HEALTH NEWS & NOTES

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INJURY PREVENTION ISSUE

2014 TRIBAL INJURY PREVENTION POLICY AND PROGRAM ASSESSMENT RESULTS

By Bridget Canniff, IPP Project Director and Luella Azule, IPP Coordinator

In September 2014, NPAIHB and the IHS Portland Area Office completed a joint Tribal Injury Prevention Policy and Program Assessment. Over the course of the year, we worked to document the current status of injury prevention efforts at the Northwest tribes. Each Tribal Health Director was asked to complete a brief survey; in many cases, NPAIHB staff also followed up with others at the tribe, including clinic administrators, clinicians, law enforcement, housing, legal, and tribal leaders.

Thirty-two tribes (74%) provided information for the assessment – 3 in Idaho, 8 in Oregon, and 21 in Washington. While only 3 of the responding tribes reported having a stand-alone injury prevention coordinator or program, the assessment results show that all of the tribes have at least some policies or programs in place to promote injury prevention and safety in their communities.

The top five areas of injury-related concern, as reported by the responding tribes, were:

1. Motor Vehicle Safety
2. Elder Safety
3. Pedestrian Safety
4. Water Safety/Drowning Prevention (tied)
4. Bicycle Safety (tied)

The assessment data will be used by NPAIHB and IHS to plan future Injury Prevention efforts in the Northwest, including applications for additional funding to support tribal programs in areas such as elder falls prevention; motor vehicle, bicycle, pedestrian, and sports safety; prevention of unintentional drug overdose and other

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CHAIRMAN'S NOTE

A Tribute to Andy Joseph
Jim Roberts, Policy Analyst
(Thank you to the National Indian Health Board for their contributions to this article).

This section of the newsletter is traditionally reserved for a report from the NPAIHB Chair however I want to break from tradition and use this space to pay tribute to a national leader. Often tribal leader contributions go unrecognized as they fall under criticism at home for traveling too much. The days, weeks, and months of travel are not fun and can be grueling on a person's wellbeing to represent—not only their own tribal members—but all Indian people throughout the United States. It's difficult for me to watch elected tribal leaders put themselves at risk of losing an election, become ill while traveling, or to lose a loved one while away from home. But their determination to protect tribal rights and resources, develop tribal services, govern their reservation for the benefit of tribal members, and promote self-determination is to be commended.

One of these leaders is our own NPAIHB Chair, Andy Joseph, Jr., who has served as the Board's Chair since 2008. He has been a member of our Executive Committee for over twelve years. This month Andy was elected to his seventh term on the Colville Business Council and upon successful completion will have served 14 years on his tribal council. I have worked with Andy for twelve years and have come to know him as a silent and gentle warrior. He has an admirable and effective quality about him in that he never loses his temper when in meetings and working on issues. This is not to say he isn't mad or passionate about the issues, in fact the opposite is true. His deliberate and soothing style along with his working knowledge of health issues has made him an extremely effective tribal leader. This has cast Andy into national prominence as a recognized expert on Indian health policy issues. He is often called upon by Congress, federal and state health agencies, the National Indian Health Board (NIHB), the National Congress of American Indians, and other tribal health advocate organizations to provide input on important Indian health issues.

Andy was born in Portland, Oregon, where his parents were relocated following the United States termination efforts of the Colville Tribe and under the Indian assimilation programs of the 1950's. He returned home in 1968 and later served in the U.S. Army 75th Airborne Ranger Battalion and is very proud of his military service. It is no coincidence about Andy's outspoken role to represent Indian

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health issues and tribal rights as he comes from a long tradition of Tribal Chiefs that include his father Andy Joseph, Sr., Lucy Covington, George and Celestine Friedlander, Mel Tonasket and Shirley Palmer. He is quick to recognize and humbled by the fact that such folks as Pearl Capoeman-Baller, Bob Brisbois, Willy Jones, Ron Allen, Linda Holt, Janice Clements, and Bernice Mitchell have been a mentor for him. Likely out of all of Andy's work and accomplishments, he is most proud of his family, and has been married to Lori Lynn for close to 30 years. He has five children and three grandchildren.

In recognition of Andy's contributions to Indian health he was recently awarded a prestigious award from the Indian Health Service (IHS). IHS recognized Andy for his years of service to advocate for IHS, tribal, and urban Indian health programs. IHS Acting Director Robert McSwain presented Andy with the IHS Director's Special Recognition Award for his significant contributions and unwavering leadership to advancing the health agenda in Indian Country. He accepted the award from Director McSwain by stating, "I am deeply honored and grateful to receive this award from the Indian Health Service. Through my many years and work on the Northwest Portland Area Indian Health Board, and the National Indian Health Board, I have witnessed many struggles in Indian health but also many victories. The work that Tribal health professionals do across the country is needed to keep our people healthy and strong, and I'm thankful that the work is recognized."

The Indian Health Service Director's Award recognizes service significantly advancing the IHS mission and goals through enhancements supporting IHS priorities. Andy has served for many years as the co-chair for the IHS Budget Formulation and Contract Support Cost Workgroups. He also sits on the Contract Health Services Workgroup and is a member of the Federal Disparity (Data) Workgroup. He previously served as the vice-chair of the Direct Service Tribes Advisory Committee. Andy has also served in various capacities on tribal committees with the Centers for Disease Prevention and Control and the Substance Abuse Mental Health Administration. In his role as the NPAIHB Chair and a member of a direct service tribe, Andy has been uniquely positioned to represent the views of both direct service and self-governance Tribes. I have observed him first hand to find a delicate balance to represent the views of both positions on controversial issues such as contract support costs and on tribal shares. He has a remarkable quality about him to balance the unique paradigm in these differing viewpoints. In the end Andy sees it all as a matter of the United States obligations under the federal trust relationship and a decision by a tribe to have

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NATIONAL INDIAN HEALTH BOARD MEMBER ANDY JOSEPH, JR. HONORED WITH PRESTIGIOUS DIRECTOR'S AWARD FROM INDIAN HEALTH SERVICE

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FOR IMMEDIATE RELEASE

Contact: April Hale at 202-507-4077 or ahale@nihb.org

NIHB Board Member Andy Joseph, Jr. Honored with Prestigious Director's Award from the Indian Health Service

Mr. Joseph recognized for years of service to Tribal health.

WASHINGTON, DC—June 3, 2015—On May 29, 2015, the Indian Health Service (IHS) Acting Director Robert McSwain presented long-time National Indian Health Board (NIHB) Board Member Andy Joseph, Jr. with the 2014 IHS Director's Special Recognition Award for his significant contributions and unwavering leadership to advancing the health agenda in Indian Country.

"I am deeply honored and grateful to receive this award from the Indian Health Service. Through my many years and work on the Northwest Portland Area Indian Health Board, and the National Indian Health Board, I have witnessed many struggles in Indian health but also many victories. The work that Tribal health professionals do across the country is needed to keep our Peoples healthy and strong, and I'm thankful that the work is recognized," said Mr. Joseph, who is in his fifth term on the Confederated Tribes of Colville Tribal Council representing the Nespelem District.

NIHB Board Member Andy Joseph, Jr. receives Indian Health Service Director's Award on May 29, 2015. Photo credit: W.K. Kellogg Foundation

The Indian Health Service Director's Award "recognizes service significantly advancing the IHS mission and goals through enhancements supporting IHS priorities; these include renewing and strengthening Tribal partnerships; bringing reform to the IHS; improving quality and access to care for IHS patients; and ensuring transparency, accountability, fairness and inclusion."

"The award reflects my sincere appreciation for your leadership and partnership in improving the IHS budget formulation process through co-chairing the Tribal Budget Formulation Workgroup," McSwain said in a letter to Joseph.

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IHS manage their health program or a tribe's decision to assume management, are an exercise of Tribal sovereignty and self-determination. As the IHS Director stated when presenting the award to Andy, "This award reflects my sincere appreciation for your leadership and partnership in improving the IHS budget formulation process through co-chairing the Tribal Budget Formulation Workgroup."

Recently re-elected Chairman of the Northwest Portland Area Indian Health Board and Member-at-Large to the National Indian Health Board, Mr. Joseph has testified before Congress on increasing the budget for IHS, health disparities in Tribal communities and provider access and vacancies. In addition, Andy represents NIHB on the Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Advisory Committee, is a voting delegate of Affiliated Tribes of Northwest Indians and the National Congress of American Indians, and serves as the Vice Chairman of the IHS Direct Services Tribes Advisory Committee. He is a constant advocate of quality and accessible health care for all American Indian and Alaska Native people.

Always humble, Andy's closing remarks when he accepted the IHS Award, "Thank you to the Indian Health Service for recognizing me and the Colville Tribe. Thank you to Northwest Portland Area Indian Health Board, NIHB and those that have guided and mentored my career."

Andy Joseph, it us that should be thanking you and we hope this small tribute recognizes how much we value your leadership!

2014 TRIBAL INJURY PREVENTION POLICY AND PROGRAM ASSESSMENT RESULTS

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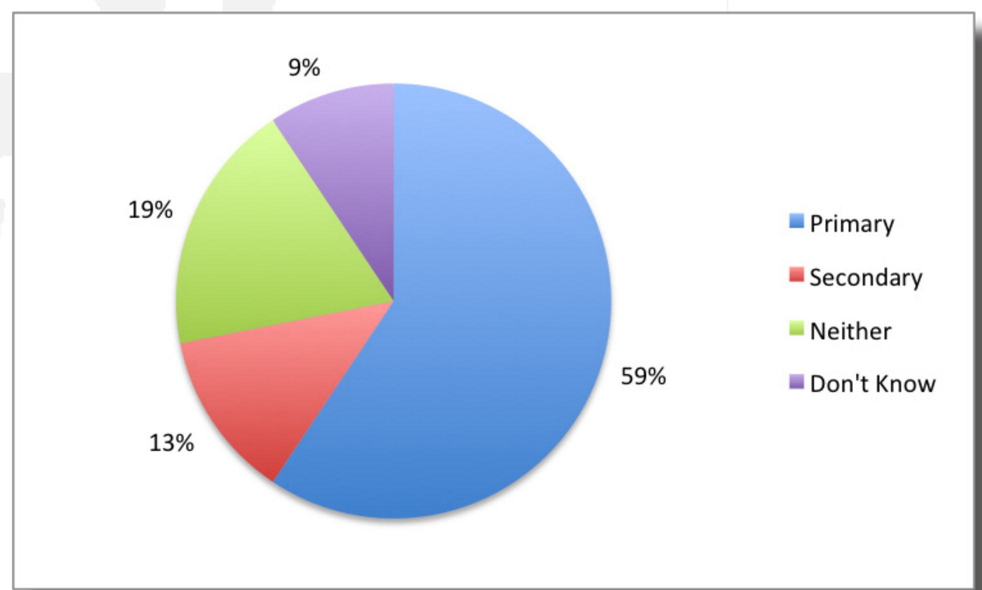
Q1: Does the tribe have either a primary or secondary seat belt law?

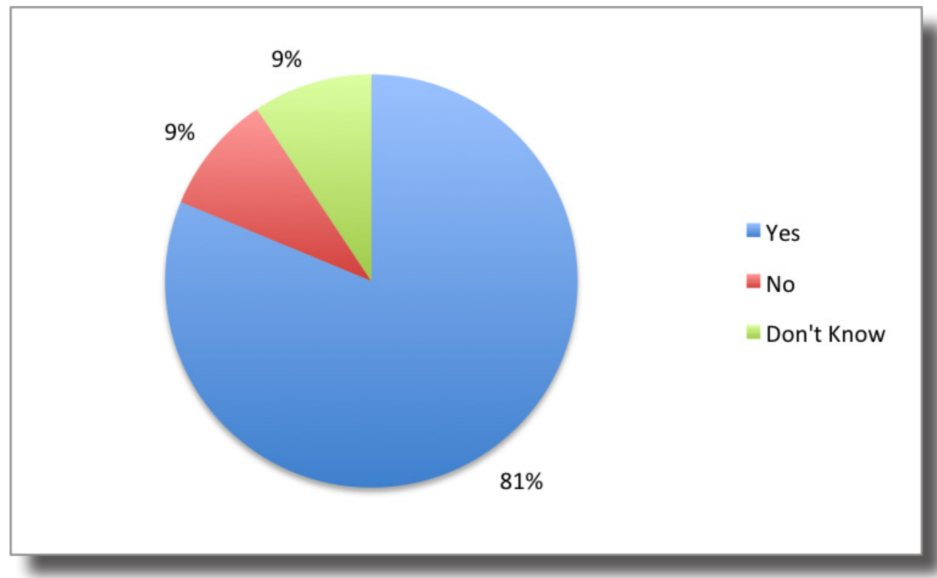
Primary law: Police can stop and ticket a driver or passenger for not wearing a seat belt, without any other traffic offense.



Secondary Law: Police can ticket a driver or passenger for not wearing a seat belt only if they have already been stopped for another offense.

Idaho has a primary seat belt law for drivers under 18, and a secondary law for all others. Both Oregon and Washington have a primary seat belt law. Tribes who follow state laws are included in the data above.

Q2: Is there a law requiring child safety seats (car seats/booster seats) for children 8 years old and younger?

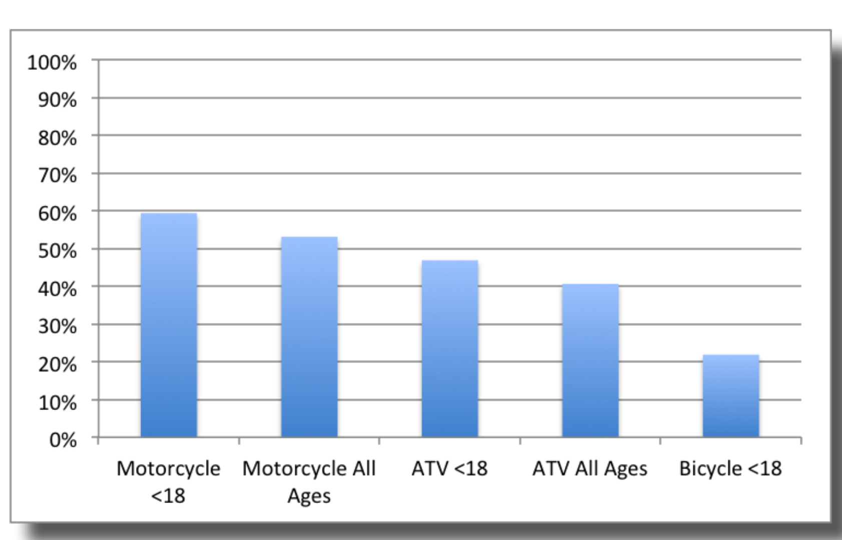


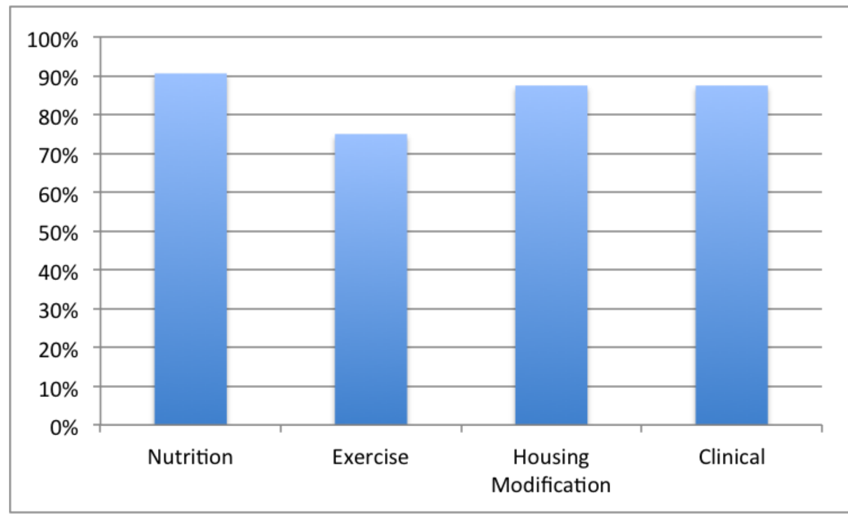
Tribes who follow state laws are included in the data above.

2014 TRIBAL INJURY PREVENTION POLICY AND PROGRAM ASSESSMENT RESULTS

Q3-Q4: Are there laws requiring helmets for any of the following?

Tribes who follow state laws are included in the data above. One tribe does not allow ATVs at all.





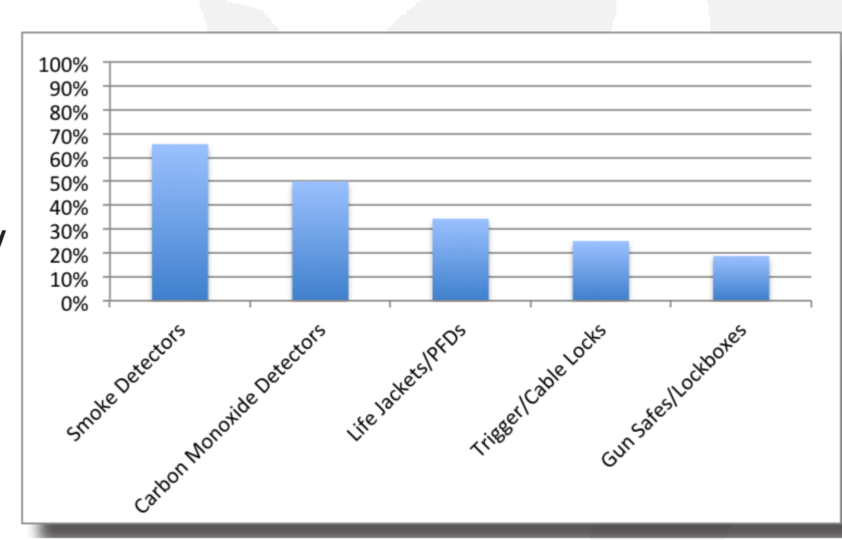
Q5: Are there programs to address the following needs for older adults at risk for falls?

Exercise includes strength training and balance. Housing modifications include grab bars, stair railings, ramps, etc. Clinical services to prevent elder falls include vision screenings and medication review.

Q6: Does the tribe have housing codes requiring smoke and/or carbon monoxide detectors?

Q7: Does the tribe have a gun safety, hunting/ firearm licensing, or other program to promote locking devices (trigger or cable locks) and/or safe storage (gun safes/lock boxes)?

Q8: Is there a water safety, fishing, boating or other program that promotes life jacket/PFD (personal flotation device) use?



OREGON'S INFANT MORTALITY COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK

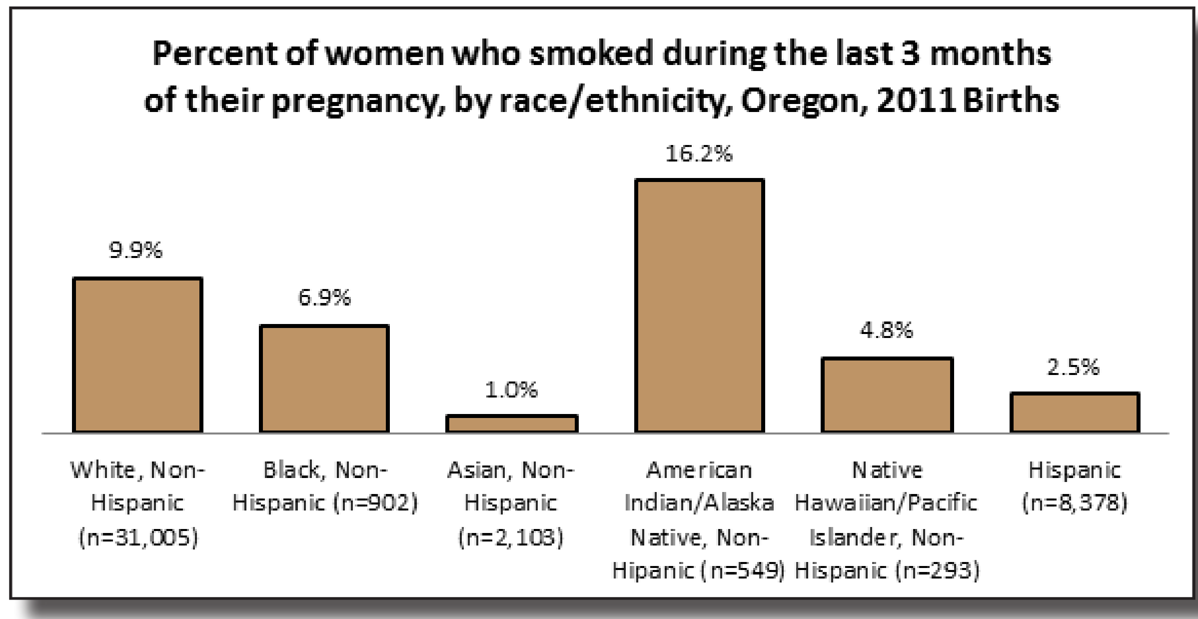
By Ann Stiefvater, Oregon Health Authority and CAPT Thomas Weiser, Portland Area IHS/NW Tribal Epidemiology Center

The Collaborative Improvement and Innovation Network to Reduce Infant Mortality (IM CoIIN) is a multiyear national project of the Maternal and Child Health Bureau at the Health Resources and Services Administration (HRSA). Each state is being asked to partner with professionals and communities to employ quality improvement, innovation and collaborative learning to reduce infant mortality and improve birth outcomes.

The IM CoIIN has identified six strategy areas that it will focus on:

- Improve safe sleep practices
- Reduce smoking before, during and/or after pregnancy
- Pre/Inter-conception Care: Promote optimal women's health before, after and in between pregnancies, during postpartum visits and adolescent well visits
- Social Determinants of Health: Incorporate evidence-based policies/programs and place-based strategies to improve social determinants of health and equity in birth outcomes
- Prevention of Preterm and Early Term Births
- Risk-appropriate Perinatal Care: Increase the delivery of higher risk infants and mothers at appropriate level facility

The Oregon IM CoIIN team, convened by the Maternal and Child Health Section of Oregon's Public Health Division, has chosen an initial focus on reducing smoking before, during and/or after pregnancy. In 2011, 10.8% of women in Oregon reported smoking during pregnancy. American Indian/Alaska Native women were more likely to smoke during pregnancy than any other race/ethnic group.



OREGON'S INFANT MORTALITY COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK

Smoking during pregnancy is associated with fetal risks including low birth weight, intrauterine growth restriction (IUGR), preterm delivery, and sudden unexpected infant death (SUID). Maternal smoking during pregnancy also increases the risk for miscarriage and ectopic pregnancy. Postnatal smoke exposure increases the infant risk for reactive airway disease or asthma and an increased risk of respiratory infections.[1]

Recognizing the important role health care providers have in coaching and supporting women to stop smoking and stay quit, two Portland Area clinics (Warm Springs Health and Wellness Center and Yellowhawk Tribal Health Center) have joined the efforts of Oregon's IM CoIIN as pilot sites. These two sites currently provide prenatal care to pregnant women and have established pharmacy-based smoking cessation clinics. Both sites have also worked closely with the Portland Area Improving Patient Care Collaborative and have an established track record in quality improvement and innovation. Building upon work that is already being done to screen and refer for tobacco use in these clinics, the defined aims of the pilot sites are to:

1) Increase the percentage of smoking women who are referred to smoking cessation counseling to 95% or higher
2) Increase the percentage of women who stop smoking during pregnancy by 10%
3) Increase the percentage of women who maintain cessation after delivery by 10%

Quality improvement tools such as Plan–Do–Study–Act (PDSA) cycles will be used to work towards these aims and identify areas for improvement and innovation. The Portland Area IHS Improvement Support Team, composed of IHS and NPAIHB staff, is providing support for these efforts. Working together, we hope to achieve the aims of the project and to ensure strong community support systems for women in their childbearing years to avoid smoking or stop and stay quit.

For questions about Oregon's IM CoIIN work, please contact: anna.k.stiefvater@state.or.us.

For more information about the Portland Area IHS Improvement Support Team, please contact: tweiser@npaihb.org or jonathan.merrell@ihs.gov

(Endnotes)

1. *Source: http://www.cdc.gov/reproductivehealth/TobaccoUsePregnancy/index.htm*

TACKLING CHILD PASSENGER SAFETY FROM VARIOUS STAGES OF COMMUNITY READINESS

American Indian children have the highest motor vehicle fatality rate of any race in the United States, with death rates 2-3 times higher than other races. We know that child safety seats work. They reduce the risk of death in passenger cars by 71% for infants, and by 54% for children ages 1 to 4 years. Part of the death disparity may be due to American Indian children being less likely to ride properly restrained in motor vehicles. We know that child safety seat use can vary widely from one tribal community to another. We also know that different communities have different norms around child passenger safety. Consequently, there is no single prescription for improving child passenger safety in all communities. Each community will need an approach as unique as its culture.

A tribe's strategy to improve child passenger safety will depend on many factors, including community readiness level. For example, a tribe whose membership has vague awareness of child passenger safety recommendations might do a community-wide media and education campaign. A tribe that already has a successful child passenger safety program might do more targeted efforts to keep children rear-facing till age 2, keep children in booster seats till 4'9", or do outreach to subgroups who are less likely to have children in child safety seats, such as elders.

The table shows the various stages of community readiness, a description of how the readiness level pertains to child passenger safety, and a list of activities a community at each stage might do to improve child safety seat use.

The six tribes that participated in the Native Children Always Ride Safe study (Native CARS) started their child passenger safety efforts from a wide variety of stages of community readiness, from vague awareness, to well-established,

Stages of Readiness	Description	Activities
1. No Awareness	Child passenger safety is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).	Establish partnerships Build awareness among key people
2. Denial/Resistance	At least some community members recognize that child passenger safety is a concern, but there is little recognition that it might be affecting people locally.	Establish partnerships Build awareness more broadly (media about motor vehicle injuries, car seat recommendations) Data collection Community outreach
3. Vague Awareness	Most feel that child passenger safety is local concern, but there is no immediate motivation to do anything about it.	Coalition building Media to increase awareness Community outreach
4. Preplanning	There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.	CPS tech training Coalition building Community education
5. Preparation	Active leaders begin planning in earnest. Community offers modest support of efforts.	CPS tech training Education program
6. Initiation	Enough information is available to justify efforts. Activities are underway.	Distribution program CPS tech training Engage with law enforcement Develop program policies Develop tribal policy
7. Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced.	Continue outreach activities Fine-tune media messages Propose modified tribal law Contact law enforcement to develop strategies to enforce the law
8. Confirmation/Expansion	Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.	Continue outreach and distribution program Outreach to hidden populations of need
9. High Level of Community Ownership	Detailed and sophisticated knowledge exists about motor vehicle injuries and child passenger safety. Effective evaluation guides	Expand to related topics (Distracted driving, bicycle helmets, etc.)

TACKLING CHILD PASSENGER SAFETY FROM VARIOUS STAGES OF COMMUNITY READINESS

thriving programs. Their community readiness level tended to correspond to the percent of children riding properly restrained in motor vehicles – tribes with well-established programs had a higher proportion of children using age and size appropriate child passenger restraints. Because of these differences, the six Native CARS tribes used many different approaches to improve child passenger safety in their communities, with their efforts tailored to their community's baseline child safety seat use, attitudes, resources, and readiness level. While all six tribes collected tribe-specific data – both quantitative and qualitative – and all six developed media materials, the combination of interventions, messages, and approaches were quite different.

Some examples follow:
A tribe that was in a stabilization phase chose to update their child passenger safety law and order code to meet the current child passenger safety recommendations. After the law was ratified, they developed a training to help tribal law enforcement identify gross misuse of child passenger restraints, and did a community education and media campaign to build awareness of the new law.

One tribe had a large portion of their community members in the denial/resistance phase, so they took a more grass-roots approach to child passenger safety. They focused on building a coalition to address child passenger safety, hoping to create buy-in from community members. They made an effort to have child safety seats available for purchase in their local store. Media messages focused on awareness of child passenger safety recommendations and consistency of child safety seat use.

One tribe with very low child safety seat use listened when people said they could not afford child safety seats. They created a child safety seat distribution program and did broad child passenger safety education and community outreach.

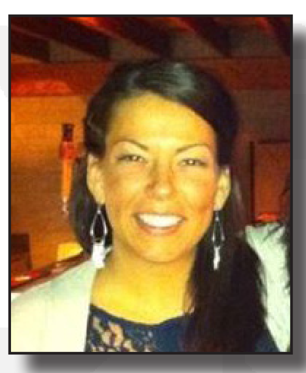
Each of the six tribes saw improvement in child safety seat use in their communities following their intervention activities. The Native CARS team, which includes child passenger safety technicians from the tribes, along with NPAIHB staff, is sharing their successful strategies, tools, and resources via The Native CARS Atlas, coming soon at nativecars.org. Content will include:

- Check Your Community's Readiness
- Build and Organize Your Coalition
- Collect Child Safety Seat Data
- Make Data-Driven Plans
- Create a Media Campaign
- Provide Child Passenger Restraint Education
- Implement a Child Safety Seat Distribution Program
- Develop Policy and Law Enforcement Interventions

Resources will include lesson plans, modified SNAP presentations, policy development guides, survey instruments, posters, billboards, and education tools. All content was developed by tribes, for tribes, based on their own successful programs.

Until motor vehicle injuries and fatalities are zero, there is work to be done to improve child passenger safety. With The Native CARS Atlas, tribes and communities in various stages of community readiness will be able to find useful and relevant tools to make their own combination of activities that will be effective for them. As communities progress to a higher level of readiness, they will be able to cycle back through the Atlas again, adopting new strategies and activities until we eliminate the disparity in American Indian children motor vehicle injuries and fatalities.

PREVENTING ADVERSE CHILDHOOD EXPERIENCES (ACE)



By Ryan Swafford, Sexual Assault Prevention Coordinator

An adverse childhood experience (ACE) is a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult. In gathering data and assessing an ACE, Kaiser Permanente has delineated traumas into eight categories and scored for likely impact: They are:

- emotional abuse/neglect
- physical abuse/neglect
- sexual abuse
- witnessing mother being treated violently
- grew up with someone in the household using alcohol and/or drugs
- grew up with a mentally-ill person in the household
- lost a parent by separation or divorce
- household member was in jail or prison

The trauma experienced in childhood increases the likelihood of adverse health consequences as an adult. When a person experiences at least three ACES's the risk of adverse health effects starts to double. In a Kaiser Permanente study, one in four adults reported three or more ACEs. The Aces study took place between 1995-1997, with more than 17,000 participants completing a standardized physical examination and questionnaire regarding ACEs. The Kaiser study found connection of ACEs to poor health in several areas. These areas include mental health, sexual and reproductive health, and general health and social problems. More information can be found at: http://www.cdc.gov/violenceprevention/acestudy/index.html . In childhood, manifestations of trauma are somewhat different. For example, disrupted neurodevelopment from maltreatment and abuse can cause a child to experience constant fear rather than only when in crisis. A person's brain undergoes an impressive amount of development between conception and age three, when capacity for cognitive ability is set. Child abuse and neglect have been shown to potentially increase risk in childhood for:

- Diabetes
- Poor lung function, asthma
- Adolescent obesity
- Low self -esteem
- Depression
- Suicide attempts in adolescence
- Anxiety
- Youth violence; girls 7% more likely and boys 12% more likely
- Post-Traumatic Stress Disorder (PTSD)

American Indian/Alaska Native (AI/AN) children experience PTSD at the same rate as veterans of the wars in Iraq and Afghanistan. According to a report from an Department of Justice advisory committee, 22 % of American-Indian and Alaskan Native juveniles have a PTSD—three times higher than the national rate.

ACE information matters to our Tribal communities because American Indians have high disease rates in all health categories and have not experienced decreases in chronic health disease as has the rest of the U.S. There is hope, we know a child's early years are a window of opportunity for Tribal parents, caregivers, and communities. Positive early experiences have a huge effect on children's chances for achievement, success, and happiness. It is important to consider safety first where children's services are provided. In providing services, policies can be implemented to ensure that intake screenings include questions regarding exposure to violence. Last, if we offer culturally appropriate mental, spiritual, physical, and substance abuse services while implementing trauma-specific services to directly address trauma and we can positively promote recovery in our communities.

TEXTING 4 SEXUAL HEALTH TO AI/AN TEENS & YOUNG ADULTS

In 2013, American Indian and Alaska Native (AI/AN) youth had second highest rates of chlamydia and gonorrhea infections among all ethnic and racial minorities in the US, and the third highest teen pregnancy rates in the US. These disparities underscore the need for effective sexual health interventions for AI/AN teens and young adults that promote condom use and STD testing.

In 2009, 78% of AI/AN youths used cell phones as the primary communication tool. The widespread use of cell phones by AI/AN youth makes text messaging a promising tool to deliver culturally-appropriate health information to AI/AN youth, but little is known about the effectiveness of such an approach.

Patricia Yao, a PhD candidate at the Oregon Health Sciences & University School of Medicine, aimed to investigate that question. The *Texting 4 Sexual Health* study was carried out in partnership with David Stephens, RN, and Stephanie Craig Rushing, PhD, at the NW Tribal EpiCenter. The text messages were delivered through *We R Native*, which sends weekly health messages to those who subscribe (text NATIVE to 24587 – www.weRnative.org).

The goal of the study was to see if text messages could be used to increase sexual health knowledge, and improve attitude, self-efficacy, intention, and behavior towards condom use and STI/HIV testing among AI/AN teens and young adults 15-24 years old. Given the range of perspectives and reading levels of study participants, each text message was pilot tested with AI/AN teens and young adults, to ensure relevance and comprehension, regardless of age, gender, and sexual orientation. Through a community based participatory research approach, iterative surveys were used to collect youth feedback before their use.

The study was structured such that the individual disclosed only his/her phone number, was incentivized for participating, and enrolled using an IRB-approved consent form – all via text message.

During the enrollment period, 408 individuals from across the US consented to participate. Once enrollment was complete, each person received a pre-survey to benchmark his or her condom use and HIV/STI testing knowledge. Over the course of 12 weeks, two sexual health text messages were sent to participants each week. Post-surveys were completed via text message immediately after the intervention and 3 months later.

To gauge intention to use condoms, participants were asked, "If you decided to have sex, how likely is it that you'd get a partner to use a condom?" To gauge STI/HIV testing behavior, participants were asked, "Have you ever been tested for HIV or STDs?" If yes, "When did you last get tested?"

It worked! Study results showed a positive change in both attitude and behavior towards condom use, and intention and behavior towards STI/HIV testing. Although baseline self-efficacy was high in both categories, there were still a large proportion of people that had early pregnancies and STIs. Overall, the study showed that text messages could be an effective tool to deliver health information and guide behavioral change in condom use and STI/HIV testing.

Given that text messaging is the most common method for communication, texting may be the most effective and efficient way to deliver important health information to AI/AN teens and young adults. This study supports future work leveraging text messages to promote health and behavior change among AI/AN teens and young adults.

USING INFLUENZA SURVEILLANCE DATA TO PLAN VACCINATION STRATEGIES FOR 2015–2016 INFLUENZA SEASON

By CAPT Thomas Weiser, MD, MPH, Medical Epidemiologist, Portland Area Indian Health Service

Influenza is a major cause of morbidity and mortality for American Indians/Alaska Natives. Annual influenza transmission in the Northwest now begins 2-3 months earlier than before the 2009–2010 H1N1 pandemic. This year, the IHS developed a plan to increase influenza vaccination coverage for American Indian/Alaska Native(AI/AN) people for the upcoming influenza season and to work towards meeting the Healthy People 2020 goal of 70% vaccination for all ages. Population vaccine coverage required to interrupt transmission and prevent or lessen the severity of an outbreak depends on two factors— 1) the effectiveness of the vaccine and 2) how infectious the circulating strain of influenza virus is (R_o). Surveillance for influenza-like illness has been ongoing in IHS, Tribal and Urban Indian clinics in the Portland Area since the 2009–2010 H1N1 pandemic. Data from the IHS Influenza-like Illness Awareness System can be used to help plan future influenza vaccination campaigns that to increase vaccine coverage in our population.

We used Influenza vaccination coverage and influenza-like illness (ILI) estimates from the Portland Area IHS ILI Awareness System during the 2014–2015 influenza season to determine influenza vaccine uptake and the timing of influenza transmission in 33 participating Portland Area IHS, Tribal and Urban clinics. Future influenza vaccine coverage was projected based on four strategies for improvement: 1) starting sooner; 2) extending maximum vaccination duration; 3) increasing the number of vaccinations given weekly by 25%; 4) combinations of these strategies.

Weekly Count of Influenza Immunizations Given, 2014-2015 Season

Period of maximum vaccination activity

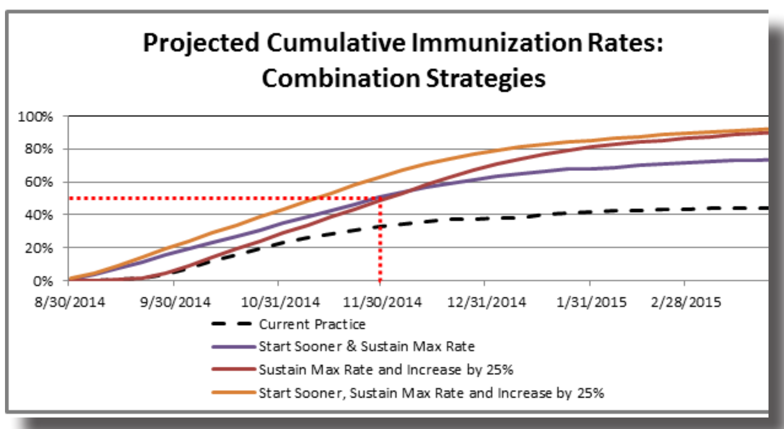
Vaccina-tion Begins

Children (6 months-17 years) — Adults (18 + years)

Figure 1. Weekly count of influenza vaccine doses given in Portland Area IHS for the 2014-15 influenza season. Vaccination activity rises 3-4 weeks after earliest vaccine arrival. Vaccine uptake is steepest from 10/4/14 to 11/1/14 as indicated by the red shaded area, then declines through the 2nd week of January. A small, late-season surge is seen after the 2nd week of January.

During the 2014–2015 influenza season, the earliest vaccinations were given in week 35 (8/30/14); the maximum influenza vaccination activity was from 10/4/14–11/1/14 with 2,563 vaccines given per week on average. The maximum vaccination uptake was in week 40 (2,700 vaccinations given). Influenza transmission lasted 13 weeks, beginning 11/15/14 and reaching its peak 12/27/14 (Figure 1).

Based on average estimates of influenza vaccine effectiveness of 37.5%–52% and seasonal influenza infectivity (R_o) of 1.28, it was estimated that the minimum population vaccine coverage needed to achieve herd immunity was about 50% (40% for those age 6 months to 64 years; 55% for those aged > 65 years). The projections of future vaccination coverage showed no single strategy could achieve 50% coverage by Thanksgiving weekend (week 48); using two or more strategies it appears that we could meet this



USING INFLUENZA SURVEILLANCE DATA TO PLAN VACCINATION STRATEGIES FOR 2015–2016 INFLUENZA SEASON

level for the Portland Area (Figure 2).

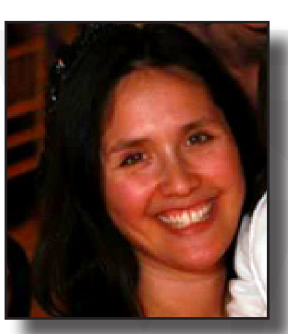
Figure 2. Projected cumulative influenza immunization rates using three combination strategies compared to current practice. Minimum herd immunity threshold to be reached by 11/30/2015 is shown in red. All three strategies are projected to meet or exceed the goal of 50% before ILI activity begins. All strategies could meet the IHS/HP 2020 goal of 70% coverage for the flu season but only on (using all three single strategies) will achieve this goal before ILI activity would be expected to peak.

We conclude that two or more strategies are needed to achieve vaccination levels capable of disrupting influenza transmission for AI/AN in the Portland Area. More work is needed to assess clinic capacity and patient demand for influenza vaccination. For now, this provides some guidance to our clinical programs of the workload capacity needed to achieve 50% coverage by Thanksgiving weekend, our best chance to prevent or lessen the impact of influenza next year.

NEW FACES AT THE BOARD

Pam Johnson joins the NPAIHB as the Oral Health Project Specialist, working to establish modern oral health care delivery systems in tribal communities. She brings 25 years of community organizing, communications and policy advocacy experience to this position, most recently working at the Children¹s Alliance coordinating the Washington Dental Access Campaign. She grew up in Southeast Idaho, attended Pacific Lutheran University in Tacoma, Washington and has lived in Seattle since graduating college. Before switching gears to work on improving access to health care, she spent most of her professional life working with communities around Puget Sound to prevent and clean up toxic pollution. Outside of work she is the PTA president of her kid's elementary school, volunteers with WA Cystic Fibrosis Foundation chapter, and does some fun stuff too: biking, backpacking, gardening and adventuring with her 10-yr old daughter and 8-yr old son.

ZERO SUICIDE KICK-OFF



Adapted by: Colbie M. Caughlan, MPH

Suicide is an issue that often has negative connotations attached to it, but it reaches into the lives of nearly everyone. Whether you have personal struggles, or know someone who has attempted or died by suicide, chances are it will touch you at some point in your life. Suicide deaths are increased in Native People, ranking seventh in leading causes of death for Natives of all ages and second in leading causes of death for Natives aged 15-44 years in Idaho, Oregon, and Washington for 2008-2012 (Project IDEA-NW, NPAIHB, 2014). Of those who die by suicide research has shown that almost half (45%) saw a primary care doctor in the month prior to their death and one in five suicide victims saw a mental health professional (Luoma, Martin, & Pearson, 2002).

As a region we need to transform our health care, and change public sentiment about suicide, so that we can reduce our number of suicide deaths. A group of Tribal Health employees of three tribal clinics are doing just that, by beginning to implement the Zero Suicide model within their Tribes. Zero Suicide sets a basis for prevention of all suicide deaths through improved care and a commitment to patient safety. Taking a continued quality improvement approach, and providing long-term follow up are some of the ways the tribal Zero Suicide implementation teams will move our tribal communities to Zero Suicide deaths in the future.

We need the help and support of the whole region. As we, and our partner sites, begin our approach with a more focused suicide prevention project, we will need community members who are willing to talk about their experiences with suicide, and hopefully help change the feelings of shame and discomfort that are associated with suicide. The THRIVE suicide prevention project at the NPAIHB will continue to update the NW Tribes on the Zero Suicide model as we move along with the SAMHSA Garrett Lee Smith youth suicide prevention grant through 2019.

It is with community support and encouragement that we all will be successful in our drive to Zero Suicide. For more information about the SAMHSA funding, Zero Suicide, the THRIVE project, or assistance around suicide prevention that the NPAIHB can offer, please contact Colbie Caughlan, project manager, at ccaughlan@npaihb.org.

(Article adapted with permission from a staff member at a NW Tribe, 2015) For data and statistics referred to in this article please contact Colbie Caughlan at ccaughlan@npaihb.org.

THE FIRST PREVENTION OF INJURY

Kay Kelly, Project Director, Fetal Alcohol and Drug Unit (FADU), University of Washington and Jacqueline Left Hand Bull, NPAIHB Administrative Officer

In this issue of Health News and Notes, the topic is injury prevention, and we often think fireworks, lakes and river activity, sunburns. As important as those risks are, there is another even more common risk that leads to lifelong impairment and loss of potential. An unintentional, but lifetime, injury to a tiny fetus happens when the pregnant woman drinks alcohol. Often, this is before the woman is aware that she is pregnant.

Imagine, at three weeks, we are still just a tiny embryo, no bigger than the "o" in the word one on a penny, though our brain is developing,[1] and we must rely on our mother to protect us from harm. But, how is this possible when our mother has had only the slightest indication that she may be pregnant? Let's think about it.

If a pregnancy is not intentional, a mother can be completely unaware of her growing offspring and may continue to drink alcoholic beverages until her pregnancy is confirmed. During this period the embryo, becoming a fetus, is powerless to metabolize the alcohol the mother drinks. That means the tiny embryo or fetus is awash in alcohol for endless hours since the blood alcohol level of mother and baby become one within minutes. The alcoholic beverages consumed by the mother during pregnancy can cause damage or death of cells of the developing fetal brain. Alcohol can cause cells to migrate wrongly, resulting in heart or other organ defects. It can also cause abnormalities of the ears, kidneys and skeleton, injury to the developing face and eyes, as well as damage to the central nervous system.

The spectrum of these disorders is wide, and permanent. Damage may be a simple inability or a severely disabling impairment. The timing of the injury or injuries determines which part of the brain is affected. Disorders may be problems with memory, impulsivity, difficulty following directions and problem solving. These injuries can be reflected in emotional problems, mental illness, substance abuse problems and a vulnerability to suggestion.

Tribal traditions teach us that pregnancy is a very important time, some say it is sacred.[2] The only way parents who customarily drink alcohol can insure that their children are not harmed by the mother's alcohol use in pregnancy is for the mother to abstain from drinking alcohol when pregnancy is possible. The pregnant woman may need support and encouragement of her abstinence from alcohol. This targeted abstinence is the earliest prevention of injury to our children.

Tribal peoples have always looked to nature for inspiration and understanding. They have studied the cycles of life - watching how all of nature works together to create a perfect balance.

If our parents insure that nothing they do is harmful to us during the nine months of pregnancy and during the time of nursing, there is a perfected balance. And, we come into this world with a gift of all the strength, courage, generosity, intelligence and caring of the 7th generation before us.

1 Sulik KK, O'Leary-Moore SK, Godin E, and Parnell S. Normal and Abnormal Embryogenesis of the Mammalian Brain, In: Alcohol, Drugs and Medication in Pregnancy –The Long-term Outcome for the Child, Clinics in Developmental Medicine, PM Preece and EP Riley (eds.), McKeith Press, London, pp23-44, 2011

2 SAMHSA FASD Center for Excellence: AAI/AN/NH Resource Kit, 2007 US Department of Health and Human Services

UPCOMING EVENTS

JULY

July 15-16
TTAG Face-to-Face Meeting
Washington, DC

July 21-22
IHS Tribal Self-Governance Advisory Committee Meeting
Washington, DC

July 21-23
IHS/Indian Self-Determination & Education Assistance Act Orientation
Issaquah, WA

July 23
All Tribes Meeting
Issaquah, WA

July 28-29
2015 Portland Area Dental Meeting
Tulalip, WA

AUGUST

August 3-6
Facilities Appropriation Advisory Board (FAAB) Meeting
North Carolina

August 3-6
CDC/TCAC Quarterly Meeting
Spokane, WA

August 13
American Indian Health Commission (AIHC) Meeting
Auburn, WA

August 19
Oregon Tribes SB 770 Meeting
Salem, OR

August 20
Oregon Tribes Tribal Consolation Meeting
Salem, OR

August 26-27
12th Annual Direct Service Tribes National Meeting
Flagstaff, AZ

SEPTEMBER

September 1-2
Nike Native Fitness
Nike HQ, Beaverton, OR

September 7
Labor Day

September 14-17
Affiliated Tribes of Northwest Indians (ATNI) Meeting
Spokane, WA

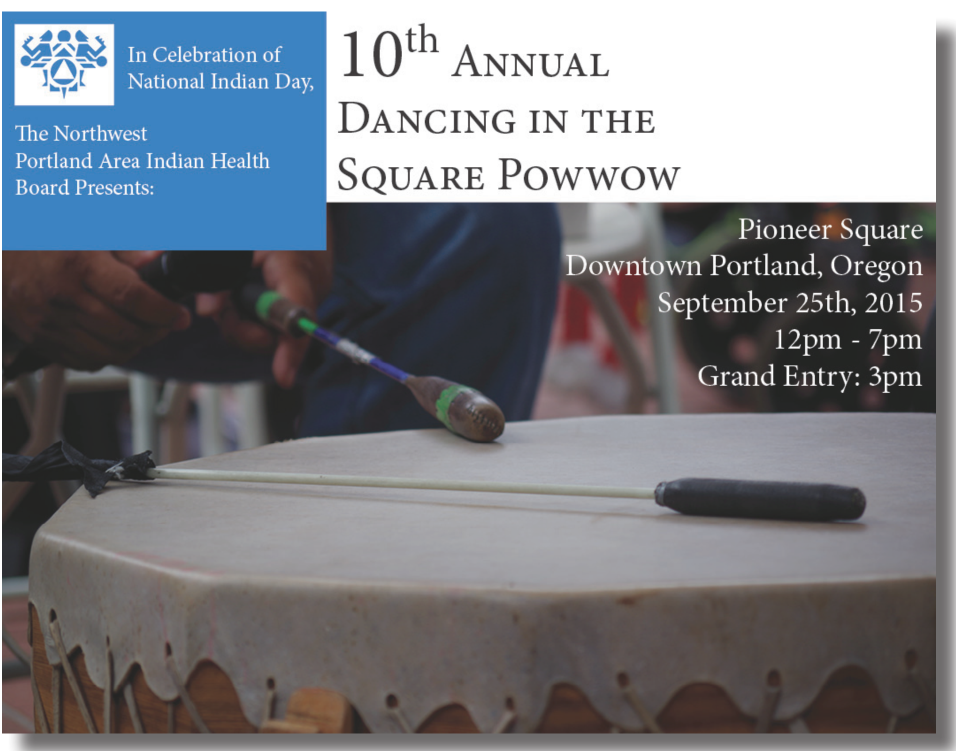
September 15
Chehalis Tribal Health Fair
Oakville, WA

UPCOMING EVENTS

September 15-16
Secretary's Tribal Advisory Committee (STAC) Meeting
Washington, DC

September 21-24
National Indian Health Board (NIHB)
Annual Consumer Conference
Washington, DC

September 25
10th Annual American Indian Day
Celebration
Dancing in the Square
Downtown Portland, OR



OCTOBER

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

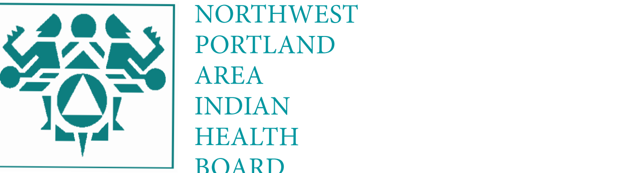
October 18-23
National Congress of American Indians (NCAI) 72nd
Annual Convention and Marketplace
San Diego, CA

October 26
NPAIHB Tribal Health Director's Meeting
Pendleton, OR

October 27-29
NPAIHB Quarterly Board Meeting
Pendleton, OR

We welcome all comments and Indian health-related news items. Address to:
Health News & Notes/ Attn: Lisa Griggs or by e-mail at
lgriggs@npaihb.org
2121 SW Broadway, Suite 300, Portland, OR 97201
Phone: (503) 228-4185 FAX: (503) 228-8182

For more information on upcoming events please visit
www.npaihb.org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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S APRIL 2015 RESOLUTIONS

RESOLUTION #15-03-01
VIOLENCE AGAINST INDIAN AND ALASKA NATIVE WOMEN RESEARCH

RESOLUTION #15-03-02
SUPPORT THE NPAIHB 2015 LEGISLATIVE PLAN & PRIORITIES FOR THE 114TH CONGRESS

RESOLUTION #15-03-03
INJURY PREVENTION PROGRAM: UNINTENTIONAL INJURY & ELDER FALLS PREVENTION

RESOLUTION #15-03-04
OFFICE OF MINORITY HEALTH'S STATE PARTNERSHIP INITIATIVE TO ADDRESS HEALTH DISPARITITES COMPETITIVE GRANT

RESOLUTION #15-03-05
NATIONAL CENTER FOR HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED DISEASES AND TUBERCULOSIS PREVENTION (NCHHSTP) PUBLIC HEALTH CONFERENCE SUPPORT