Health News & Notes

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

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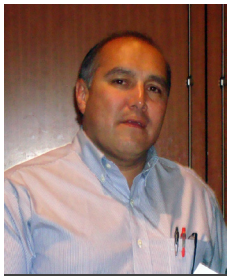
FISCAL YEAR 2015 IHS BUDGET UPDATE



By Jim Roberts, Policy Analyst

Both the House and Senate Interior Appropriations Committee have completed their mark-up of their spending bills for the Indian Health Service (IHS) appropriation. Since Congress was unable to reach agreement on overall spending they have passed a continuing resolution that runs through December 11, 2014 and will reconvene following the November elections to finalize work on the appropriation bills. Unfortunately this is unlikely to happen due to the imminent lame-duck session that will complicate the ability of either party to reach a budget deal. This means we are likely to see a series of CRs into next year.

The House and Senate bills for IHS' FY 2014 budget are alarmingly different. The House bill pretty much mirrors the President's request. The House bill requests a $207 million increase for the IHS, while the Senate bill only requests $111 million for IHS. The Senate bill is $88 million less than the President's request of $199.6 million. Important to note for Northwest Tribes is that the Senate only request $881 million for the Purchased & Referred Care (formally called Contract Health Services), which is a slight increase of $2.5 million over the FY 2014 level, and is less than $47.8 million than the President and House requests. The House bill is a much better budget for all of the health services accounts and overall is a 4.5% increase, while the Senate bill only provides a 2.2% increase. The key difference in the amounts is in the PRC/CHS program.

The amounts in the House and Senate bills for the prevention accounts are negligible with the House bill providing a 5.3% increase and the Senate bill providing a 4% increase. The difference in the amounts rests in the Community Health Representative (CHR) and Alaska Immunization programs.

The amounts in the other programs such as the Urban Indian Health Program, Health Professions, Tribal Management and Direct Operations are also very different. The House bill provides good increases and restores funds that were reprogrammed to cover contract supports cost requirements from last year. While the Senate bill flat lines these provides and does not provide an increase for any except

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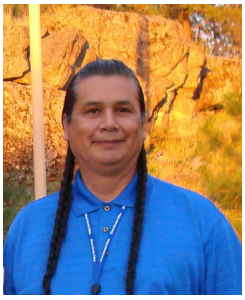
CHRONIC DISEASES

CHAIRMAN'S NOTE



Andy Joseph, Colville Tribal Council , NPAIHB Chairman
NIHB Executive Committee Member

The focus of this newsletter is on chronic disease. When I first got involved in Indian health issues I learned right away that chronic diseases like heart disease, stroke, cancer, diabetes, obesity, and arthritis affect our Indian people at higher rates than the general population. I have come to learn that the effects from chronic disease are among the most common, costly, and preventable of all health problems. This is why the work of the Board is so important to me.

I truly believe that if IHS was to receive regular and adequate funding to carry out many of the programs in the Indian Health Care Improvement Act we could avoid the affects and costs of chronic disease. It might take some time to see these gains by our health programs and in our people but the best way to address health disparities on our reservations is to fully fund the Indian health system. I hope you enjoy the articles about chronic disease as it demonstrates some of the good work at the Board.

This past quarter has been really busy for me. I attended a Cancer Project meeting in July and also attended the NIKE Native Fitness week in Beaverton, Oregon. The NIKE Native Fitness week is always a wonderful event for me to see as it showcases many great people in Indian Country working in their communities on health promotion and staying fit. In August, I attended an Affordable Care Act training sponsored by the Board and IHS Portland Area Office which was held in Seattle, Washington. There were over 70 participants that met to talk about how to improve outreach and enrollment and get our Indian people covered in Medicaid and in the Exchanges. I also attended the CDC Tribal Consultation Advisory Committee meeting in Grand Traverse, Michigan.

On August 27th, Dr. Yvette Roubideaux held her listening session for the Portland Area. While the attendance was not great, those Tribes that attended were able to discuss many important issues with the IHS Director. Tribes brought up concerns about Tribal consultation and FACA issues and how consultation could be improved by allowing greater participation of Tribal staff. Contract Support Cost issues were also addressed and the need to continue full funding and that we need to develop a strategy to not cut program increases in order to fund CSC. Facilities construction and staffing packages also were addressed by the Colville Tribe. This led into a discussion on resource equity in the CHS formula and the Indian Health Care Improvement Fund. We also talked about advance appropriations and the need to expand Medicare like rates. Those Portland Tribes that

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FISCAL YEAR 2015 IHS BUDGET UPDATE

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the Direct Operations line item. The Contract Support Cost amounts are the same in the President's request and in the House and Senate bills.

There will be lots of work involved to reconcile the differences in the House and Senate bills. Clearly the House bill is much better for Indian Country and Tribe should let their Congressional delegation know that the Senate mark is not very good for Indian health programs. The contract support cost issue will continue complicate the appropriation process as well given that IHS needed to reprogram $25 million from the FY 2014 budget. This will now make the baseline used to develop the President's request to Congress deficit by the same amount and likely an additional amount will be needed for new and expanded programs as well as for those Tribes that will renegotiate their direct contract support cost requirements.

FY 2015 Allocations under CR

On September 30th, the IHS Director reported that under the CR the IHS is funded at the same level as FY 2014 except for a reduction of 0.0554 percent and that the Agency was in the process of sending Headquarters, Area and Service Unit leadership and finance staff instructions for distribution of funds. Dr. Roubideaux clarified that Tribes and Tribal Organizations operating programs under the Indian Self-Determination and Education Assistance Act will receive the lump sum payment for the duration of the CR, which is 19.73 percent of your annual funding, minus the reduction. The Director explained that IHS will make CR payments as expeditiously as possible in accordance with the negotiated terms of annual funding agreements.

Contract Support Costs

Two months ago IHS announced it would have to reprogram $48 million however that projection was adjusted down to $32 million a couple of weeks later. By the end of the fiscal year that amount was adjusted down to $25 million. The reductions were due to finishing new CSC negotiations and Tribes renegotiating their direct contract support costs. IHS announced that the $25 million reprogramming will mostly come from headquarters services line items but some must still come from IHS Areas but it is less. IHS reported that it is working on providing more information on the impact and will share this information with Tribes soon. While the amount was less than initially expected and is welcome news, it points to the need for a long term solution

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FISCAL YEAR 2015 APPROPRIATION UPDATE

By Jim Roberts, Policy Analyst

The U.S. Congress approved a short term continuing resolution (CR) to continue to fund federal government programs and services through December 11, 2014. The joint resolution adopted by the House and Senate is capped at the FY 2014 appropriation levels to not allow any growth in the programs until the full Congress can return and begin work on a larger omnibus appropriations bill. The likelihood of Congress passing an omnibus that funds government operations through September 30, 2015 is not very good. Much of this depends on the November elections and if the House remains, and Senate changes to republican, it will make for a complicated lame duck session that will prolong the appropriations process.

If the Senate changes and House remains the same, Republicans will likely stall the appropriations process until the new 114th Congress is seated, while outgoing Democrats may be unreasonable to "bring home the bacon" and both will make for tenuous negotiations that will likely result in a series of CRs through next year.

The details of the CR provide funding at the current annual cap rate of $1.012 trillion until December 11, 2014 and will remain in place for the length of the CR, or until Congress approves annual appropriations legislation for fiscal year 2015. The bill also provides funding for an amendment adopted by the House to fund training and equipping of Syria to fight the Islamic State of Iraq and the Levant (ISIL), as requested by the President. At the time of this writing there may be likely an emergency appropriation request to combat the effects of the Ebola epidemic in Africa.

Many people throughout Indian Country also wonder about whether there will be another "sequester" budget cut in FY 2015. This is highly unlikely to occur this year and in FY 2016 as long as the Administration and Congress comply with the two year agreement developed by Sen. Patty Murray and Rep. Paul Ryan, chairs of the Senate and House Budget Committees. The Murray-Ryan deal lifted some of the discretionary budget caps required under the Budget Control Act to avoid harmful cuts from sequestration. So as long as Congress can comply with the amount agreed to by Sen. Murray and Rep. Ryan there should not be a sequester in FY 2015. This will likely be the case in FY 2016 as well, but we will not know this until the President submits his 2016 budget to Congress and we see the Congressional budget resolutions next year.

FISCAL YEAR 2015 APPROPRIATION UPDATE

Indian Health Service FY 2015 Budget

Comparing FY 2014 Operating Plan to President's FY 2015 Request and H.R. 5016 & Senate Marks

Prepared by: NW Portland Area Indian Health Board - July 22, 2014

Sub-Sub Activity	FY 2014 Final Operating Plan	PRESIDENT'S REQUEST			House Bill vs. FY 2014			Senate Bill vs. FY 2014		
		FY 2015 President's Request	Change over FY 2014	Pct. Of Change	H.R. 5016	Change over FY 2014	Percent of Change	Senate S. 000	Change over FY 2014	Percent of Change
SERVICES										
Hospitals & Health Clinics	$ 1,790,904	$ 1,862,501	$71,597	4.0%	$ 1,857,625	$66,721	3.7%	$ 1,838,665	$47,761	2.7%
Dental Services	$ 165,290	$ 175,654	$10,364	6.3%	$ 176,154	$10,864	6.6%	$ 173,982	$8,692	5.3%
Mental Health	$ 77,980	$ 82,025	$4,045	5.2%	$ 82,025	$4,045	5.2%	$ 81,145	$3,165	4.1%
Alcohol & Substance Abuse	$ 186,378	$ 193,824	$7,446	4.0%	$ 193,824	$7,446	4.0%	$ 190,981	$4,603	2.5%
Contract Health Services	$ 878,575	$ 929,041	$50,466	5.7%	$ 929,041	$50,466	5.7%	$ 881,147	$2,572	0.3%
Subotal, Clinical Services	*$ 3,099,127*	*$ 3,243,000*	*$143,873*	4.6%	*$ 3,238,669*	*$139,542*	4.5%	*$ 3,165,920*	*$66,793*	2.2%
Public Health Nursing	$ 70,909	$ 76,353	$5,444	7.7%	$ 76,353	$5,444	7.7%	$ 75,640	$4,731	6.7%
Health Education	$ 17,001	$ 18,263	$1,262	7.4%	$ 18,263	$1,262	7.4%	$ 18,026	$1,025	6.0%
Comm. Health Reps	$ 58,345	$ 59,386	$1,041	1.8%	$ 59,386	$1,041	1.8%	$ 58,469	$124	0.2%
Immunization AK	$ 1,826	$ 1,855	$29	1.6%	$ 1,855	$29	1.6%	$ 1,826	$0	0.0%
Subtotal, Preventive Health	*$ 148,081*	*$ 155,857*	$7,776	5.3%	$ 155,857	$7,776	5.3%	$ 153,961	$5,880	4.0%
Urban Health	$ 40,729	$ 41,375	$646	1.6%	$ 44,250	$3,521	8.6%	$ 40,729	$0	0.0%
Indian Health Professions	$ 33,466	$ 38,466	$5,000	14.9%	$ 48,342	$14,876	44.5%	$ 33,466	$0	0.0%
Tribal Management	$ 1,442	$ 2,442	$1,000	69.3%	$ 2,442	$1,000	69.3%	$ 1,442	$0	0.0%
Direct Operations	$ 67,894	$ 68,065	$171	0.3%	$ 67,894	$0	0.0%	$ 68,065	$171	0.3%
Self-Governance	$ 4,727	$ 5,727	$1,000	21.2%	$ 5,727	$1,000	21.2%	$ 4,727	$0	0.0%
Contract Support Cost	$ 587,376	$ 617,205	$29,829	5.1%	$ 617,205	$29,829	5.1%	$ 617,205	$29,829	5.1%
Subtotal, Other Services	*$ 735,634*	*$ 773,280*	*$37,646*	5.1%	*$ 785,860*	*$50,226*	6.8%	*$ 765,634*	*$30,000*	4.1%
TOTAL, SERVICES	***$ 3,982,842***	***$ 4,172,182***	***$189,340***	**4.8%**	***$ 4,180,386***	***$197,544***	**5.0%**	***$ 4,085,515***	***$102,673***	**2.6%**
FACILITIES										
Maintenance & Improvement	$ 53,614	$ 53,614	$0	0.0%	$ 53,614	$0	0.0%	$ 53,614	$0	0.0%
Sanitation Facilities Constr.	$ 79,423	$ 79,423	$0	0.0%	$ 79,423	$0	0.0%	$ 79,423	$0	0.0%
Health Care Fac. Constr.	$ 85,048	$ 85,048	$0	0.0%	$ 85,048	$0	0.0%	$ 85,048	$0	0.0%
Facil. & Envir. Hlth Supp.	$ 211,051	$ 220,585	$9,534	4.5%	$ 220,585	$9,534	4.5%	$ 219,612	$8,561	4.1%
Equipment	$ 22,537	$ 23,325	$788	3.5%	$ 23,325	$788	3.5%	$ 22,537	$0	0.0%
Total, Facilities	$ 451,673	$ 461,995	$10,322	2.3%	$ 461,995	$10,322	2.3%	$ 460,234	$8,561	1.9%
TOTAL, IHS	**$ 4,434,515**	**$ 4,634,177**	**$199,662**	4.5%	**$ 4,642,381**	**$207,866**	4.7%	**$ 4,545,749**	**$111,234**	**2.5%**

ORAL HEALTH FOR NATIVE AMERICAN POPULATIONS THROUGH THE LIFE STAGES: HEALTH DISPARITY OR HEALTH DISASTER?

By Bonnie Bruerd DrPH - Health Policy Consultant NTDSC

American Indian and Alaska Native (AIAN) populations have a higher prevalence of dental caries and untreated tooth decay in all age groups compared to the general U.S. population.

Dental Access

According to CDC (Vital and Health Statistics, 2012) 60% of adults in the U.S. visit a dentist at least once a year. According to 2014 GPRA data, 36% of the AIAN population (all ages) in the Northwest had a dental visit last year. There are many barriers to dental access for AIAN people including a lack of dental providers, long geographical distances between dental providers, and limited services available. To ration dental treatment, AIAN people often are faced with complicated call-in systems and long waits for a dental appointment. BUT, the answer isn't just more dental clinics and more dentists. Most dental disease is preventable!

Strategies to Improve Oral Health through the Life Stages

Prevention

- Build knowledge and motivation to improve oral health among Tribal Health Boards and other community leaders, health providers, and consumers.
- Develop marketing campaigns to promote the daily use of fluoride toothpaste. Develop a system to provide low-cost toothpaste and toothbrushes to community members.
- Support school and community-based topical fluoride and sealant programs.
- Support community efforts to decrease tobacco use and to prevent and control diabetes.

Access

- Recruit dentists who are committed to working in AIAN communities and who are comfortable working with children and special population groups.
- Support expanded functions for dental hygienists and dental assistants to make better use of current dental staff.
- Explore training of mid-level dental providers.
- Train general dentists and their staff in caries stabilization techniques using minimally invasive dentistry.
- Collaborate with current tribal programs like daycares, schools, and elder programs to increase dental access.

Policy

- Advocate for increased funding for IHS and tribal dental programs.
- Advocate for policy to include dental visits in all well-child visits.
- Advocate for policy to support expanded functions for current dental staff and mid-level dental providers.

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@gmail.com or Ticey Casey at tcasey@npaihb.org

ORAL HEALTH FOR NATIVE AMERICAN POPULATIONS THROUGH THE LIFE STAGES: HEALTH DISPARITY OR HEALTH DISASTER?

ORAL HEALTH FOR AIAN PEOPLE THROUGH THE LIFE STAGES

LIFE STAGE	KEY ISSUES	U.S. COMPARISONS
Young children	**Tooth Decay: 2-5 year olds** 62% had experienced dental caries in their primary teeth. **44% had experienced dental caries by the age of two years old.** 44% had untreated tooth decay	**Tooth Decay: 2-5 year olds** 27% had experienced dental caries in their primary teeth 19% had untreated tooth decay
School-Age Children	**Tooth Decay: 6-9 year olds** 83% had experienced dental caries 47% had untreated tooth decay **Tooth Decay: 13-15 year olds** 66% had experienced dental caries 38% had untreated tooth decay	**Tooth Decay: 6-19 year olds** 42% had experienced dental caries 14% had untreated tooth decay
Adults	**Tooth Decay 35-44 year olds** 79% had lost at least one tooth 68 % had untreated tooth decay **Periodontal Disease 35-44 year olds** 96% had gingivitis (bleeding gums)	**Tooth Decay: 40-59 year olds** 26% had untreated tooth decay **Periodontal Disease: 40-49 year olds** 24% had gingivitis
Elders	**Tooth Decay: 55+ years** 61% had untreated tooth decay **Tooth Loss: 55+ years** 21% were edentulous	**Tooth Decay: 60+ years** 19% had untreated tooth decay **Tooth Loss: 65+ years** 21% were edentulous

These data were compiled from the IHS Oral Health Surveys of AIAN Preschool Children (2011), 6-9 year olds (2012), and 13-15 year olds (2013), 1999 IHS Oral Health Survey, the National Health and Nutrition Examination Survey 1999-2002, and the Behavioral Risk Factor Surveillance System.

TRIBAL PUBLIC HEALTH, ACCREDITATION AND CHRONIC DISEASE

The Public Health Accreditation Board (PHAB) now has 306 health departments going through the accreditation process. Fifty-four health departments are accredited, and more are getting ready every day. There are two Tribes in the process. PHAB knows that many Tribal public health departments are preparing for accreditation and will be entering the PHAB system at some point. PHAB is very interested in continuing to support Tribes as they become accredited health departments. To that end, PHAB has planned a number of initiatives for 2015 that will strengthen its accreditation work with Tribal public health departments:

- PHAB will convene a Tribal think tank for the purpose of obtaining updated Tribal consultation about its standards and measures and accreditation process. PHAB will partner with the National Indian Health Board (NIHB) to hold this meeting. If anyone is interested in being considered to participate in this meeting, please contact Kaye Bender at PHAB, kbender@phaboard.org.

- PHAB plans to hold listening sessions in as many of the twelve IHS regions as possible. The purpose of these sessions is to hear the questions, barriers, concerns and suggestions that Tribes have with regard to accreditation. PHAB will kick-off these listening sessions in the Northwest Area, in partnership with the Northwest Portland Area Indian Health Board. Watch for more details on the date and location in the PHAB newsletter and in this newsletter.

- PHAB will update its webinars and written materials for use by Tribal public health departments and policy-makers. These updates will include some clarification of the differences between PHAB accreditation for public health departments and health care accreditation offered by the Joint Commission (JC), the Accreditation Commission for Health Care (ACHC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

PHAB knows that Tribal public health departments have placed an emphasis on the prevention of chronic disease. A tip in working on accreditation is that all health departments can use their examples of best and promising practices, health education and communication, and policies about chronic disease as some of their documentation for accreditation. Please see the documentation guidance in the PHAB Accreditation Standards and Measures, Version 1.5, for specific mention about chronic disease examples.

For those of you who attend the NIHB Public Health Summit or the Consumer Conference, please look for PHAB's booth when you attend. PHAB is always pleased to talk with Tribal public health representatives about accreditation.

And, finally, if you are interested in applying to be a PHAB Accreditation Site Visitor, PHAB is always looking for them. Site Visitors who have served in this capacity have told us that the experience is rewarding and provides tangible benefits such as networking with other leaders in public health; gaining in-depth information about the accreditation process; participating in a meaningful peer review process; enhancing verbal, written, and technical communication and interviewing skills; learning about new, innovative, and promising public health practices; engaging in professional development; and contributing to the overall improvement of the field of public health. For more information on the role and how to apply, see www.phaboard.org.

DON'T WAIT – GET A FLU SHOT TODAY!

By CAPT Thomas Weiser, MD, MPH - Medical Epidemiologist

Although this issue of Health News and Notes is dedicated to chronic diseases, infectious disease have been in the news headlines more than usual over the past several weeks, and with good reason. The Ebola virus outbreak in West Africa has taken over 3,000 lives since it began in March of this year. The deadly virus has ravaged the countries of Liberia, Guinea and Sierra Leone and now people with Ebola virus disease have been identified in Senegal, Nigeria, Spain and the U.S. While it is highly unlikely that Ebola virus could spread to others in the United States, it has everyone concerned.

What should Tribes do in response to the Ebola virus epidemic? The most important thing for Tribes and Tribal organizations to do with regard to Ebola virus is to be prepared in the event that a person from an affected country seeks medical care in their facility. To that end, all IHS, Tribal and Urban Indian clinics should take steps to ensure that their staff has been properly trained in the use of personal protective equipment and that this equipment is readily available. At a minimum, this includes gowns, gloves, face masks and goggles or eye-shields. Many clinics have these supplies stockpiled from the H1N1 pandemic. A recent IHS-sponsored training on infection control practices in Spokane highlighted the importance of proper use of personal protective equipment and policies and procedures to keep staff safe. To get more information about keeping healthcare workers safe in the event they encounter a patient with any communicable disease, you can contact Matthew Ellis with the Portland Area Office IHS at (503) 414-7788 or Matthew.Ellis@ihs.gov.

Communication is also important. Staff should be sure to ask about travel history and history of contact with recent travelers when interviewing a patient with any illness that includes fever, cough, diarrhea or rash. As soon as an infectious disease is suspected, staff should take steps to minimize contact with other patients and take appropriate precautions by putting on the appropriate personal protective equipment. This is not just for Ebola virus – it also applies for suspected measles, chickenpox, tuberculosis, rotavirus and many other diseases.

Enterovirus D-68

Another infection that has been in the news is enterovirus D-68. This virus is one of the causes of the common cold. The virus was first detected in 1962, so is not a new virus. What has gotten so much attention is that there have been an increased number of children with severe respiratory illness requiring admission to pediatric intensive care units. More recently, there may be an association between infection with this virus and a polio-like illness causing paralysis. Almost all states have now reported cases of respiratory illness with this virus. Paralytic disease has so far only been seen in California and Colorado.

At this time, CDC is only recommending testing children for this virus if they are severely ill; that is, if they will be hospitalized or admitted to an intensive care unit. This is because the vast majority of children with this infection will have only mild respiratory symptoms: cough, sore throat, wheezing, low grade fever. Preventing the spread of this illness involves very simple steps: 1) Cover your cough; 2) Wash your hands; and 3) Stay home if you are ill. If that sounds familiar, it's because it is the same advice we recommend for preventing the spread of influenza.

Children with asthma may be more likely to have severe illness. These children should take their asthma medications regularly and have an "Asthma Action Plan" with their provider. The Asthma Action Plan should be written down and include: current medications/dosages, provider/clinic contact information, detailed peak flow values and symptom descriptions to indicate when a child's asthma is controlled or healthy ("Green Zone"), getting worse ("Yellow Zone") or needs urgent medical attention

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2014 ANNUAL THRIVE CONFERENCE

By Colbie Caughlan, Suicide Prevention Project Manager, Northwest Portland Area Indian Health Board

The Annual THRIVE Conference is a national opportunity for Native youth to learn about the signs of suicide, the impacts of drug and alcohol abuse, how to be a resource for friends and family, and much more. The THRIVE suicide prevention project (http://www.npaihb.org/epicenter/project/thrive) here at the Northwest Portland Area Indian Health Board has hosted this conference with *Meth & Suicide Prevention Initiative* dollars from the Indian Health Service annually since 2010. This year's conference took place at the Lloyd Center DoubleTree hotel June 23-26 and was attended by 75 Native youth from over 21 different federally-recognized Tribes in the U.S. 74% of the youth came with a NW Tribe! Conference sessions incorporated American Indian/Alaska Native culture, traditional learning strategies, and skill-building activities that educated youth about healthy behaviors. Participants learned to positively express their emotions and feelings about challenging topics through interactive, educational workshop tracks.

The first workshop, digital storytelling, included: writing and revising a script; learning to use audio, video, and photo editing software; recording a voiceover; selecting photos and music; and putting all the elements together to complete the story. Digital stories can be used to heal from trauma, bring a voice to an important population or topic, teach others about the impacts of chronic diseases or suicide, and much more. At the conference we had many youth who shared their favorite things about life in their story and a few others who used to heal after having struggled through family loss due to cancer or alcoholism, and one teen even disclosed her own struggles with alcohol, drugs, risky sexual behaviors, homelessness, and how she has now overcome these things all before the age of 15.

The We Are Native (WRN) Youth Ambassador workshop taught 16 Native youth how to promote positive change in their communities. Each ambassador applied for this opportunity, received leadership training, and learned from other native youth who have taken action in their communities regarding issues important to them. After the conference, the WRN Ambassadors have committed to a yearlong journey to help promote WRN and encourage positive youth leadership. WRN is a multimedia health resource for Native teens and young adults (www.wearenative.org) and the Ambassadors work hard to share this resource with Native youth all across Indian Country.

The film production workshop showed youth how to use film as a positive communication outlet and gave them an introduction into what film is, i.e. skills and the power of storytelling. The youth were also taught the technical side of film production including: interviewing, how to create basic animation, storyboarding, and editing. The theme of the video created by this workshop was a compilation of: respect for nutrition; education; friendships; relationships and; the importance of having a connection to elders. To view the workshop video please visit: https://www.youtube.com/watch?v=LaSYhQnKHAo&list=UUIxRTVKkCkedeQr6WA8sWlQ.

The final workshop was Beats Lyrics Leaders (BLL), http://www.beatslyricsleaders.com. These facilitators utilized storytelling and native instruments to enhance the music development experience and make it as informative, fun, educational, and experiential as possible. BLL offered a hands-on approach to learning as they taught each participant, the ins and outs of beat making, lyric/song writing, and recording. BLL facilitators

2014 ANNUAL THRIVE CONFERENCE

included short presentations to increase other skills as well (i.e. empowerment, goal setting, and skills vs. talents).

Like the three years prior, this year's conference yielded very positive comments and outcomes by the youth who attended. A few of the quotes from the post-conference evaluations were:

"I liked being able to be nervous around others to become more confident"
"You got to express yourself through music"
"That I got taught how to let a bit of my emotions out"
"That I made a new friend"
"That we got to communicate better and got to know one another"

The youth were taught various skills throughout the conference and in their specific workshops, when asked about how the youth would take those skills home and utilize them, some amazing answers were given:

"Reach out to my dreams"
"To learn to talk about stuff that bothers you"
"To change the world"
"I plan to lead people more and make a difference"

Beats Lyrics Leaders

Film Production

WRN Youth Ambassadors

Digital Storytelling

Alaska Native youth from Togiak presenting a traditional dance to the THRIVE participants!

CHRONIC UNPREPAREDNESS – THE NEXT EPIDEMIC?

Public health emergencies – like outbreaks, and natural disasters – can happen at any time, usually when you least expect it. Being un- or underprepared for such emergencies can have lasting, harmful effects to individuals, families and whole communities. In honor of National Preparedness Month (September) we'd like to know: are you ready?

A good start to being prepared is simply knowing who to contact. At The Board, we're working to compile a list of resources and protocols to follow for public health emergency situations. In the meantime, there are several things you can do to turn a potential public health crisis into an effective public health response.

- See if you're eligible (and if so, sign up!) to receive updates from your state's Health Alert Network (HAN):
  - Washington: https://www.wasecures.org/
  - Oregon: https://oregonhealthnetwork.org/default.aspx
  - Idaho: https://health.dhw.idaho.gov/idhan/

- Check out the NPAIHB website:

Did you know that NPAIHB has a "help request" for emergency response? Simply visit www.npaihb.org, and look for the 'Emergency Response Info' button, as pictured here:

This provides a direct line of communication with NPAIHB staff.

More information can also be found by visiting:

CDC's Office of Public Health Preparedness and Response: http://www.cdc.gov/phpr/
The National Institutes of Health: http://americanindianhealth.nlm.nih.gov/tribal-prep.html
Future issues of Health News and Notes – be ready!

NEW EPICENTER PROJECT TO ADDRESS HEART DISEASE, STROKE AND DIABETES

The Northwest Portland Area Indian Health Board was awarded a grant of $850,000 from the Centers for Disease Control and Prevention for prevention of heart disease, stroke and diabetes in the communities of the 43 federally recognized tribes in Idaho, Oregon and Washington.

The Wellness for Every American Indian to Achieve and View Health Equity – Northwest, or WEAVE-NW, is a part of the Comprehensive Approach to Good Health and Wellness in Indian Country awards. These awards are part of a U.S. Department of Health and Human Services (HHS) initiative to support public health efforts to reduce chronic diseases, promote healthier lifestyles, reduce health disparities, and control health care spending. The Centers for Disease Control and Prevention (CDC) will administer the grants, which will run for five years, subject to availability of funds.

Overall, HHS awarded $11.2 million in 22 grants to prevent heart disease, diabetes, stroke, and associated risk factors in American Indian tribes and Alaskan Native villages through a holistic approach to population health and wellness. Grantees will work to reduce commercial tobacco use and exposure to secondhand smoke, improve nutrition and physical activity, increase support for breastfeeding, increase health literacy, and strengthen team-based care and links between community resources and clinical services.

Half of the awards will support tribes directly and the other half will support tribal organizations to provide leadership, technical assistance, training, and resources to tribes and villages in their Indian Health Service Administrative Areas. The program is financed by the Prevention and Public Health Fund of the Affordable Care Act.

"The need for this project is clear; chronic diseases such as heart disease, cancer, and diabetes are interrelated with many other factors that must each be understood and addressed. We are pleased to have the opportunity to take steps in doing just that." said Dr. Victoria Warren-Mears, the Principal Investigator of the project. In this country, chronic diseases account for 7 of 10 deaths among Americans each year, and more than 80 percent of the $2.7 trillion our nation spends annually on medical care."

The WEAVE- NW Project will award five (5) awards of $50,000 to tribes in the Northwest Portland Area to focus on improved chronic disease prevention in the areas of heart disease and diabetes. These awards will focus on prevention strategies throughout the three state region. An application for these awards will be available in early December 2014. Tribes or groups of tribes may apply for one year of funding, and request additional years of funding with the successful attainment of progress toward chronic disease prevention goals. Up to twenty tribes may be funded over the five year duration of this program award from CDC.

The EpiCenter staff will also work in partnership with two tribes that received grants from CDC, the

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	Percent of All Deaths	
	AI/AN	**White**
1	Heart Diseases (23.3%)	Heart Diseases (30.1%)
2	Cancer (19.1%)	Cancer (23.8%)
3	Unintentional Injury (11.4%)	Chronic Lower Respiratory Disease (6.2%)
4	Diabetes (5.1%) - tied	Unintentional Injury (5.3%)
5	Chronic Lower Respiratory Disease (5.1%) -	Alzheimer's Disease (5.1%)
6	Chronic Liver Disease and Cirrhosis (4.9%)	Diabetes (3.2%)
7	Suicide (3.1%)	Suicide (1.9%)
8	Alzheimer's Disease (1.9%)	Influenza and Pneumonia (1.7%)
9	Influenza and Pneumonia (1.8%)	Chronic Liver Disease and Cirrhosis (1.4%)
10	Homicide (1.4%)	Parkinson's Disease (1.1%)

CHAIRMAN'S NOTE

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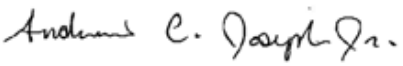
were in attendance were not shy about bringing their concerns on the issues and I think it was a good session.

In September I attended the National Indian Council on Aging and the National Indian Health Board conferences. The NIHB conference was very good and I was pleased to see representatives from our Board on the agenda. The Board programs and our Tribes were involved in many workshops and it demonstrates the expertise we have in the Portland Area. I also attended the Affiliated Tribes of Northwest Indians in Pendleton, Oregon and we worked on several important issues there. We continue to work on bringing dental health aide therapists to the Portland Area in partnership with ATNI.

As you can see it was a very busy quarter for us all at the Board. I hope you all are looking forward to the holiday season. I hope we can all reflect on our work and what it means for our Indian people, our families, and elders. It is important work and I am glad you all support our work. Happy holidays to you all!

Whi Leem lem (Thank You)
Euuhootkn (Badger)



FISCAL YEAR 2015 IHS BUDGET UPDATE

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to avoid the potential of this on a recurring basis.

The reprogramming of $25 million has caused a bit of a stir in Indian Country as direct service tribes have stated they will absorb these costs in their programs. However it is important to note that there are a number of Title I contracting tribes that have retained shares with IHS that will also be effected. There is not a pure direct service tribe in IHS system every Tribe has a Title I contract with IHS. ory In fact many Tribes that classify themselves as direct service programs actually contract for more of the program than IHS manages. The definition of direct service is if IHS operates the ambulatory care portion of the health program. Title V compacting tribes will also be affected if residual amounts are reduced to cover these CSCs as well. The flip side to reprogramming direct service costs is that those programs get 100% of their administrative costs covered by the federal government and Title I and V programs are disadvantaged. Or alternatively, that those tribes carrying out self-determination agreements have had their programs cut for over 40 years to fund direct service programs. While no Tribe has stated this, it is an alternate point of view and should be acknowledged. The point here is to not cause consternation but to look at all the perspectives to this issue. The concerns of both direct service tribes and self-determination tribes are important and need to be addressed in manner that does not divide Indian Country. That cannot happen unless each acknowledges the concerns of the other. Over the long run Indian Country has proven that it has the leadership to overcome this issue.

There are already solutions being proposed by the IHS Contract Support Cost Workgroup and they need time to be accepted by IHS and implemented. IHS is in the process of moving tribal recommendations forward for discussion with the administration and Congress. The IHS Director has indicated that she plans to send a letter to update Tribes about this in the near future.

Coming Soon! The TOT to Tweens Study

A Follow-Up Study on Oral Health of NW Tribal Families Participating in the TOTS Study

A staggering proportion, 3 of 4 American Indian/Alaska Native (AI/AN) children between the ages of 2-5, have experienced tooth decay, over two-thirds have untreated decay, and over half have severe tooth decay (1). While this may politely be referred to as a "health disparity," it could more aptly be termed a "health disaster." Many AI/AN children experience tooth decay before the age of two. Tooth decay in that age group leads to further tooth decay and other oral health problems later in childhood (2,3).

The newly funded TOTS to TWEENS is a follow up study to *The TOTS Study (Toddler Obesity and Tooth Decay) Study)* an early childhood obesity and tooth decay prevention program. The goal of this study is to survey and conduct dental screenings with the original group of toddlers to test whether interventions delivered in the TOTS will influence the prevalence tooth decay in older children. Through qualitative approaches, the study will also assess current community, environmental and familial factors that can influence oral health in children to understand any maintenance of preventive behaviors over the last ten years within the entire family.

The TOTS to Tween Study is administered through the NW NARCH program and is based at the Northwest Portland Area Indian Health Board. The *TOTS to TWEENS* Study will be led by Co-Principal Investigators, Thomas Becker, MD, PhD and Tam Lutz, MPH, MHA.

For more information about the TOTS to Tweens Study, contact Tam Lutz at **tlutz@npaihb.org** or visit:

http://www.npaihb.org/epicenter/project/TOTS_to_Tweens

1. *Indian Health Service. The 1999 Oral Health Survey of American Indian and Alaska Native Dental Patients: Findings, Regional Differences and National Comparisons. Rockville, MD: US Department of Health and Human Services; 1999.*

2. *Casamassimo PS, Thikkurissy S, Edelstein BL, Maiorini E. Beyond the dmft: the human and economic cost of early childhood caries. J Am Dent Assoc., 2009; 140(6):650-7.*

3. *Schroth RJ, Harrison RL, Moffatt ME. Oral health of indigenous children and the influence of early*

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MORE SUICIDE PREVENTION COMING TO A TRIBE NEAR YOU!!

In May the Board's suicide prevention project, THRIVE, submitted a proposal for the Garrett Lee Smith Suicide Prevention Grant administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). **We are thrilled to announce that our application was funded!**

This funding will greatly expand the range of suicide prevention services that THRIVE is able to provide to the NW tribes, and will fund three NW tribes, three NW tribal clinics, and Heritage University to expand the prevention and treatment services that they deliver as well.

In short, THRIVE will be:

- Updating and expanding the current suicide prevention media campaigns that it runs (*Community is the Healer that Breaks the Silence*),
- Providing technical assistance and training to the NW tribes on ASIST, QPR and other evidence-based interventions,
- Offering mini-grants for tribal suicide prevention activities, and
- Working with regional partners to improve collaboration and access to treatment and crisis response services.

For more information about the grant, please contact Colbie Caughlan, Suicide Prevention Project Manager, at 503-416-3284 or by email at ccaughlan@npaihb.org

DON'T WAIT – GET A FLU SHOT TODAY!

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("Red Zone"). For examples of Asthma Action Plans, see http://www.cdc.gov/asthma/tools_for_control.htm.

Influenza – The Annual Epidemic

Every year in the United States, we have an epidemic of respiratory disease that causes an average of 200,000 hospitalizations and between 3,000 and 49,000 deaths. The majority of these hospitalizations and deaths can be prevented through vaccination. In the Portland Area, fewer than half of all those who received care at IHS, Tribal or Urban Indian clinics received a flu vaccine last year. While the flu vaccine does not prevent everyone from getting the flu, recent studies have shown that those who get vaccinated have fewer days with symptoms, are less likely to be hospitalized and much less likely to die from influenza.

While the threat of Ebola virus in the U.S. may be frightening, there is little we can do at this time to prevent it. All clinics should be prepared for the unlikely possibility that they will see an affected patient. Soon, though, we will face a recurring, annual epidemic of influenza. It's an epidemic that we can prevent, it's a disease that you can protect yourself and your family from. Don't wait – get a flu shot today!

NEW EPICENTER PROJECT TO ADDRESS HEART DISEASE, STROKE AND DIABETES

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Confederated Tribes of Umatilla Indians, through the Yellowhawk Clinic and Nez Perce Tribe.

NPAIHB is pleased to have funds to address the leading cause of death among Portland Area American Indians/Alaska Natives. Sound prevention efforts are keys to reducing illness and death from heart disease.

UPCOMING EVENTS

OCTOBER

OCTOBER 26-31
NCAI Annual Conference
Atlanta, GA

NOVEMBER

NOVEMBER 4
Idaho State/Tribes Meeting
Boise, ID

NOVEMBER 11
Veteran's Day

NOVEMBER 13-14
5th Annual Native American Health Care Conference
Cabazon, CA

NOVEMBER 17-18
Tribal State Leaders Health Summit
Anacortes, WA

NOVEMBER 18
Northwest Tribal Cancer Coalition Meeting
Portland, OR

NOVEMBER 21-22
Indigenous Health Conference
Toronto, ON

NOVEMBER 27
Thanksgiving Day

DECEMBER

DECEMBER 11
American Indian Health Commission Meeting
Auburn, WA

DECEMBER 11
4th Annual NW Tribal Opiate Symposium
Auburn, WA

DECEMBER 25
Christmas Day

JANUARY 2015

JANUARY 1
New Year

JANUARY 14
TTAG Face-to-Face Meeting
Washington, DC

JANUARY 20 -22
NPAIHB Quarterly Board Meeting
Centralia, WA

We welcome all comments and Indian health-related news items. Address to:
Health News & Notes/ Attn: Lisa Griggs
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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RESOLUTION

RESOLUTION #14-04-01
Urging Congress to Conduct Oversight Hearings on the Funding Inequities Under the Older Americans Act and on the Needs of American Indian, Alaskan Native and Native Hawaiian Elders

RESOLUTION #14-04-02
Wellness for Every American Indian to Achieve and View Helath Equity - Northwest (WEAVE-NW) CDC-RFA-DP14-1421PPHF14; PPHF 2014: A comprehensive Approach to Good Health and Wellness in Indian County

RESOLUTION #14-04-03
Support NPAIHB Proposal to CMS Proposal for Connecting Kids to Coverage Outreach and Enrollment Grants Focused on Increasing Enrollment of American Indian and Alaska Native (AI/AN) Children

RESOLUTION #14-04-04
Approving and Authorizing Settlement of Contract Support Cost Claims Against the Indian Health Service for Fiscal Years 2005-2012