Health News & Notes

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

A Publication of the Northwest Portland Area Indian Health Board

January 2015

FY 2015 IHS BUDGET UPDATE

By Jim Roberts, Policy Analyst

Following a continuing resolution, the President signed into law the FY 2015 Omnibus Appropriations Bill on December 16, 2014 wrapping up the FY 2015 appropriations process for most federal agencies. It included a short-term continuing resolution to wrap up work on the Homeland Security appropriation into January 2015. The omnibus bill provides $1.013 trillion for government spending and complies with discretionary spending caps set out in the Murray-Ryan deal for discretionary spending, which means there will not be a sequestration in FY 2015.

The Murray-Ryan deal includes additional amounts for the FY 2016 appropriations and then discretionary amounts will revert back the amounts set forth in the Budget Control Act. This means there is a possibility of another sequestration in FY 2017 unless the BCA is amended or another deal similar to the Murray-Ryan deal can be struck. The challenge for and amendments is that the Republicans control both chambers of the Congress and the likelihood of passage of an amendment does not seem good.

The Indian Health Service (IHS) appropriation is funded at $4.64 billion, which is a $207.9 million increase over the FY 2014 enacted level. The Congress supported the IHS budget by providing an additional $8.2 million over the President's request. Report language accompanying the bill requires the IHS to provide a final spending plan to the committees of jurisdiction within 30 days of enactment of the bill. The IHS budget increase for FY 2015 may seem good given the limited increases for other agencies funded with discretionary funds.

Services budget

The omnibus provides $4.182 billion for clinical, prevention, and other services (commonly referred to as H&C budget line items). Congress agreed to provide the amount requested by the President for the Service sub-account line items and but also provided an additional $9.97 million. Congress did not agree to fund the Clinic and Prevention sub-accounts as requested by the President and reduced these items to cover an additional $45.8 million for the Contract Support Cost line item. This reduced the overall increases for items like Purchased and Referred Care

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FY 2015 IHS BUDGET UPDATE

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(PRC), for which the President requested a $50.5 million, however the final appropriation only included a $35.6 million increase. The effect of this is that the overall allocation for the IHS appropriation continues to be reprogrammed to cover the cost of contract support costs. Budget highlights include the following:

- Clinical Services received an increase of $97.9 million (3.2% increase)
- Prevention Services received an increase of $5.8 million (4% increase)
- Contract Support Cost increase of $75.6 million (12.9% increase)
- Other Service accounts received an increase of $95 million increase (a 13% increase).*
- Indian Health Professions increase of $14.8 million (44.5% increase)*
- Urban Indian health programs increased by $2.9 million (7.1% increase)

*The large increases for the Other Service sub-accounts is due to restore funding from the FY 2014 budget that was reprogrammed to cover additional contract support cost need. This included restoring $1 million for the Tribal Management and Self-Governance line items. It also included $5 million that was cut from the Indian Health Professions line item. Congress also provided an additional $9.8 million to the scholarship line item to make the total increase $14.8 million for Indian health professions.

The President's request included a recommended increase of $29.8 million for contract support costs and the Congress provided an additional $45.8 million. This makes the total appropriation $663 million for contract support costs. Add to this an additional $25 million that was reprogrammed in FY 2014, which likely brings the CSC line item to $688 million in FY 2015. These details will be confirmed when IHS submits its final spending plan to the Congress.

Facilities

The omnibus bill provides $460.2 million for the facilities accounts, which is a slight increase of $8.6 million over the FY 2014 enacted level. The President did not request an increase, and the Congress concurred by not providing additional funding, for the Maintenance and Improvement, Sanitation Facilities Construction, and Health Facilities Construction accounts. The additional funding of $8.6 million lies entirely in the Facilities & Environmental Health Support account. The Equipment line item was flat lined funded, with no increase, even though the President's request included

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CHAIRMAN'S NOTE

Happy New Year to you all! I hope the holidays treated you well and you all had a chance to enjoy time with your family and loved ones. This is an important time of the year to take time for yourself, family and loved ones.

As you know the 114th Congress has been seated and begins its work and this will be an important time for Tribes and the Board. The Republican Party is now the majority in both the House and the senate. The leadership on the Senate committees will change. A challenge will occure for Tribes to make sure that the new leadership understands the issues and needs of tribes. Needless to say the upcoming months will be a very busy time for Portland Area Tribes as they hit the hill to do this important work. This includes the Board making hill visits and I also hope you all are planning to do the same

This last quarter I attended the National Congress of American Indians (NCAI) annual convention held in Atlanta. The issues covered at NCAI included on-going contract support cost issues, the need for advanced appropriations, developing Medicare-like rates, reauthorizing the Special Diabetes Program for Indians, and ongoing issues related to implementation of the Affordable Care Act. While many of these issues might be new or updates not timely for some, I am proud to report that our Board has been instrumental and in the thick of things working on all of these issues. Northwest Tribes are some of the best informed and working on almost all health care issues affecting Indian Tribes thanks to your support of the Board.

In November, I attended the American Indian Health Commission's Tribal Leader Health Summit hosted by the Swinomish Tribe. While the Summit covered important health issues for Washington State Tribes, these issue impact all of our programs. Primarily the agenda included public health issues, ACA and insurance exchange issues like insurance carrier contracting and the Indian addendum, oral health, and a number of Medicaid issues.

On December 2nd, the IHS Portland Area office conducted the FY 2017 budget formulation session. This year's session was not as well attended as past years. This year Portland Area Tribes decided to submit budget marks at the 5% ($291 million) and 17% ($768 million) levels. The Board and Area office are in the process of submitting documents to the IHS headquarters office and should be available for your review very soon.

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Northwest Portland Area Indian Health Board

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DENTAL THERAPISTS CAN CLOSE THE ORAL HEALTH GAP FOR NATIVE YOUTH

THE ASPEN JOURNAL OF IDEAS

Reprint with permission from the Center For Native American Youth at the Aspen Institute Edition: January/ February 2015

By Ryan Ward and Joaquin Ray Gallegos

On a winter morning, Alayna Eagle Shield, 24, rises early in her home on the Standing Rock Indian Reservation in North Dakota. She wakes her two children and readies them to embark on a long trek across the frozen prairie in search of dental care.

"In my community the only time we are seen by a dentist is when we stand in line before the sun comes up on Monday mornings…even then we are not guaranteed care," she explains. "Since we cannot afford to get our teeth fixed in a big city, many of our youth grow up with missing teeth."

Too many Native Americans like Alayna and her family go without dental care each year. This is especially true of Native American youth. Seventy-two percent of Native youth currently suffer from untreated tooth decay. As a result, they experience severe health problems that, when left untreated, can lead to life-threatening conditions like cardiovascular disease and diabetes.

Beyond the long-term health problems stemming from lack of access to care, there is the simple yet devastating issue of the pain. Littlebear Sanchez, 22, Mescalero Apache from New Mexico, described this problem recently in an op-ed: "Last year, as a result of poor access to dental care, I suffered in pain for many months with a broken, infected tooth. As the pain became unbearable, I even tried pulling the tooth out myself."

The biggest obstacle to improving dental care in tribal communities is their remote location. The dentists that do come often leave soon after.

According to Health Resource Services Administration (HRSA), the primary federal agency tasked with improving access to health care, 77 percent of U.S. counties are designated as dental care shortage areas (a full list can be found http://aspen.us/journal/editions/januaryfebruary-2015/dental-therapists-can-close-oral-health-gap-native-youth). This means there are simply not enough dentists to serve the population in a given geographic area. In some cases, there are no dentists at all. Native children are particularly hard hit by lack of dental care access. Utilizing HRSA's data and the 2010 U.S. census information, the Center for Native American Youth determined that nearly 50 percent of the nation's 2.1 million Native youth live in one of these dental care shortage areas.

Though this problem impacts nearly one million Native American children, it is not just a Native American problem. Low income populations and rural communities are similarly affected. Even if there is a dentist, data suggests that 80 percent don't accept Medicaid as payment for services, meaning many people — even ones with a dentist in their community — are still left behind.

But the positive side of the story is in the U.S., Indian tribes have led the way in delivering life-changing care despite those challenges.

Ten years ago, the Alaska Native Tribal Health Consortium (ANTHC) and Alaska tribes looked at the oral health of rural communities and saw an alarming problem. Untreated dental decay was ravaging communities — some with rates of decay five times that of the general population. Communities that once

DENTAL THERAPISTS CAN CLOSE THE ORAL HEALTH GAP FOR NATIVE YOUTH

had incredibly low rates of decay began seeing spikes in cavities due to the introduction of processed foods and other changes in diet.

Alaska tribes had attempted to improve oral health and attract dentists with lucrative employment packages and loan-payback models but those failed to bring dental providers to their remote communities. Learning from this shortfall, they sought a new way to bring care to remote villages. Eventually they landed on an evidence-based, tried and true method in existence for nearly a century: mid-level providers.

Alaska tribes dental health aide therapists (DHAT) — think of them as nurse practitioners or physician's assistants, but for teeth — are part of a dentist-led team. While prevention through education is fundamental to the goal of DHATs, within their limited scope of practice, DHATs are able to safely treat active oral disease.

Unlike dentists, who are required to learn an expansive set of procedures, DHATs focus on a small number of the most common preventive care procedures and train extensively on those. They are thoroughly trained on pediatric care, which makes up sixty-percent of their work, and they learn motivational interviewing to better interact with families. Once they have finished more than 3,000 hours of training, including 400 hours of work alongside a dentist, DHATs continue their practice under the general supervision of a dentist. This means that they can work in off-site locations like small villages accessible only by plane while their supervising dentist is back at a regional clinic. This model means that the supervising dentist has more time to perform complicated, higher cost procedures while still having final say over all the work done by the DHATs.

As a result of this innovative program, instead of seeing a dentist every couple of years, if at all, Alaska Native communities have continuous care from DHATs who use airplanes, boats, and snowmobiles to reach their rural patients. For the first time in more than a hundred years, Alaska Native communities are seeing cavity-free children.

This cost-effective mid-level model has been part of health systems in more than 50 countries for a hundred years. In fact, the first Alaskan dental therapist class was educated in New Zealand, where dental therapists have practiced since 1921. Dental therapists are the most studied dental providers in the world. Regardless, Alaska continues to demonstrate the effectiveness and safety of mid-level providers through their 27 practicing DHATs.

Despite this success, the DHAT model is opposed at every turn by mainstream organized dentistry. In 2006, the American Dental Association (ADA) and the Alaska Dental Society unsuccessfully sued the tribal health consortium and each of the original practicing DHATs. While mid-level providers are now legally protected in Alaska, the ADA continues to block legislation establishing mid-level providers for low income communities in other states. As a result, those who are most at-risk are left without care and often take drastic measures, like Littlebear Sanchez's effort to pull out his own tooth.

Ryan Ward is a senior program associate and Joaquin Gallegos is a health policy fellow with the Aspen Institute Center for Native American Youth. Learn more about the CNAY's work at cnay.org.

"DISPARITIES IN LIFE EXPECTANCY OF PACIFIC NORTHWEST AMERICAN INDIANS AND ALASKA NATIVES" PUBLISHED IN PUBLIC HEALTH REPORTS

By Sujata Joshi, IDEA NW Project Director

NPAIHB's work is featured in the January/February 2015 issue of the journal Public Health Reports. The article, entitled "Disparities in Life Expectancy of Pacific Northwest American Indians and Alaska Natives: Analysis of Linkage-Corrected Life Tables"[1], describes a study of life expectancy for Northwest AI/AN using linkage-corrected death certificates. The study was conducted by NPAIHB's Improving Data and Enhancing Access-Northwest (IDEA-NW) project, in collaboration with staff from the Urban Indian Health Institute in Seattle, WA.

It is well-known that AI/AN in the Northwest face many health disparities throughout the life-span. The study's authors note that AI/AN are "…twice as likely to die from unintentional injuries, diabetes, chronic liver disease, and homicide compared with their NHW counterparts in the Northwest. These statistics are alarming, and yet they fail to adequately convey the profound effect such health inequities have on tribal communities, in which each untimely death impacts the entire Tribe."

Estimates of life expectancy at birth are a convenient and easy-to-understand indicator of a population's health. Until recently, researchers have avoided publishing life tables for AI/AN populations because of racial misclassification in death certificate data. Racial misclassification occurs when AI/AN individuals are coded as another race (usually White) in public health datasets. This results in the underestimation of disease and death rates for AI/AN populations. Racial misclassification can be corrected through record linkage with tribal registries. Since 1999, NPAIHB has been conducting record linkages between the Northwest Tribal Registry (NTR) and public health datasets in Idaho, Oregon, and Washington.

In this study, members of NPAIHB's IDEA-NW project conducted record linkages between the NTR and death certificates from Idaho, Oregon, and Washington for the years 2008-2010. Out of 2,648 matched records, they found 423 records that were misclassified or were missing race information. After correcting the misclassified records, the analysts calculated life expectancy estimates for AI/AN and non-Hispanic Whites (NHW) in the three states. Some key findings from the analysis were as follows:

- Life expectancy at birth was 6.9 years shorter for Northwest AI/AN compared to NHW in the region.
- Life expectancy for AI/AN across the three states was 72.8 years. The life expectancy for AI/AN females (74.6 years) was 3.7 years longer than for AI/AN males (70.9 years).
- Oregon AI/AN had the longest life expectancy (74.8 years), followed by Idaho AI/AN (74.5 years). AI/AN in Washington had the shortest life expectancy (71.4 years).
- The racial gap in life expectancy was larger for females than males. Female AI/AN life expectancy was 7.3 years shorter than for NHW females, while male AI/AN life expectancy was 6.9 years shorter than for NHW males.
- If racial misclassification had not been corrected through record linkage, the AI/AN life expectancy estimates would have been overestimated by more than two years.

The article also describes the points during the life span when AI/AN mortality rates are especially high compared to NHW. During infancy and childhood, AI/AN mortality rates are twice those of NHW children. By early adulthood, the mortality rates are almost 2.5 times higher. NPAIHB analysts found that these disparities in early life are driven by deaths due to injuries and suicide.

The authors note that the AI/AN life tables produced for this study "are the first of their kind published for the Northwest AI/AN population". The life tables are one of many examples of the groundbreaking work supported by NPAIHB member tribes. For more information about this study, please contact the study's lead author Jenine Dankovchik (jdankovchik@npaihb.org, 503-416-3265). For general information about record linkage and the IDEA-NW project, please contact Sujata Joshi (sjoshi@npaihb.org, 503-416-3261).

"DISPARITIES IN LIFE EXPECTANCY OF PACIFIC NORTHWEST AMERICAN INDIANS AND ALASKA NATIVES" PUBLISHED IN PUBLIC HEALTH REPORTS

[1] Dankovchik J, Hoopes MJ, Warren-Mears V, Knaster E. Disparities in Life Expectancy of Pacific Northwest American Indians and Alaska Natives: Analysis of Linkage-Corrected Life Tables. Public Health Rep 2015; 130: 71-80.

AI/AN		Life Expectancy at Birth (95% Confidence Interval)	
		NHW	
Idaho	Male	73.49 (71.41 - 75.56)	77.36 (77.15 - 77.58)
	Female	75.38 (73.63 - 77.13)	81.54 (81.33 - 81.76)
	All	74.46 (73.13 - 75.79)	79.45 (79.30 - 79.60)
Oregon	Male	73.01 (72.05 - 73.97)	77.17 (77.03 - 77.30)
	Female	76.51 (75.48 - 77.55)	81.65 (81.52 - 81.78)
	All	74.77 (74.06 - 75.48)	79.43 (79.34 - 79.53)
Washington	Male	69.58 (68.87 - 70.28)	77.86 (77.75 - 77.96)
	Female	73.24 (72.53 - 73.94)	82.00 (81.89 - 82.10)
	All	71.40 (70.90 - 71.90)	79.95 (79.87 - 80.03)

AI/AN: American Indian/Alaska Native; NHW: non-Hispanic white

SEXUAL ASSAULT NURSE EXAMINER (SANE) RESPONSE TEAM INITIATIVE

By Ryan Swafford, Sexual Assault Prevention Coordintor

The National Coordination Committee (NCC) of the American Indian/Alaska Native on Sexual Assault Nurse Examiner (SANE) Response Team Initiative recently released a report in which it recommends that the Department of Justice and Federal Bureau Of Investigations employees assigned to work in Indian country should receive training in areas of tribal sovereignty, governance, impacts of historical trauma on tribal nations, dynamics of sexual violence, crime victims' rights, and the purpose and functioning of Sexual Assault Response Team (SARTs), in order to create a work environment that is effective and respectful within tribal nations.

The NCC report also stated that United States Attorneys' Offices and the FBI should assign employees to actively participate in the local SART(s). Building protocol in collaboration with tribal law enforcement agencies through which sexual violence cases will be reported to various branches of the law enforcement structure will decrease misunderstanding of responsibility. The committee has recommended that culturally appropriate specific guidelines be used while facilitating Child/Adolescent Forensic Interviews for federal prosecution.

The NCC closed its recent report by describing a need to increase and stabilize the Department of Justice's source of funding for tribal criminal justice programs, and to guarantee that victims of sexual violence in an AI/AN communities receive culturally appropriate responses from federal and state agencies. The full report can be accessed at: http://www.ovc.gov/AIANSane-Sart/pdf/NCC_June2014_FinalReport_508.pdf

At the Northwest Portland Area Indian Health Board (NPAIHB), we are proud to confirm that we do implement culturally competent trainings and facilitators for our Northwest tribes, with recommendations for non-tribal partnering communities to join SARRC (Sexual Assault Response and Resources Circles) to bring better-quality responses and close communication gaps between the entities. NPAIHB partnership with the Oregon Sexual Assault Task Force (SATF) has made it a priority to hire instructors who demonstrate cultural competency in working with our tribal populations. Our agencies created a curriculum review board, SARTs have included tribal members, to develop culturally competent, Pacific Northwest specific curricula. Evaluations from our tribal trained sites are reviewed and help us continuously incorporate changes into the format and content of the training.

The Northwest Portland Area Indian Health Board in collaboration with the Oregon Sexual Assault Task Force are offering the 4th annual:

Tribal Sexual Assault Nurse Examiner (SANE) Training

March 9-13, 2015
Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300
Portland, Oregon 97201

This training is a 40 hour didactic Sexual Assault Nurse Examiner (SANE) training course on adult and adolescent medical response to sexual assault in tribal communities.

Eligible participants will:
- Have a current RN, NP, PA, MD or DO license;
- Have two years of nursing or clinical experience;
- Be actively participating as an RN, NP, PA, MD or DO; and
- Work in a Tribal community or facility which serves Tribal members.

This training is offered at no cost to participants and all expenses are paid. CEU's approved and provided by the State of California, Dept of Consumer Affairs, Continuing Education Provider, and Board of Registered Nursing.

Contact Jenna Harper for more information at jennaharper@oregonsatf.org or by phone at 503-990-6541

SATF OREGON

This project was supported by Award No. 2011-NE-BX-K569, awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice.

NPAIHB held its first Sexual Assault Nurse Examiner (SANE) training in June 2011 and continues to provide the annual training for its member tribes in Oregon, Washington, and Idaho through open invitation. Since the beginning of the project, 64 nurses who work in our tribal health clinics have successfully completed the course. Additionally, 7 nurses have completed advanced SANE training.

This year's SANE training will be held in Portland on March 9-13, 2015. Registration is now open at: https://docs.google.com/forms/d/1V_C5NOrHRUEJOGf896Hx8nvNFu8LO-fhNQJUNzfyXIs/viewform

Other 2014 SARTs activities of the NPAIHB Sexual Assault Response Project focused on SARRC and Sexual Assault Dynamics Training for 12 tribes. "Mini-grants" were given to SARTs to assist them in bringing awareness of sexual assault responses within the communities.

STRIVING FOR ZERO SUICIDES IN THE PACIFIC NORTHWEST

By Colbie Caughlan, Suicide Prevention Project Manager

The suicide prevention project – THRIVE – housed at the NPAIHB, was awarded a Garrett Lee Smith (GLS) youth suicide prevention grant by the Substance Abuse and Mental Health Services Administration (SAMHSA). The five-year grant will run through September 2019. In addition to the GLS funds, THRIVE received a continuation award from the Indian Health Service's Meth & Suicide Prevention Initiative. The goals of these grants align well with the overarching goal of THRIVE: to prevent suicide among AI/AN youth.

Many are aware of the high suicide rates that affect AI/AN youth, but for those who are not:

- AI/AN youth are disproportionally impacted by high rates of depression and suicide, which heightens their need for prevention programs that align to their unique culture and social context.
- Among high-school aged AI/ANs, 21.8% seriously considered attempting suicide and 14.7% attempted suicide at least once in the last year (national averages respectively, 15.8% and 7.8%) (Centers for Disease Control and Prevention, 2011).
- Moreover, 78% of high-school aged AI/ANs have consumed alcohol (national average, 71%), and 22.3% have been bullied at school (national average, 20.1%) both of which contribute to suicide attempts.

In recent data from the CDC, suicide was the second leading cause of death for AI/AN teens and young adults. In many cases, Native suicide rates more than double the state and national average. At the national level, in 2010, the suicide death rate was highest among AI/AN youth aged 15-24 at 20.8 cases per 100,000, compared to 11.4 per 100,000 for White youth and 6.5 for Black youth. Suicide rates for AI/ANs are highest in early adulthood and decrease with age, while suicide rates in the general population tend to increase with age.

Fortunately, 9 of the new 26 GLS grants were awarded to Tribes and tribal organizations. In addition to the NPAIHB, other Northwest awardees included: Yellowhawk Tribal Health Center at the Confederated Tribes of the Umatilla Indian Reservation (CTUIR); the Oregon Health Authority and; the Washington State Department of Health. Both OR and WA States included services for Tribes in their scope of work. Together, suicide prevention in this region should expand dramatically in the next five years, and there will be many opportunities for collaboration toward the common goal of zero suicide.

The Zero Suicide Model is a relatively new approach to suicide that is described by the National Action Alliance for Suicide Prevention, as:

> "Zero suicide is a commitment to suicide prevention in health and behavioral health care systems and also a specific set of tools and strategies. It is both a concept and a practice... The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety--the most fundamental responsibility of health care--and also to the safety and support of clinical staff who do the demanding work of treating and supporting suicidal patients."

Within the GLS grant, THRIVE's four primary goals are designed to build regional suicide-prevention capacity across the social-ecological spectrum. THRIVE's goals are to:

Goal 1. Improve tribal suicide prevention policies and environments through coordination, collaboration, and resource sharing across tribes, departments, and programs.

Goal 2. Enhance organizational systems and practices in IHS, Tribal, and Urban (I/T/U) clinics to provide suicide treatment (screening, assessment, and care management) and prevention services to AI/AN youth 10-24 years old.

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Goal 3. Promote healthy family and community norms, including the identification of suicidal intent among youth, and the use and social acceptability of mental health services.

Goal 4. Improve knowledge, attitudes and behaviors among AI/AN youth (10-24 years old) in the Pacific Northwest using evidence-based suicide prevention interventions.

To achieve these goals, the THRIVE project will:

- Fund three I/T/U clinics to provide suicide screening and mental health services to 100 or more AI/AN youth 10-24 years old in their local community. Clinics will utilize evidence-based screening, treatment, and prevention practices endorsed by the Zero Suicide campaign.
- Fund three NW tribes to implement an evidence-based intervention (EBI) or promising practice targeting twenty or more AI/AN youth 10-24 years old in their local community. The available interventions are appropriate for youth across the entire 10-24 year age range. Each tribal subcontract awardee will select an intervention that meets the needs and readiness level of their community.
- Host the annual THRIVE Conference for Native Youth every June.
- Host NW Tribal Adolescent Health Alliance meetings throughout the region.
- Provide technical assistance to the NW tribes to improve their ability to track, prevent, and treat suicide, including the development of tribal crisis response plans.
- Update and expand the current suicide prevention social marketing campaign to reach Native Lesbian, Gay, Bisexual, Transsexual, Transgendered, Intersexual, Queer, Questioning, 2-Spirited (LGBTQ2S) youth in years 1 and 2 and expanding the campaign to reach returning veteran populations in years 3 and 4.
- Host webinars and trainings on topics that will improve the NW tribes' delivery of suicide prevention interventions. Trainings may include topics such as suicide risk factors, prevention, and treatment strategies.

Together, these activities will increase knowledge and awareness about suicide among tribal communities in the Pacific Northwest, increase the number of AI/AN youth (age 10-24) who are exposed to suicide awareness campaigns, and will shift community norms and individual behaviors towards accessing mental health services. By fulfilling the four goals above, the THRIVE project will increase the availability and use of culturally-appropriate suicide prevention services, resources, and messages that meet the unique needs of AI/AN teens and young adults – reaching a high-risk, underserved population.

For more suicide prevention information, resources, or to request a training or materials, please contact Colbie Caughlan, suicide prevention project manager, at ccaughlan@npaihb.org.

NATIVE VOICES

The Native VOICES Project is thrilled to announce the official release of the Native VOICES video, a CDC-recognized STD/HIV evidence based intervention (Video Opportunities for Innovative Condom Education and Safer Sex - VOICES) for Native teens and young adults (15-24 years old).

After five long years in the making - in partnership with our NW tribes and project stakeholders - we have successfully completed all of our project goal and objectives, to:

- Improve our understanding of sexual norms and risk/protective factors affecting the behavior of AI/AN teens and young adults;
- Produce an evidence-based HIV/STD intervention that addresses the needs of AI/AN youth in a culturally responsive manner; and
- Offer AI/AN communities a cost-effective sexual health intervention that is readily integrated into IHS/Tribal/Urban clinical services and easily transferrable across Indian Country in various settings.

During the first two years of the project, the NPAIHB partnered with 2 NW Tribes and an Urban Indian clinic to carryout focus groups and key informant interviews with teens and young adults, to better understand their knowledge and attitudes towards sexual health. Young men who have sex with men (MSM) and young women who have sex with women (WSW) were also consulted, to ensure their perspectives and concerns were reflected in the video. Personnel at tribal health departments, tribal clinics, schools, and other youth-serving programs were also consulted to ensure the resultant intervention could be practically implemented and sustained over time.

During the third year of the project, AI/AN teens and young adults from across the U.S. read or reenacted

iterative drafts of the adapted script, and provided feedback on the characters, scenes, tone, and dialogue. The adapted Native VOICES video was shot on location in Oklahoma City in August 2013.

Since then, the NPAIHB has been working with nine tribes across the U.S. to evaluate the effectiveness of the Native VOICES intervention. The sites were randomized into one of three study arms:

1. Fact sheets alone (control)
2. Fact sheets plus the Native VOICES video (intervention)
3. Fact sheets plus the Native VOICES video plus a facilitated discussion (intervention+)

Together, the sites recruited and consented nearly 800 AI/AN youth 15-24 years old to participate in the study. And due to the hard work and perseverance of the local site coordinators, nearly 75% of the participants completed six-month follow-up surveys.

Satisfaction surveys collected at red carpet showings of the video suggest promising results: Over 94% of those

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surveyed enjoyed the video, 97% found the video to be culturally appropriate for American Indian people, and 100% felt the information could be trusted. Nearly 88% felt the video showed real life situations with characters they could relate to, and 94% thought the things the actors did and said about condoms and negotiating safe sex would work for them. After watching the video, 74% felt more likely to get tested for STDs/HIV, and 61% felt more likely to use condoms. The final evaluation report will be done in April 2015.

Get the Native VOICES Toolkit

A toolkit was designed to support the intervention's dissemination and implementation in diverse tribal settings. The toolkit includes the Native VOICES video (23 minutes), a condom demonstration video (1:40 minutes), a dental dam demonstration video (1:08 minutes), a selection of condoms and dental dams, and a users' guide.

While the toolkit encourages users to facilitate a 30-45 minute, small-group discussion after watching the video, the video can also be used independently in settings or situations where the small-group discussion is not practical or appropriate.

The NPAIHB will be sending the Native VOICES Toolkit to the Behavioral Health contacts at each of the 43 NW Tribes this January 2015. However, if another contact person in a separate department would also benefit from receiving a toolkit, please contact Mattie Tomeo-Palmanteer at Mattie@npaihb.org to receive an additional copy.

Native VOICES on We R Native

We also plan to market the video directly to young adults. Starting on Valentine's Day, the NPAIHB will release the video as a series of six mini-episodes on We R Native's Facebook page and YouTube channel. At present, We R Native's Facebook page has over 21,000 likes. In 2014, the www.weRnative.org website received over 75,000 page views. Altogether, We R Native reaches over 32,000 users per week through its various media channels.

WHY SHOULD BABY BOOMERS GET TESTED FOR HEPATITIS C?

Hepatitis C

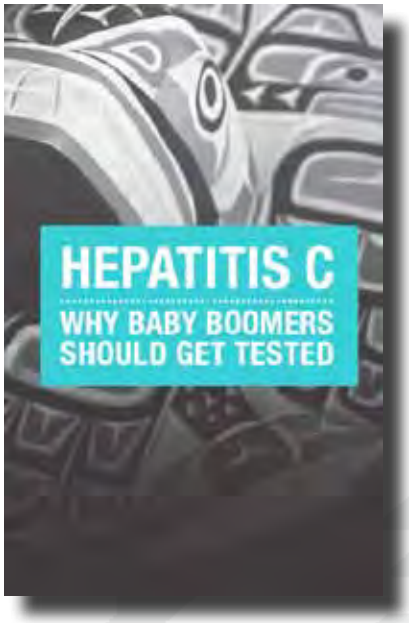
If you were born between 1945 and 1965, you're automatically at high risk of hepatitis C infection. Effective treatment is now available, so get tested.

New drugs for hepatitis C has minimal side effects and high cure rates. Treatments can be as simple as one pill a day for 12 weeks. These breakthroughs mean that early diagnosis, follow up, and treatment of hepatitis C has never been more important.

Why should baby boomers get tested for Hepatitis C?

While anyone can get Hepatitis C, more than 75% of adults infected are baby boomers, people born from 1945 through 1965. Hepatitis C can be in your body for many years with no symptoms. Most people with Hepatitis C do not know they are infected.

- Baby boomers are five times more likely to have Hepatitis C.
- The longer people live with Hepatitis C, the more likely they are to develop serious, life-threatening liver disease.
- Getting tested can help people learn if they are infected and get them into lifesaving care and treatment.



It is recommended that anyone born from 1945 through 1965 get tested for Hepatitis C.

Why do baby boomers have such high rates of Hepatitis C?

The reason baby boomers have high rates of Hepatitis C is not completely understood. It is believed most boomers became infected in the 1970s and 1980s when rates of Hepatitis C were very high. Since people with Hepatitis C can live for decades without symptoms, many baby boomers are living with an infection they got many years ago.

Hepatitis C is mostly spread through contact with blood from an infected person. Many baby boomers could have been infected from contaminated blood and blood products before widespread screening of the blood supply began in 1992. Others may have become infected from injecting drugs, even if only once in the past. Still, many baby boomers with Hepatitis C do not know how or when they were infected.

What should baby boomers know about Hepatitis C?

Hepatitis C is a serious liver disease that results from infection with the Hepatitis C virus. Some people who get infected with Hepatitis C are able to get rid of the virus, but most people who get infected develop a lifelong infection. Over time, chronic Hepatitis C can cause serious health problems including liver damage, cirrhosis, liver cancer and even death. In fact, Hepatitis C is a leading cause of liver cancer and the leading cause of liver transplants.

People with Hepatitis C:

- Often have no symptoms
- Can live with an infection for decades without feeling sick
- Can usually be successfully treated with medications

How would someone know they have Hepatitis C?

The only way to know if someone has Hepatitis C is to get tested. Doctors use a blood test to find out if a person has ever been infected with Hepatitis C.

Hepatitis C Antibody Test results

When getting tested for Hepatitis C, be sure to ask when and how test results will be given to you. The test results usually take anywhere from a few days to a few weeks to come back.

What do the results mean?

Non-reactive or a Negative Hepatitis C Antibody Test

- A **non-reactive**, or negative, antibody test means that a person does not have Hepatitis C.
- However, if a person has been recently exposed to the Hepatitis C virus, he or she will need to be tested again.

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WHY SHOULD BABY BOOMERS GET TESTED FOR HEPATITIS C?

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Reactive or a Positive Hepatitis C Antibody Test

- A **reactive**, or positive, antibody test means that Hepatitis C antibodies were found in the blood and a person has been infected with the Hepatitis C virus at some point in time.
- A reactive antibody test **does not** necessarily mean a person still has Hepatitis C.
- Once people have been infected, they will always have antibodies in their blood. This is true if even if they have cleared the Hepatitis C virus.
- A reactive antibody test will need to be followed up with a HCV RNA test to see if a person is currently infected with Hepatitis C. Your provider will let you know if this testing is done.

For more information talk to your primary care provider.

NEW FACES AT THE BOARD

Celena McCray is of the Bitter Water People (Tódích'íi'nii) born for the Mountain Cove People (Dziltl'ahni). Her maternal grandparents are the Tangle People (Ta'néészahnii), and her paternal grandparents are the Towering House People (Kinyaa'aanii). She is from Crownpoint, NM. Ms. McCray received her B.S. degree in education with a concentration in health education from the University of New Mexico. She served as a Legislative District Assistant for the 22nd Navajo Nation Council, where she provided legislative work related to health, education, human services, veteran affairs, and intergovernmental relationships. She has also served as a coordinator with Native Health Initiative, a grass-roots partnership that works with indigenous communities to addresses health inequities through loving service. Ms. McCray currently works as the THRIVE Project Assistant with the Northwest Portland Area Indian Health Board.

CHAIRMAN'S NOTE

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Finally, on December 9-11th, I attended the NIHB Board of Directors retreat held in Fantasy Springs Resort Casino in Indio, CA. NIHB continues to do a very good job of staffing federal advisory committees for Tribal leaders and tracking issues for the Medicare, Medicaid and Policy Committee (MMPC) and the CMS Tribal Technical Advisory Committee (TTAG). All of these issues are very important and I am glad the Board can support my participation on NIHB's Board.

The next three months will be very important and busy work for the Board. We have ATNI Winter Session, NCAI winter session and lobbying trips, IHS National Budget Formulation, HHS Annual and Regional Consultations, and the CMS TTAG meeting coming up.

Thank you all for the support you provide to the Board!

Whi Leem lem (Thank You)
Euuhootkn (Badger)

Andrew C. Joseph Jr.

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

FY 2015 IHS BUDGET UPDATE

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a small increase of $788,000 for the equipment line item. Overall, the funding level for the Facilities accounts in this FY 2015 budget is not a good thing. The lack of program increases for the Maintenance and Improvement and Sanitation Facilities Construction program are very concerning for Tribes. Over the last four years these programs have not received adequate program increase to keep pace with inflation and ongoing need.

Indian Health Service FY 2015 Budget
Comparing FY 2014 Operating Plan to President's FY 2015 and pending Omnibus H.R. 83

Prepared by: NW Portland Area Indian Health Board - 12/10/2014 @11:00 a.m. PST

Rules Committee Print 113-59 House Marks to the Senate Amendment fo H.R. 83 (12/10/2014)

Sub-Sub Activity	FY 2014 Final Operating Plan	PRESIDENT'S REQUEST			Omnibus vs. FY 2014			Omni vs Request	
		FY 2015 President's Request	Change over FY 2014	Pct. Of Change	Omnibus H.R. 83	Change over FY 2014	Percent of Change	Change Over Request	Pct of Chg Request
SERVICES									
Hospitals & Health Clinics	$ 1,790,904	$ 1,862,501	$71,597	4.0%	$ 1,836,789	$ 45,885	2.6%	$ (25,712)	-1.4%
Dental Services	$ 165,290	$ 175,654	$10,364	6.3%	$ 173,982	$ 8,692	5.3%	$ (1,672)	-1.0%
Mental Health	$ 77,980	$ 82,025	$4,045	5.2%	$ 81,145	$ 3,165	4.1%	$ (880)	-1.1%
Alcohol & Substance Abuse	$ 186,378	$ 193,824	$7,446	4.0%	$ 190,981	$ 4,603	2.5%	$ (2,843)	-1.5%
Contract Health Services	$ 878,575	$ 929,041	$50,466	5.7%	$ 914,139	$ 35,564	4.0%	$ (14,902)	-1.6%
Subotol, Clinicol Services	*$ 3,099,127*	*$ 3,243,000*	*$143,873*	*4.6%*	*$3,197,036*	*$97,909*	*3.2%*	*$ (45,964)*	*-1.4%*
Public Health Nursing	$ 70,909	$ 76,353	$5,444	7.7%	$ 75,640	$ 4,731	6.7%	$ (713)	-0.9%
Health Education	$ 17,001	$ 18,263	$1,262	7.4%	$ 18,026	$ 1,025	6.0%	$ (237)	-1.3%
Comm. Health Reps	$ 58,345	$ 59,386	$1,041	1.8%	$ 58,469	$ 124	0.2%	$ (917)	-1.5%
Immunization AK	$ 1,826	$ 1,855	$29	1.6%	$ 1,826	$ -	0.0%	$ (29)	-1.6%
Subtotal, Preventive Health	*$ 148,081*	*$ 155,857*	*$7,776*	*5.3%*	*$ 153,961*	*$5,880*	*4.0%*	*$ (1,896)*	*-1.2%*
Urban Health	$ 40,729	$ 41,375	$646	1.6%	$ 43,604	$ 2,875	7.1%	$ 2,229	5.4%
Indian Health Professions	$ 33,466	$ 38,466	$5,000	14.9%	$ 48,342	$ 14,876	44.5%	$ 9,876	25.7%
Tribal Management	$ 1,442	$ 2,442	$1,000	69.3%	$ 2,442	$ 1,000	69.3%	$ -	0.0%
Direct Operations	$ 67,894	$ 68,065	$171	0.3%	$ 68,065	$ 171	0.3%	$ -	0.0%
Self-Governance	$ 4,727	$ 5,727	$1,000	21.2%	$ 5,727	$ 1,000	21.2%	$ -	0.0%
Contract Support Cost	$ 587,376	$ 617,205	$29,829	5.1%	$ 662,970	$ 75,594	12.9%	$ 45,765	7.4%
Subtotol, Other Services	*$ 735,634*	*$ 773,280*	*$37,646*	*5.1%*	*$ 831,150*	*$95,516*	*13.0%*	*$ 57,870*	*7.5%*
TOTAL, SERVICES	***$ 3,982,842***	***$ 4,172,182***	***$189,340***	**4.8%**	***$ 4,182,147***	***$199,305***	**5.0%**	**$ 9,965**	**0.2%**
FACILITIES									
Maintenance & Improvement	$ 53,614	$ 53,614	$0	0.0%	$ 53,614	$ -	0.0%	$ -	0.0%
Sanitation Facilities Constr.	$ 79,423	$ 79,423	$0	0.0%	$ 79,423	$ -	0.0%	$ -	0.0%
Health Care Fac. Constr.	$ 85,048	$ 85,048	$0	0.0%	$ 85,048	$ -	0.0%	$ -	0.0%
Facil. & Envir. Hlth Supp.	$ 211,051	$ 220,585	$9,534	4.5%	$ 219,612	$ 8,561	4.1%	$ (973)	-0.4%
Equipment	$ 22,537	$ 23,325	$788	3.5%	$ 22,537	$ -	0.0%	$ (788)	-3.4%
Totol, Facilities	*$ 451,673*	*$ 461,995*	*$10,322*	*2.3%*	*$ 460,234*	*$8,561*	*1.9%*	*$ (1,761)*	*-0.4%*
TOTAL, IHS	**$ 4,434,515**	**$ 4,634,177**	**$199,662**	**4.5%**	**$ 4,642,381**	**$207,866**	**4.7%**	**$ 8,204**	**0.2%**

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UPCOMING EVENTS

JANUARY

January 27-28 2015
The IHS Tribal Self-Governance Advisory Committee [TSGAC]
Washington, DC

FEBRUARY

February 2-5
ATNI Winter Convention
Lincoln City, OR

February 18-19
TTAG Face-to-Face Meeting
Washington, DC

February 23-25
NCAI Executive Council Winter Session
Washington, DC

MARCH

March 9-13
Sexual Assault Nurse Examiner (SANE) Training
Portland, OR

March 12-13
HHS Region 10 Tribal Consultation Meeting
Seattle, WA

March 17-18
Secretary's Tribal Advisory Committee (STAC) Meeting
Washington, DC

March 24-25
IHS Tribal Self-Governance Advisory Committee (TSGAC)
Washington, DC

APRIL

April 8
TTAG Face-to-Face Meeting
Washington, DC

April 19-22
NICWA 33rd Annual Protecting Children Conference
Portland, OR

April 20
NPAIHB Tribal Health Directors Meeting
Grand Ronde, OR

April 21-23
NPAIHB Quarterly Board Meeting
Grand Ronde, OR