 times per month

(Suicide prevention resource center issue brief, 2013)

Signs of bullying (www.stopbullying.gov)

- Unexplainable injuries
- Lost or destroyed clothing, books, electronics, or jewelry
- Frequent headaches or stomach aches, feeling sick or faking illness
- Changes in eating habits, like suddenly skipping meals or binge eating. Kids may come home from school hungry because they did not eat lunch.
- Difficulty sleeping or frequent nightmares
- Declining grades, loss of interest in schoolwork, or not wanting to go to school
- Sudden loss of friends or avoidance of social situations
- Feelings of helplessness or decreased self esteem
- Self-destructive behaviors such as running away from home, harming themselves, or talking about suicide
- Displaying extreme mood swings.

Signs that a child is a bully (www.stopbullying.gov)

- Gets into physical or verbal fights
- Has friends who bully others
- Is increasingly aggressive
- Get sent to the principal's office or to detention frequently
- Has unexplained extra money or new belongings
- Blames others for their problems

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SUICIDE & BULLYING

- Doesn't accept responsibility for their actions
- Is competitive and worry about their reputation or popularity

Bullying is something we see in many different settings, including as adults in the workplace. It can be difficult for a child, teen, adult, or elder to know how to intervene when bullying is occurring right before their eyes. One may think that if they try to intervene that they will become the target of the bully, feel embarrassed, or even just feel too intimidated to step in. It is not easy to know what to do to stop bullying. The following tips can help you decide when and where to intervene if bullying occurs in front of you:

- Stay calm
- Do not ignore it, if you feel uncomfortable intervening, find someone who will respond immediately
- Tell the bully to stop in a calm and clear voice
- Try to separate the persons involved
- Be sure that everyone is safe (i.e. no weapons are involved)
- Address any medical or mental health needs immediately
- Be respectful when intervening
- Do not put yourself in harm's way if weapons are involved, call 9-11 immediately (www.stopbullying.gov)

Cyber-bullying is something we also hear about and may even experience or have experienced in the past. Cyber-bullying is a little more difficult to try to control. Since multimedia keeps streaming, and staying away from electronics may not keep the cyber-bullying from occurring. The NPAIHB and the IHS worked collaboratively with Tribes and other partners in 2011 to create a cyber-bullying prevention brochure. The brochure discusses important factors that can help one stand up to cyber-bullying. 1) Safety – be sure the child/teen feels safe and that they have support from you no matter what. Positive role modeling is important. If as adults we do not engage in bullying or cyber-bullying the teens we are around will see that these are unacceptable behaviors; 2) Communicate – Decide as a team how the child/teen would like to try to improve a cyber-bullying situation. This may include the school, parents of the bully, and possibly even law enforcement; 3) Set ground rules – Discuss cyber-bullying with your kids/teens and be sure they know it is a serious problem and that these behaviors are unacceptable online, over the phone (texting too), or in person. Set consequences if your child/teen engages in bullying behavior. Teach your child/teen the skills and language to use against a bully. Teach your child/teen about safe and responsible internet use, and; 4) Build protections – Protective factors like having an adult that teens can turn to, or feeling personally connected to their culture can protect teens from thoughts of suicide. Teach teens how to stand up to bullies and to tell a trusted adult about any bullying (or cyber-bullying) they witness or experience.

Suicide in Indian Country

According to the CDC (2011) from 1999-2008, the suicide rate in the American Indian/Alaska Native (AI/AN) population, the suicide rate was 14.68 per 100,000 while the overall U.S. suicide rate was 11.15. The CDC (2010) also reports that among AI/ANs aged 15-34 years suicide rates are almost double the rates of the national average for those ages (20 vs. 11.4 per 100,000). Suicide is the second leading cause of death for AI/ANs aged 10-34 years (CDC, 2011).

If you or someone you know is thinking about suicide please call **1-800-273-TALK (8255) f**or help!! It can be very easy for *anyone* to help someone thinking about suicide-- in fact, the helper does not need to be a healthcare professional or work at a mental health clinic. Anyone can try to help especially if they are supportive and have time to listen and talk with the suicidal person. Anyone can help save a life. The helper can be a family member, close friend, elder, mentor, religious

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A HEALTHY SMILE!

It's What Happens at Home That Matters Most

Hurry!!! There's a crisis in the bathroom, the faucet is running and the sink is clogged and water is spilling over the sink and all over the floor. What should we do? Should we get some buckets and start bailing out the water…. or should we turn off the faucet? This is an old story often told to demonstrate the principles of public health. We really do have a crisis of dental cavities among AI/AN people, beginning when children are just babies. Sure, we need more dental health professionals to serve everyone, but honestly, it's mostly what we do at home that really prevents cavities and gum disease! The way to end this crisis (turn off the faucet) is through improved oral health behaviors, beginning with babies and spanning an entire lifetime.

5 Ways to a Healthy Smile for all ages

- **Brush twice daily with fluoride toothpaste**. Brushing with a small dab of fluoride toothpaste and a soft toothbrush should begin with babies when the first tooth erupts and continue throughout our lives.
- **Limit sweet drinks and snacks**. Every time you drink or eat something with sugar or refined carbohydrate like white bread or crackers, you create an acid attack on your teeth for about 20 minutes. The more acid attacks each day, the more cavities.
- **Rinse before bed every night with a fluoride mouthrinse beginning around six years of age**. This is especially important if you are still getting new cavities.
- **Get a dental check-up**. Babies should have their first oral health screening soon after the first tooth erupts. Make sure you remind your dentist to seal your child's teeth. Everyone should visit the

dentist at least once a year and be sure to follow through with any needed dental treatment.

- **Stop using tobacco**. Chewing tobacco and cigarettes can cause gum disease, cavities, bad breath, and stained teeth. Most importantly, tobacco causes cancer.

Ways to Promote Oral Health in your Community

- Encourage families to take babies to the dental clinic soon after the first tooth erupts.
- Establish programs to provide oral health assessments and fluoride varnish at Head Start and daycare centers.
- Establish school-based fluoride and sealant programs.
- Use newsletters and other local forms of communication to support "5 Ways to a Healthy Mouth"
- Support community water fluoridation.

If you have any questions about promoting oral health in your community, contact the Northwest Tribal Dental Support Center, Dr. Bonnie Bruerd at bonnie.bruerd@comcast.net or Ticey Casey at tcasey@npaihb.org

NORTHWEST FETAL ALCOHOL SPECTRUM DISORDERS PROJECT

By Jacqueline Left Hand Bull

FASD – Fetal Alcohol Spectrum Disorders – touches all of our lives, directly or through someone we love. The range of disorders is from mild, and even hidden from easy diagnosis, to truly debilitating. The cost is impossible to compute. Yet, it is well understood that it is entirely preventable.

The Northwest Tribal FASD Project continues to gather information as the spectrum of disorders is better understood, and it actively works with tribal communities to learn and develop prevention education opportunities, and to develop accommodation strategies for those living with an FASD.

This past year, the Project presented two webinars – available to the entire United States through collaboration with the Indian Health Services' Telebehavioral Health Center of Excellence. CME/CMU credit was offered. The webinar was an effort of the University of Washington's Fetal Alcohol and Drug Unit (FADU).

The first webinar on July 17th was an overview of FASD that included diagnostic criteria and appropriate interventions for behavioral health providers. The presenter was Dr. Julian Davis, a clinical professor at the University of Washington.

The second webinar, on September 9th, was titled "Beyond the Diagnosis: Effective Interventions for Children and Adolescents with FASD". It included such things as practical sleep/feeding/sensory strategies, positive behavior supports, and help for self-regulation and executive functions, medications, educational approaches and adolescent transitions.

Both of the webinars were over-subscribed; however, both are available in archives.:

Understanding Fetal Alcohol Spectrum Disorders (FASD) Webinar Recording http://ihs.adobeconnect.com/pzhq65lq43/ and Beyond the Diagnosis: Effective Interventions for Children and Adolescents with FASD Webinar Recording http://ihs.adobeconnect.com/p9se0zrd5xl/

These links are live on the NPAIHB website (www.npaihb.org, under projects, under NW Tribal FASD Project)

The University of Washington FADU will also host in-person training for service providers later this year. Please watch for announcements in the weekly posting of the NPAIHB.

In addition to the work of the University of Washington FADU, the project has two FASD Specialists who have continued to work with a number of tribes to succeed in preventing FASD, and to develop community based support to accommodate those who have been directly affected by exposure to alcohol in utero. The Specialists are available to all NPAIHB member tribes for technical assistance and staff training.

SUICIDE & BULLYING

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leader, healthcare professional, coach, crisis line staff, etc.

Suicide Warning Signs (www.suicidepreventionlifeline.org)

- Talking about wanting to die or to kill themselves.
- Looking for a way to kill themselves, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or isolating themselves.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

For more information on project THRIVE and the suicide prevention trainings we offer please visit http://www.npaihb.org/epicenter/project/thrive/ or contact Colbie Caughlan at ccaughlan@npaihb.org.

REFERENCES:

http://www.cdc.gov/ViolencePrevention/pdf/Suicide_DataSheet-a.pdf

http://www.npaihb.org/images/epicenter_docs/MSPI/THRIVE/2012/8-21-12_revised_CyberBullying%20Brochure.pdf

http://www.sprc.org/sites/sprc.org/files/library/AI_AN%20Sheet%20Aug%2028%202013%20Final.pdf

http://www.stopbullying.gov/at-risk/warning-signs/index.html

https://www.suicidepreventionlifeline.org/learn/warningsigns.aspx

NEW FACES AT THE BOARD

Greetings everyone, my name is Nancy Scott. I began working at NPAIHB in the finance department as the Account Payable Specialist in February, 2103, initially as a temporary employee. In June 2013 I accepted the position permanently.

In the summer of 2012, I joined my children in relocating to Vancouver, WA from the California Redwood Coast, Humboldt County, CA.

Previously, I was employed at a non-profit organization called Open Door Community Health Centers. My duties included: Accounts Receivables, Accounts Payables, and payroll backup. In 2005 I transitioned from payroll backup to payroll full time. This entailed compiling payroll for 350-375 employees from 7 different medical clinics, 2 mobile units and 3 admin/IT/maintenance locations. My other duties included reconciling credit card and insurance statements and invoicing for the CEO's travel reimbursements.

Prior to this, I spent ten years in the Cash Office at Kmart. General accounting duties included counting cashiers tills, balancing the daily banking summary sheets and processing invoices for payment.

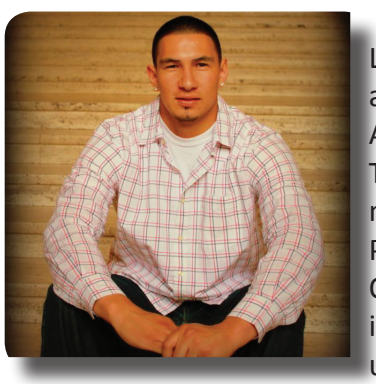
I enjoy walking in the redwoods when visiting California, going to the beach, playing tennis, crafting and meditation. I look forward to learning more about the Portland/Vancouver communities by attending local events and activities with my friends and family.

Congratulations to Carrie Sampson, Clay Plume and big sisters Avery and Fallyn on the birth of Hayden Emily Plume 12~9~13 6 lb 13 oz and 20 in

NEW FACES AT THE BOARD

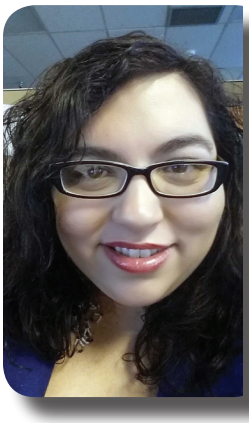
Hello, my name is Andra Wagner. I joined the Board in November as the HR Coordinator and I feel very lucky to be working in a support role for such a talented and dedicated staff. My experience in HR includes working as an HR Generalist for Food Services of America, an HR Manager for Home Depot and an HR Generalist and Recruiter for Salem Hospital. I have a B.A. in Communications, a certificate of HR Management from PSU and a Professional of Human Resources (PHR) certification from the Human Resources Certification Institute. I love working in HR and my future goals are to teach HR as an adjunct faculty member at PSU and to mentor those who are new to the profession.

My family includes my husband Wes, our 5-year-old son Ian, and our two very friendly conure parrots Kiwi and Jade. We enjoy scenic drives and other outdoor activities throughout Oregon, but especially trips to the coast. My husband enjoys hiking and our son enjoys anything that allows him to use his high energy level or gives him the chance to be social. My husband and I love living in the Great Northwest and we live just outside of Wilsonville the antiques district of Aurora.



Hi, my name is Thomas Lee Ghost Dog Jr (Tommy) and I am the new Project Assistant for Project Red Talon. I am an enrolled member of the Burns Paiute Tribe as well as Oglala Lakota. I was born in Salem, OR, but grew up in Burns, OR. I have a passion for sports and love to live an active lifestyle. In high school I was a three sport athlete earning all-state accolades. I continued my love of sports by playing baseball at a Junior College and later transferred to Oregon State University. I graduated from Oregon State in the Fall of 2013 with a degree in Public Health with my emphasis being Health Promotion/Health Behavior. With this degree, I hope to influence positive change among the Native American youth across the nation. Some of my hobbies include: sports, coaching, lounging, spending time with friends/family, eating bacon, and all around just enjoying life. I'm very glad to be a part of the Northwest Portland Area Indian Health Board and appreciate this incredible opportunity I've been given.

NEW FACES AT THE BOARD



Sarah Addis, (Siletz) has joined the Epicenter as the Project Assistant for the Western Tribal Diabetes Project (WTDP). She is a member of the Confederated Tribes of Siletz Indians located on the Oregon coast. Sarah will assist with coordination for trainings, conferences, project activities, data collection, data entry, administrative support functions, and other duties. Before working with the WTDP she received her AA in Graphic Design, worked with the Confederated Tribes of Siletz Indians as a graphic designer for the Lori Johnson Memorial Learning Garden, an event planner for the diabetes luncheons, and assisted the media planner for the American Indian college fund at Wieden + Kennedy.

UPCOMING EVENTS

JANUARY

January 29-30
CHEF Subworkgroup Meeting
Washington, DC

FEBRUARY

February 4-6
NPAIHB Digital Storytelling Workshop
Portland, OR

February 12-13
HHS Secretary's Tribal Advisory Committee Meeting
Washington, DC

February 17-20
Affiliated Tribes Northwest Indians
Bellingham, WA

February 18-20
CDC Tribal Advisory Committee Meeting
Atlanta, GA

February 19-20
IHS Direct Service Tribes Advisory Committee Meeting
Phoenix, AZ

February 19-21
MMPC & TTAG Face-to-Face Meeting
Washington, DC

February 24-25
Region X Tribal Consultation
TBD

February 25-27
IHS National Budget Formulation Work session
Washington, DC

MARCH

March 10-13
NCAI Executive Council Winter Session
Washington, DC

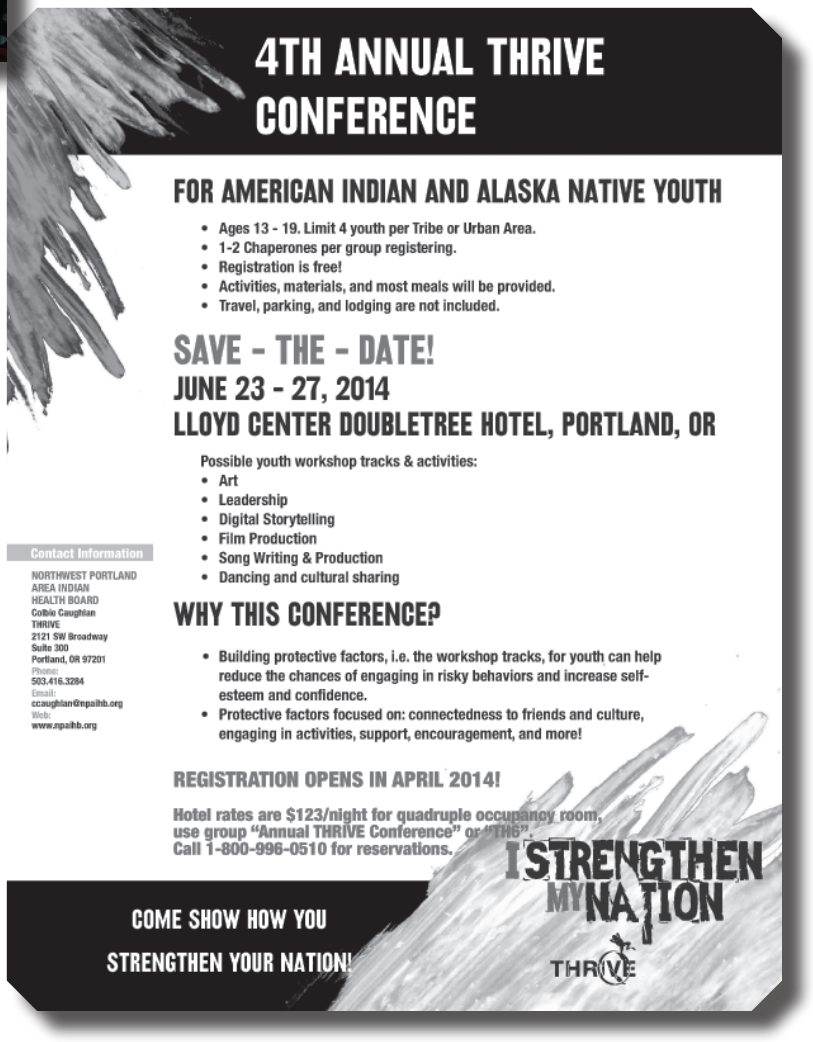
APRIL

April 1-3
5th Annual NIHB Tribal Public Health Summit
Billings, MT

April 21-24
NPAIHB THD & QBM
Suquamish/Port Gamble, WA

UPCOMING EVENTS

Please register for this free training!! The maximum # of participants is now 30 people due to a limited materials. Priority will be given to those working with Tribal populations. Please respond by Feb. 1, 2014 Please email Colbie Caughlin at ccaughlan@npaihb.org or call at 503.416.3284



NPAIHB SCRAPBOOK

Jacqueline Left Hand Bull showing her white elephant gift

Jessica Leston and baby Cater Rushing

Andy Joseph, Jr. NPAIHB Chair giving a blessing before the luncheon

Jim Roberts

Katie Johnson showing off her white elephant gift

Executive Committee Members enjoying luncheon

Elaine Dado and Shawna Gavin

NPAIHB Staff. family and friends

Luella Azule and Nancy Bennett laughing at White Elephant gag gift

Evy Kakuska helping pass out White Elephant gifts to staff

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S OCTOBER 2013 RESOLUTIONS

RESOLUTION #14-01-01

Support for the Adolescent Health Tribal Action Plan

RESOLUTION #14-01-02

Support Advance Appropriations for the Indian Health Services