COVID-19 ISSUE
July 2020

Northwest Portland Area
Indian Health Board
Indian Leadership for Indian Health

Health News & Notes

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NPAIHB's COVID-19 Telehealth Service

The Indian Health System of federal, tribal, and urban (I/T/U) health facilities are mainly rural, far from specialists, underfunded and understaffed. American Indian/Alaska Native communities have an elevated prevalence of underlying health conditions such as heart disease and diabetes. Together, these factors indicate that Indian Country is at higher risk of poor outcomes from COVID-19. During the COVID-19 pandemic, obtaining up-to-date guidance and dialogue on rapidly changing research outcomes on infection control, treatment, and public health policy is of utmost importance.

In order to share emergent COVID-19 epidemiology, surveillance, research and clinical policy and practice updates, the Northwest Portland Area Indian Health Board's Indian Country ECHO program launched COVID-19 telehealth sessions available to clinicians. Held every Monday at 12pm PDT, participants are invited to join the 1 hour session via Zoom to engage in didactic sessions and discussion. To sign-up, receive connect details, view past sessions, or browse clinical and community resources, visit: https://www.indiancountryecho.org/program/covid-19/.

In addition to the COVID-19 ECHO, providers can subscribe to an opt-in texting service (text COVID19 to 97779). This service provides weekly summaries and links on key clinical developments, and allows clinicians to submit their priorities/questions for specialists.

Starting March 18, the NPAIHB hosted twice weekly COVID-19 Indian Country ECHO telehealth clinics. From March 18 to July, the NPAIHB telehealth program had over 4,570 attendees from 24 states. While the majority of participants have been from the Pacific Northwest, the wide reach of pre-existing networks has brought in participants from 24 states, Guam, and Canada. Other key outputs include 79,208 text messages sent to 399 subscribers, and 289 messages received via text. The service provided 528 Continuing Education (CE) credits. Questions linked to CEs showed that 94% of clinicians reported that their knowledge increased, 93% felt they have greater social support for their work, and 65% likely to make a change in their practice. Archived sessions were viewed 1,355 times, and page views on IndianCountryECHO.org (14,501) were greater than the number of pageviews (12,980) in the previous eight months combined.

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Chair's Notes

Nickolaus D. Lewis
Lummi Nation
NPAIHB Chairman

I want to say how grateful I am for each and every one of the staff and leaders at NPAIHB. They have worked tirelessly to provide support to all of our people as we work with tribal, federal, and state agencies responding to the COVID-19 pandemic. Our lives and our communities will be forever changed by this crisis. My hands go up to each of my fellow Board members because I know that you are also working 24/7 for all of our people.

Hard on the heels of COVID-19, our country is seeing an explosion of protests due to the senseless murder of George Floyd. As Native people, we all know first hand the pain of racism and discrimination. I am chairing a National Indian Health Board committee on racism, and we are preparing testimony (to be given on July 17, 2020) to the US Commission on Civil Rights. We will build off of the work from the Broken Promises Report, and experiences from the paternalistic response the federal government has had in Indian Country to the COVID-19 pandemic.

As we learn to live with COVID-19, we need to look to the future of health care delivery for our people. I am so happy that the Community Health Aide Program has finally gotten federal approval for moving forward in the lower 48. NPAIHB and our Tribes have led the way in this effort. I look forward to the educational opportunities this will bring into our communities, as we raise up the next generation to be healers, leaders, and caregivers.

Nickolaus Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

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Indian Health Update

Geoff Strommer
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This article provides updates regarding litigation involving the Affordable Care Act, CARES Act Funding, and recent tribal complaints filed against Juul and other e-cigarette manufacturers, as well as brief updates on contract support costs and Section 105(l) leasing developments.

Affordable Care Act Litigation (Texas v. United States)

Briefing is underway in the United States Supreme Court in *California v. Texas*, the case in which Texas and other states are challenging the constitutionality of the Affordable Care Act (ACA). While the legal challenge focuses on the constitutionality of the ACA's individual mandate provision, Texas and certain other parties to the litigation have asked the Court to invalidate the entire Act on the grounds that the individual mandate was considered by Congress to be an essential component of the legislation and therefore cannot be legally "severed" from the remainder.

The case has major implications for Indian Country because critical amendments to the Indian Health Care Improvement Act, as well as other important Indian health provisions, were enacted as part of the ACA in 2010. If the entire Act is invalidated by the Courts, those Indian provisions would be struck down as collateral damage in the lawsuit, even though they have nothing to do with the individual mandate. A large coalition of tribes and tribal organizations from across the country, including NPAIHB, filed an amicus brief with the Court arguing that those Indian provisions can and should be preserved, regardless of how the Court rules on the remainder of the law.

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COVID-19 HHS Provider Relief Fund

Sarah Sullivan
Health Policy Analyst

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, P.L. 116-136 and the Paycheck Protection Program and Health Care Enhancement Act, P.L. 116-139 provide $175 billion to the Provider Relief Fund, administered by the U.S. Department of Health and Human Services (HHS). There is not an expenditure deadline for the Provider Relief Funds. The purpose of these funds are to prevent, prepare for, and respond to coronavirus, for necessary expenses to reimburse eligible health care providers for health care related expenses or lost revenues attributable to coronavirus; building or construction of temporary structures; leasing of properties; medical supplies and equipment; increased workforce and trainings; emergency operation centers; retrofitting facilities; and surge capacity. The deadline to apply for the Medicaid and CHIP Provider Relief Fund ($15 billion) is July 20, however providers are deemed ineligible if they have received the General Distribution (GD) Medicare Fee-for-Service (MFFS) funds. A timeline of the distribution and allocation methodologies of the various Provider Relief Funds is provided in Table 1.

Table 1. HHS Provider Relief Funds Distribution Timeline

APRIL

- **April 10-17: General Distribution 1**
  $30 billion distributed to Medicare FFS billing providers based on 2019 payments.
  Allocation:

$$\frac{\text{2019 MFFS payments}}{\text{\$435 Billion (total MFFS 2019)}} \times \$30\text{Billion}$$

- **April 24: General Distribution 2**
  $9.1 billion distributed to Medicare FFS billing providers based on revenues from CMS cost report data. The allocation equates to approximately 2% of net patient revenues per eligible provider.
  Allocation:

$$\frac{(\text{Most Recent Tax Year Annual Gross Receipts}) \times \$50\text{ Billion}}{\$2.5\text{ Trillion}} - \text{GD 1 Payment}$$

- **Starting April 24: General Distribution 2**
  $10.9 billion available to Medicare FFS billing providers based on revenue submissions to the provider portal.

MAY

- **May 29: IHS/Tribal Targeted Distribution**
  $500 million to approximately 300 IHS and Tribal programs.
  Allocation:
  IHS & Tribal Clinics: $187,000 + 5% (estimated service population x average cost per user.

JULY

- **July 20: Medicaid and CHIP Application Due Date**
  $15 billion available to providers participating in state Medicaid and CHIP programs (who have not received funding from the General Distribution funds.
  Allocation:
  2% (Gross revenues x Percent of Gross Revenues from Patient Care) for CY 2017, 2018, or 2019.

Targeted Funding not received by Portland Area Tribes: Rural funding ($10 billion), High-Impact Areas ($12 billion), Skilled Nursing Facilities ($4.9 billion), Safety Net Hospitals ($10 billion).

Update on Portland Area COVID-19 Surveillance

Bridget Canniff, *Project Director, Public Health Improvement and Training (PHIT)*

Ashley Hoover*, Communicable Disease Epidemiologist*

Kimberly Calloway*, Project Specialist, PHIT*

Nancy Bennett*, Washington Tribal Public Health Improvement Manager*

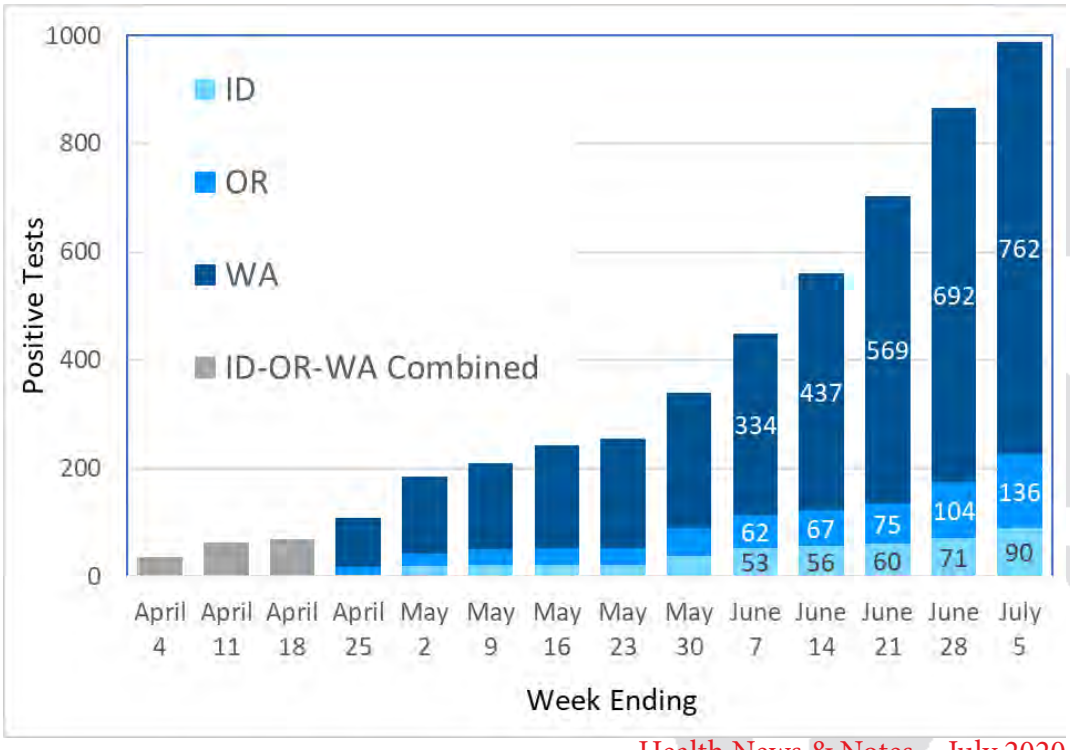
Staff from the Public Health Improvement and Training (PHIT) project team within the Northwest tribal Epidemiology Center (NWTEC) at NPAIHB have been collecting and reporting out COVID-19 data from Portland Area I/T/Us (IHS/Tribal/Urban clinics) since late March. In close collaboration with the Northwest Tribes, IHS Portland Area Office (PAO) and Service Units, and Urban Indian Health Programs (UIHPs), NPAIHB is monitoring COVID-19 test results in Tribal and Urban communities across Idaho, Oregon, and Washington.

As of July 5, 40 Portland Area I/T/Us have provided data to NPAIHB/IHS-PAO, including 31 Tribal health programs and clinics, 6 IHS Service Units, and 3 UIHPs. The total number of positive tests as of that date were 988, with 23 deaths reported during that period, all from I/T/Us in Washington.

Cumulative COVID-19 Positive Test Results Reported by Portland Area I/T/Us, April-July 2020

NPAIHB is also monitoring PPE and test kit supply status, as well as clinic staff exposures and illness. Tribal and Urban health programs reporting directly to NPAIHB receive weekly summary data reports for data validation.

Portland Area I/T/Us can report COVID-19 data to NPAIHB at www.surveymonkey.com/r/NPAIHBCovid-19 or email tphep@npaihb.org for more information or assistance. We are grateful to all Tribal and Urban partners for their contributions to our efforts to document and better understand the impact of COVID-19 in Native communities in the Northwest.



This chart shows reporting by Portland Area I/T/Us to NPAIHB and IHS Portland Area Office for the week ending July 5, including tribal community members not tested at an I/T/U facility but known to be positive.

Nutrition Support for Patients with COVID-19

Victoria Warren-Mears, PhD, RDN, FAND
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Nora Frank-Buckner, MPH (Nez Perce/Klamath)
Food Sovereignty Initiative Director

For patients hospitalized with COVID-19, nutrition support is essential during hospitalization and after they return home. For those that are ill at home, nutrition can help the recovery process.

Hospitalized patients, especially those that were in the intensive care unit (ICU) often don't remember how they were cared for by the health care professionals in the hospital. This can be due to medications or the trauma of the ICU. It may be helpful for them to hear from their providers about how they were fed while they were sick.

The simplest answer is: To fight this infection, you might have been fed into the stomach with a tube that was put into your nose or mouth or, you received nutrition through a vein. The feeding tube might have remained in place when you left the ICU to go to another place in the hospital or it may have been removed in the ICU.

At home, patients may feel too weak or tired to eat, and may notice that they have lost weight. They may also be eating and drinking less than before they became ill. This is completely normal, however, recovering patients need to prevent further weight loss to rebuild their strength. As they recover from COVID-19, patients should continue to eat a high calorie, high protein diet (10 – 14 ounces of protein per day). This diet along with regular exercise, will help them regain any muscle mass that was lost during illness and help the patient get back to normal activities.

Recommendations for quarantined patients: Patients in quarantine should continue regular physical activity while taking precautions. Quarantine is necessary for all infected people to prevent the spread of COVID-19. Prolonged home stay may lead to increased sedentary behaviors, such as spending excessive amounts of time sitting, reclining, or lying down for screen time activities (playing games, watching television, using mobile devices); reducing regular physical activity and lowering energy expenditure. Quarantine can lead to an increased risk for, and potential worsening of, chronic health conditions, weight gain, loss of skeletal muscle mass and strength. It may also contribute to loss of immune competence. Several studies have reported positive impact of aerobic exercise activities on immune function. Quarantined patients should be encouraged to get physical activity as they are able, some good examples would be yoga, Tai chi, indoor walking, and light weight lifting.

Keeping hydrated is essential while infected and in recovery: Adults with a fever of 102 degrees or higher lose an extra 30 oz of fluid every 24 hours. That is a lot. Recommending that patients drink water, even if they aren't feeling particularly thirsty is very important. If patients are not well hydrated, their respiratory secretions can thicken, making them more difficult to clear. If patients cannot clear these secretions from the lungs, they may be at greater risk for pneumonia. Signs of dehydration include dark colored urine, increased thirst, fever, tiredness and confusion. Patients should try to drink 2 - 4 oz of water every 15 minutes. This is about 8 to 16 oz per hour. This will help keep them hydrated, during illness. In recovery, water should still be the primary fluid. Monitoring a consistent weight and light-colored urine is the best way for someone to tell if they are hydrated.

Traditional foods can play an essential role in recovery: Many traditional foods are nutrient dense and can be an important part of the recovery diet. Exceptional sources of protein are found in traditional foods

Traditional Food	Sample portion size	Calories	Protein
Salmon	3 oz	196 calories	22 grams of protein
Clams	4 oz (without shells)	192 calories	33 grams of protein

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Nutrition Support for Patients with COVID-19

Traditional Food	Sample portion size	Calories	Protein
Crab	4 oz	100 calories	26 grams of protein
Venison	4 oz (cooked or stewed)	212 calories	40 grams of protein
Moose	4 oz cooked	151 calories	33 grams of protein
Elk	3 oz cooked	124 calories	25 grams of protein
Bison	3 oz	121 calories	24 grams of protein
Duck	½ Duck cooked	440 calories	51 grams of protein

Foods that boost immunity can also be very helpful during times of recovery. Many traditional foods such as teas (particularly nettle, fir tips, and berries) are useful for enhancing immunity. Teas and broths could also be added for increased vitamin, mineral, and fluid intake. Other immune supportive plants, seasonings, or spices to add to your diet include: echinacea, elderberry, garlic, oregano, rosemary, sage, Oregon grape, yarrow, and mint, as examples. Many of them have immune-building, decongestant, expectorant, or soothing properties.

It may also be best to avoid strong flavors while you are recovering. Patients may want to try cold or room temperature foods if the smell of hot cooked foods is unappetizing. If foods have a metallic taste a temporary change to plastic utensils is helpful for some people or bamboo utensils if they are available.

Resources:
https://www.nutritioncare.org/Guidelines_and_Clinical_Resources/Resources_for_Clinicians_Caring_for_Patients_with_Coronavirus/

Food composition:
https://www.nal.usda.gov/fnic/food-composition; accessed 7/8/2020

Kallas, John, Edible Wild Plants, Gibbs-Smith Publishing, Layton UT 2010.

Krohn, et al (2020, July). Immune & Respiratory Herbs: A resource for tribal communities during COVID-19.

Food Security and System Impacts During COVID-19

Nora Frank-Buckner, MPH (Nez Perce/Klamath)
Food Sovereignty Initiative Director

Increased demand through the Food Distribution Program on Indian Reservations (FDPIR):
The Food Distribution Program on Indian Reservations (FDPIR) provides USDA approved foods to income-eligible households that live on Indian reservations. American Indian households residing in approved areas near reservations are also eligible for FDPIR services. As COVID-19 began to spread across the nation, and stay at home orders were in place, the National Association of FDPIR conducted surveys to better understand the needs of the FDPIR sites. At that time, there was an average 11% increase in new participants, and some sites were seeing increases of up to 50%. The "take-rate" of the food also increased at 80% of the FDPIR sites, leaving less food availability, or items such as fresh fruits and vegetables completely out of stock. In just one week, FDPIR saw 600+ new households certified in 50% of the FDPIR sites.

Through the CARES Act funding, $100 million was allocated for the FDPIR sites. Fifty million dollars was to be used for food purchasing and another $50 million for infrastructure updates. These funds are available until September 30th, 2021.

Upcoming USDA FDPIR 638 Opportunity to further food sovereignty: The 2018 Farm Bill extended, for the first time ever, 638 Tribal self-governance authority to USDA in the FDPIR program for food procurement. This means that FDPIR sites would be able to enter into self-determination contracts and acquire foods of their choice for their program's food packages, including traditional and cultural-relevant foods.

There would be only three requirements:
1. The food would supplant, not supplement, current FDPIR foods
2. The food must be domestically sourced
3. The food must be of equal or higher nutritional value

The USDA has not yet released the application process. However, tribes are encouraged to begin strategizing

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Food Security and System Impacts During COVID-19

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and planning for how they would implement the funds. Funds would be available until September 30th, 2021.

How Northwest tribal communities are addressing food access and insecurity: Food availability, access, and affordability, particularly of healthy and fresh foods, continues to be an issue within many tribal communities. This inequality is rooted in the effects of colonization and the federal policies that have impacted how native communities interact with the food system. Although COVID-19 has not created the food system issues we are currently seeing, it has, however, exacerbated them. Tribes in the Northwest region have been responding to the needs of their communities during this time in a multitude of ways. Below are some examples:

Community gardening: Tribes across the region have increased their food production by expanding their community gardens, offering free food boxes to community members, delivering to households/elders, or offering a drive-thru food box pick-up site. Often the community gardens are partnering with other food distribution programs in their area, such as FDPIR sites, food banks serving the tribal community, or with health clinics.

Another innovative way that tribal communities have been engaging their members in gardening is in the delivery of home garden kits, complete with a small garden box/container, soil, seeds and/or plant starts.

Virtual cooking and traditional food classes: The COVID-19 pandemic has put a hold on in-person classes for healthy cooking, food preservation, and traditional foods courses for the time being. However, many tribes have went virtual to keep up the momentum of their programs. Some have offered to drop of the cooking kits to participants complete with ingredients and the recipe so that they can log-on during the virtual cooking demo and participate. Others have offered virtual courses on traditional plants and medicines to their members and have included Facebook Livestreaming to give "quick tips" on properly harvesting or preparing these foods.

New partnerships: In some areas, tribes have been able to partner with local/regional farmers who have been impacted by the decreased demand for their products due to restaurant closures. Rather than throwing the food away, tribes were successful in receiving donations to supplement food distribution programs or boxes, at least temporarily.

NPAIHB response to food systems change during COVID-19: We have been seeing an increase in food sovereignty efforts across the region, with NW tribal leaders in the forefront of this movement. Solutions to food system disparities is multifaceted and requires partnerships across sectors. Now more than ever we are seeing the need for a local and regional intertribal food system. Through the efforts of NPAIHB's NW Tribal Food Sovereignty Coalition and Food Sovereignty Initiatives, NW tribes, tribal organizations, and other partners are working to assess the current food distribution channels and regional food sovereignty efforts. This will inform next steps to planning and designing what a regional intertribal food system could look like.

Funding Opportunity: The NPAIHB was awarded funding through the Native American Agriculture Fund (NAAF) to support the NW Tribal Food Sovereignty Coalition activities, technical assistance, trainings, and food sovereignty assessment. However, a significant portion of the funds were dedicated to travel and in-person meeting expenses. Due to COVID-19, these funds were reallocated to providing "Food Sovereignty Implementation Awards" of up to $3000. These funds are to support tribes in food distribution, food access, or food sovereignty related projects. For more information, please see the Request for Applications or contact Nora Frank-Buckner at nfrank@npaihb.org.

Sources:

https://indigenousfoodandag.com/covid-19/

https://jm4.e6c.myftpupload.com/wp-content/uploads/2020/04/COVID19-Nutrition-Webinar-4.15.20-1.pdf

Returning to Work Amid the COVID-19 Pandemic

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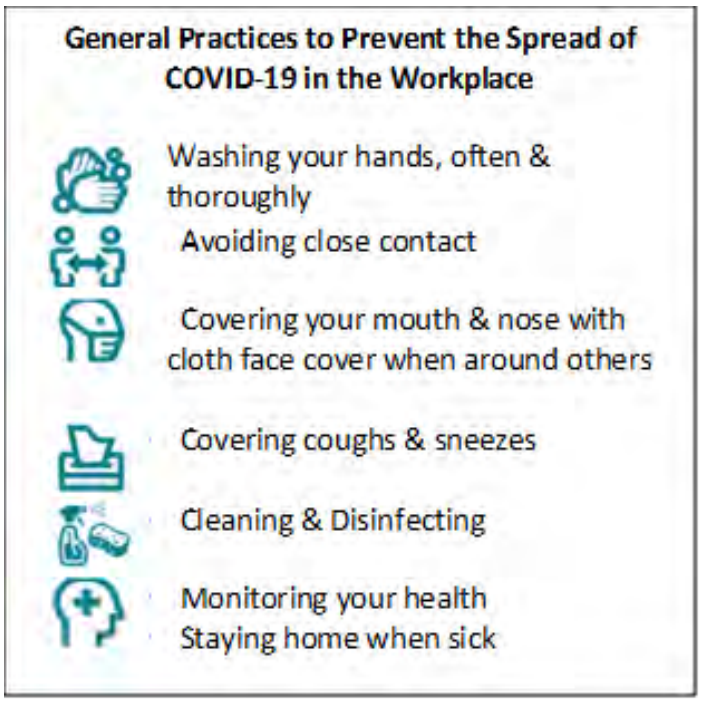
COVID-19 is a respiratory illness that has many symptoms that vary person to person, from no symptoms to severe. Common symptoms include:

1. Fever or chills (100.4 or higher)
2. Cough
3. Shortness of breath or difficulty breathing

Other symptoms include headache, fatigue, muscle or body aches, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Those at higher risk for severe illness include older adults (risk increases with age, with 85+ at greatest risk) and people of any age with underlying medical conditions such as: COPD, immunocompromised state, Type 2 diabetes, obesity, sickle cell disease, chronic kidney disease and serious heart conditions. See CDC's website for more information.



COVID-19 spreads from person-to-person through respiratory droplets when an infected person coughs, sneezes, or talks. These droplets can land in the mouths or noses of people who are nearby, be inhaled into the lungs or settle on surfaces where people pick them up. COVID-19 may be spread by people who do not have any symptoms.

PREVENTION MEASURES

Physical Distancing: Staying at least 6 feet from other people at all times!

- Telework if you can
- Stagger work schedules to reduce congestion at entrances during common hours and the number of people in the building at one time
- Reconfigure desk chairs and/or workstations to ensure 6' of distance
- Limit the number of guests in the building and how long they can stay
- Use virtual meetings and communication boards or

EXPOSURE RISK VARIES BY JOB

Some jobs are higher risk than others. Work with your employer to determine your level of risk. This will help determine the appropriate PPE to wear to protect yourself as well as identify effective policies and procedures for infection control.

Very High Risk- High potential exposure to known or suspected sources of COVID-19 during close contact medical procedures
High Risk- high potential exposure to known or suspected COVID-19 sources
Medium Risk- jobs with frequent or close contact with others who may be infected but not known to be
Low Risk- jobs that can maintain 6' from others most of the day

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Returning to Work Amid the COVID-19 Pandemic

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to convey information
- Limit the number of staff in break rooms and other communal areas (water jug, hallways, etc.).
- Maintain 6' from others when smoking
- Use designated entrances and exits

Personal Hygiene
- Wash hands before/after eating, using the restroom, touching your face, etc.
- Use hand sanitizer station & let management know when it is out
- Wear masks when not able to maintain 6'
- Wear gloves as necessary
- All guests should wear masks or face covers

Cleaning & Disinfecting
- First clean, then disinfect: disinfecting is less efficient on dirty surfaces
- All high touch surfaces should be cleaned and disinfected routinely
- Read & follow all label directions for mixing, applying, storage & disposal
- All cleaning agents used need to approved for use and effective against COVID-19
- Wear gloves and ventilate the area
- Let management know if products are running low

Daily Screening & Health Checks
- Upon arrival each day (guests & staff)
- Temperature screening
- Symptoms self-check process and/or log
- Leave work if feeling ill
- Do not come to work if sick or someone in the home is sick with COVID-19 symptoms

Other Health & Safety Practices:
- Cancel all nonessential travel
- When you have to travel be extra vigilant. Monitor yourself for 14 days and if symptoms present, quarantine for 14 days.
- Talk to you supervisor about flexible leave policies
- Request accommodations to reduce risk if you or someone in your home is at higher risk
- Ask questions and request training for cleaning, safety, wearing PPE, etc.
- Express your concerns, observations and new knowledge of how to prevent the spread of COVID-19

FACE COVERINGS, MASKS & RESPIRATORS

When combined with other measures such as physical distancing, cleaning and disinfecting and washing hands, wearing masks can be very effective in preventing and controlling the spread of COVID-19 in the workplace. Masks protect you and those around you. Masks should be worn when 6' of distance between you and other persons cannot be maintained.

Face coverings, masks and respirators can help prevent the spread of COVID-19. Consider the risk level of your job when choosing the type of covering you should be wearing:

DOs & DON'Ts of Wearing Face Coverings

DO wash after each use
DO air dry in sunlight if possible
DO wear a tight fitting cover or mask
DO make sure it covers nose and mouth
DO ask questions or make requests
DO wash your hands before putting on and after taking off
DO remove by the straps
DON'T touch the front while wearing or taking off
DON'T share with others
DON'T wear a cover that obstructs your breathing
DON'T wear under your nose

Nonmedical fabric covering or mask- These may be homemade or purchased but should have a minimum

Resources and References:
CDC. (2020). COVID-19 Resources. https://www.cdc.gov/coronavirus/2019-ncov/index.html
NPAIHB. (2020). COVID-19 Resources for Tribes. http://www.npaihb.org/covid-19/
Washington Department of Labor & Industry. (2020). COVID-19 Workplace Safety and Health.
OSHA. (2020). Guidance on Preparing Workplaces for COVID-19. https://www.osha.gov/Publications/OSHA3990.pdf
WHO. (2020). Advice on the Use of Masks in the Context of COVID-19. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/when-and-how-to-use-masks
EPA. (2020). List of products. https://www.epa.gov/coronavirus/disinfectant-use-and-coronavirus-covid-19

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of 3 layers. Recommended for those work in low or medium risk jobs.

Medical Mask- should be reserved for at risk persons or those working in high to very high risk jobs.

Respirators- The N95 respirator is the most common. Be sure any respirator used is certified by NIOSH, OSHA or FDA.

RESIDENTIAL AIR CLEANER PURCHASING GUIDELINES & CONSIDERATIONS

Air cleaners or purifiers can effectively remove many air contaminants, including viruses and smoke which is a great idea during the COVID-19 pandemic and wildfire season in the Pacific Northwest.

FUNCTION AND FILTER

Air cleaners are used to filter the air for different contaminants. Most units filter for particles OR gases; although you can find units that will filter for both. To reduce gases and odors, look for a thick activated charcoal filter.

Recommended: **"true" High Efficiency Particulate Air or HEPA filter** are most efficient tested and certified to meet the highest standard, filtering a wide variety of contaminants including wildfire and tobacco smoke as well as most viruses. There are 6 different types, A-F, that range in efficiency from 99.97%-99.999%.

SIZE

Air cleaners are designed to work in rooms, not whole houses. Consider the size of the room in which the unit that is designed. For example, you might buy a unit designed to filter up to 700 sq. foot room for a bedroom and a larger unit designed to filter up to 1500 sq. feet in a living room.

CARE AND MAINTENANCE

The life of a filter (how often it needs to be changed out). Most manufacturers recommend checking filters every six months and replacing them annually, but some last as long as 5 years!

AVOID OZONE GENERATING UNITS

Ozone is a lung irritant and strictly regulated pollutant. ***Never use any ozone generators in occupied spaces.*** The California Air Resources Board maintains a list of units that emit very little to no ozone (see link below).

RESIDENTIAL BRANDS TO CONSIDER

Keep in mind a lot of brands have several units that serve different functions and are designed for different sized rooms and equipped with different filtration systems. (AIRMEGA, COWAY, AUSTIN AIR, HONEYWELL, BLUEAIR)

WEB LINK

Resources and References:

- EPA. (2020). Air Cleaners & Air Filters in the Home. https://www.epa.gov/indoor-air-quality-iaq/air-cleaners-and-air-filters-home-0
- California Air Resources Board. https://ww2.arb.ca.gov/our-work/programs/air-cleaners-ozone-products/california-certified-air-cleaning-devices
- National Air Filtration Association. (2020). "How many Types of HEPA Filters Are There? https://www.nafahq.org/how-many-types-of-hepa-filters-are-there/

MCH Programs and the MCH Core Workgroup

Tam Lutz, MPH, MHA (Lummi)
MCH Programs Director

The Northwest Tribes recognize that healthy mothers and children are at the heart of healthy Native communities. Healthy Native moms and babies need a continuum of support that extends across families, communities, health care and social services systems. The Northwest Portland Area Indian Health Board (NPAIHB) sustains a MCH Core workgroup of staff who collaborate to support tribal Maternal and Child Health (MCH) efforts by providing health research, data surveillance, technical assistance, policy development, and health promotion and disease prevention efforts.

Staff participating in the MCH core workgroup meet bi-weekly and include representatives from the IDEA NW Project, NW Native American Research Center for Health, WEAVE-NW Project, Native Boost Project, TOTS to Tween Study, Native CARS Studies, MCH Opioid Study, Environmental Health, IHS Medical Epidemiology, Western Tribal Diabetes Project, the Administration Officer, THRIVE, Parenting Teens, and Communicable Disease Epidemiology. Given the collaborative nature of the NPAIHB, additional staff also utilize the MCH Core workgroup episodically as MCH needs arise. The workgroup is an excellent venue to discuss new ideas or opportunities and to access staff with various expertise.

NPAIHB's MCH webpage has recently been updated at: http://www.npaihb.org/maternal-child-health/. If you have an opportunity to check it out and have suggestions or requests for information to be included please contact cjimenez@npaihb.org and tlutz@npaihb.org. We are always grateful for your input. Of particular interest may be the new section to provide resources related to COVID-19.

MCH and COVID-19

The COVID-19 pandemic has and will continue to have an impact on families. MCH-focused programs and collaborating staff at NPAIHB aim to support our NW Tribes as they work to improve the health and wellbeing of the families they serve. In addition to looking at

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MCH Programs and the MCH Core Workgroup

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both the NPAIHB MCH web page and the NPAIHB COVID-19 web page, we also recommend referring the Centers for Disease Control and Prevention (CDC) as a resource for all up-to-date information, including the impact of COVID-19 on pregnant and breastfeeding women and children and children with special health care needs.

Native Boost

Immunization rates have declined to dangerous levels in Portland Area Tribal and IHS clinics, even before COVID-19, and childhood vaccine orders and vaccine administration has declined even further this spring. Clinical providers suspect some of the falling immunization rates is due to vaccine hesitancy, and this has now been compounded by the decrease in well-child visits during the pandemic. This increase of unvaccinated or under vaccinated children is now colliding with decreased social distancing as families head out of homes and begin interacting or gathering with others this summer. This raises the risk of outbreak of other infectious disease such as measles, concurrent with continued exposure and risks of outbreak of COVID-19. NPAIHB has launched Native Boost, a collaboration with Portland Area IHS, Northwest Tribal Immunization Project, and Boost Oregon to deliver new approaches for providers to listen to and communicate with vaccine-hesitant parents. The goal is to provide health education and awareness about the safety and efficacy of vaccines and the need to improve immunization rates before any new phases of COVID-19 or flu viruses appear. Provider trainings are being offered this summer and community workshops will be available in the future. Check out www.boostoregon.org, or contact Tam Lutz at tlutz@npaihb.org for more information.

BREAKING NEWS – Should we develop an MCH ECHO or regular monthly conference call

Tuesday July 7, 2020 the MCH Core Workgroup polled IHS,Tribal and Urban (I/T/U) program attendees at NPAIHB's Tribal COVID-19 Weekly Update Call to assess interest in a recurring MCH-specific ECHO. Twenty-eight I/T/U staff respondees represented 17 unique Tribes along with state, regional and NPAIHB staff attended the call . Of the 28 I/T/U staff respondees 43% were interested in an ECHO or conference call to discuss any emerging MCH topic, 21% indicated that they would not be interested but someone else from their program would be, 18% were not sure, 11% were only interested in MCH ECHO sessions related to COVID-19, and 7% said their Tribal program would not be interested in an MCH ECHO or regularly monthly MCH conference call. With a total of 75% of respondents interested in some level of participation, the MCH Core Workgroup is reviewing the reported priority MCH topics, including those specifically related to COVID-19, to pilot an MCH ECHO or monthly conference call.

TOTS to Tweens Journal Article

The results of the dental study that assessed the long-term impact of tribal interventions to support breastfeeding, decrease the introduction of sugar-sweetened beverages to infants and toddlers, and promote water consumption by families on the teeth of adolescent children ten years post intervention, has been accepted for publication in the journal of Community Dentistry and Oral Epidemiology. Children who received these tribal interventions as babies had fewer cavities at age 11 to 13 than children who did not receive interventions. We are eager to showcase the work of Northwest tribes to a global audience, and are

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MCH Programs and the MCH Core Workgroup

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excited to share the message that establishing healthy behaviors, like breastfeeding and water consumption, and setting up a supportive environment, can lead to sustained health benefits. We will share the article when it is published. For more information, contact Nicole Smith at nsmith@npaihb.org

The MCH Core Workgroup offers our thanks to our I/T/U staff and programs who watch over and provide support or native children and families. If you have questions or ideas for us, please feel welcome to contact Tam Lutz at tlutz@npaihb.org

Northwest Inter-Tribal Breastfeeding Coalition (NITBC): Development and Progress

The NPAIHB's WEAVE-NW Project is continuing its efforts to prevent chronic disease through supporting breastfeeding through the development of a Northwest Inter-Tribal Breastfeeding Coalition (NITBC). This coalition will merge the previous WEAVE-NW efforts to develop a coalition and the work of Roberta Eaglehorse-Ortiz who originally developed the Oregon Inter-tribal Breastfeeding Coalition (OITBC). The NITBC seeks to promote unity through education, support and respect for the diverse American Indian/Alaska Native (AI/AN) communities present across the Northwest – reclaiming breastfeeding as a first foods. In its support of community, content areas within the coalition will include amplifying breastfeeding support through lactation education and peer breastfeeding support training, prenatal education and postpartum support including breastfeeding as a first food and traditional ways of knowing.

Currently, staff at the health board are in the process of completing breastfeeding posters that will be shared across NW Tribal Communities that highlight major themes that look to support women and birthing peoples through understanding the role of breastmilk, inter-generational support, traditional first food, role of the workplace in creating space and policies for breastfeeding and the role of partners/families in the continuum of care for both babies and mothers.

To learn more about the NITBC, please reach out to Candice Jimenez, cjimenez@npaihb.org

NPAIHB's COVID-19 Telehealth Service

continued from cover

Examples of Questions Answered During ECHO

I am interested in a summary of clinical trials attesting to the efficacy of wearing face masks to reduce the risk of infection from COVID-19

We're seeking policies, procedures on on-going testing with workforce and community

What travel restrictions should there be from an area with a large number of cases to one with few cases?

During the COVID-19 pandemic, the tribal telehealth program has been able to quickly provide surge capacity to respond to the pandemic. In a short time, COVID-19 telehealth services reached a high number of participants across a wide geographical range. The telehealth and ancillary services were highly used resources, rated highly useful by clinicians in Indian Country.

Texting services have been an additional resource for clinicians to obtain personal, but scalable information and give input to specialists. The IndianCountryECHO.org website has assisted with scheduling, linkages to teleECHO sessions, and archived material. An established telehealth network serving Indian Country has been an important part of emergency preparedness to support local health professionals navigate an appropriate response based on their community and resources.

Indian Health Update

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The federal government is involved in the suit as well. Originally, the federal government agreed that the individual mandate was unconstitutional, but generally defended the remainder of the law. In the court of appeals, however, the government shifted course and argued, along with Texas, that the entire statute was invalid. In its brief to the Supreme Court, filed on June 25, the federal government argued that the whole statute is indeed invalid, but that the *relief* granted by the Court should be more limited.

Disturbingly, the brief filed by the Department of Justice for the federal government ignored the federal responsibility to Tribes by failing to even mention the Indian provisions of the ACA. As the tribal amicus brief clearly demonstrates, those provisions are legally severable from the ACA's individual mandate and other more controversial insurance reform provisions. The federal government could have taken a position in support of the Indian health provisions, regardless of its position on the remainder of the law, but chose not to.

The Supreme Court could hear arguments in the case as early as October of this year, but likely will not issue a decision until after the November elections.

CARES Act Chehalis Litigation

The *Chehalis* litigation challenges the Department of the Treasury's (Treasury) decision that Alaska Native Claims Settlement Act regional and village corporations (ANCs) are eligible for funds from the $8 billion set aside for tribal governments from the Coronavirus Relief Fund in Title V of the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

On June 26, 2020, the district court concluded ANCs are eligible for CARES Act tribal government relief funds. In that decision, the court found ANCs are "tribal governments" under the CARES Act as well as "Indian tribes" under the Indian Self-Determination and Education Assistance Act.

On July 7, 2020, the district court granted the plaintiff tribes' motion for an injunction pending appeal and stayed its June 26, 2020 judgment. Thus, Treasury is once again prohibited from disbursing CARES Act tribal government relief funds to ANCs. The court stayed its June 26, 2020 order until the earlier of September 15, 2020, or resolution of the matter by the circuit court. If the circuit court does not resolve the case by September 15, 2020, it said, the injunction may be extended by motion of a party or by the circuit court—but such a motion must address whether the funds expire if the circuit court does not issue a decision by September 30, 2020. The court issued its injunction on the condition that the plaintiff tribes file their notice of appeal and motion for expedited review by July 14, 2020. If the plaintiff tribes do not file their appeal, the injunction expires on July 15, 2020.

Finally, there are several other cases currently being litigated related to CARES Act funding and Treasury distribution of funds. The tribal plaintiffs in the *Agua Caliente* litigation are seeking to force Treasury to immediately disburse the tribal government relief funds. The *Prairie Band* litigation challenges Treasury's use of the Department of Housing and Urban Development's Indian Housing Block Grant (IHBG) program dataset as the basis of its disbursement based on population. The *Shawnee* litigation challenges Treasury's use of population to measure allocations (arguing population does not measure "increased expenditures") and the use of the IHBG population figures.

Tribes sue e-cigarette manufacturer JUUL

A number of Tribes[1] recently filed lawsuits against JUUL and other vaping product manufacturers, including Altria Group, Nu Mark, LLC, and Phillip Morris USA. In their complaints these tribes are asking for injunctive relief and abatement to combat the vaping epidemic that has resulted from the deceptive marketing and sale of JUUL products to the tribes and their members, including under-age youth and students at their tribal schools. The complaints also seek compensatory damages to recoup the resources that it has expended and will need to continue to expend to address the youth vaping epidemic created by JUUL's misconduct.

The tribes' complaints allege that JUUL's design,

[1] The tribes include the Fond du Lac Band of Lake Superior Chippewa, Jamestown S'Klallam Tribe, Klamath Tribes, Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin, Oglala Sioux Tribe, Pala Band of Mission Indians, Port Gamble S'Klallam tribe, Red Cliff Band of Lake Superior Chippewa Indians, and Saint Regis Mohawk Tribe. The Ramah Navajo School Board, Inc. also filed a complaint in the litigation.

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Indian Health Update

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marketing, and distribution of its vaping products to minors—specifically targeting tribal youth, despite knowing that they are more susceptible to addiction than non-Native Americans—has resulted in a youth vaping epidemic in tribal communities. In addition, the tribes allege that JUUL deceptively pushed e-cigarettes as a way to help people stop smoking, while in reality the devices were intended as a new delivery vehicle for nicotine that raked in profits for the companies. For instance, JUUL has specifically targeted Native American communities through "switching programs," in which tribe members were encouraged to take up vaping instead of combustible cigarettes.

The lawsuits were filed in the U.S. District Court for the Northern District of California – the court in charge of current Multi-District Litigation coordination for the many lawsuits already filed against JUUL.

Contract Support Costs

The recently released House draft appropriations bill retains the separate, indefinite appropriation for contract support costs (CSC) that has been in place since FY 2016. This appropriation for "such sums as may be necessary" ensures sufficient funding for full payment of CSC without impacting any program funding lines. The draft bill contains a pernicious provision on CSC funding for the Indian Health Service (IHS)—but not the Bureau of Indian Affairs (BIA): CSC funds obligated by IHS but not spent by a Tribe in FY 2021 will count against the CSC due in the next fiscal year. This carryover offset provision last appeared in the FY 2017 appropriations act. Tribes successfully fought to have it removed the next year, and may want oppose it this year as well.

Important CSC cases being litigated include *Swinomish Indian Tribal Community v. Azar*, where the issue is whether IHS must pay CSC on the portion of the Tribe's health care program funded with third-party revenues, such as Medicare, Medicaid, and private insurance. The district court ruled for IHS, holding that third-party revenues are not part of the "federal program" that generates CSC requirements. The ruling appears to conflict with a different federal court's decision in *Navajo Health Foundation—Sage Memorial Hospital, Inc. v. Burwel*l. The Swinomish Tribe has appealed to the D.C. Circuit. In *Cook Inlet Tribal Council v. Mandregan*, the question is whether the Indian Self-Determination and Education Assistance Act (ISDEAA) prohibits duplication of funding categories, as IHS argues, or simply of funds, as the Cook Inlet Tribal Council (CITC) maintains. The district court ruled in favor of CITC; IHS has appealed.

Section 105(l) Leasing

Terrific news on the appropriations front: the latest House appropriations bill contains a new indefinite appropriation—"such sums as may be necessary"—to fund leases under section 105(*l*) of the ISDEAA. If the Senate follows suit and the provision becomes law, it would ensure full payment without IHS or BIA having to reprogram funds to cover leases, as happened to IHS in the last few years. On the downside, the House bill would also impose new cost-cutting restrictions on 105(*l*) lease compensation, including a provision allowing funding only for that portion of a facility devoted to the "Federal program." This provision appears to endorse IHS's recent decisions to limit lease funding to that portion of the facility IHS deems necessary to serve IHS beneficiaries, and not that portion IHS deems as serving non-beneficiaries—even when a tribe has a resolution in place under section 813 of the Indian Health Care Improvement Act that brings such services within the scope of the ISDEAA funding agreement. This issue is currently being litigated by the Jamestown S'Klallam Tribe.

While IHS has entered hundreds of leases over the past few years, Interior's office of Indian Affairs—which encompasses BIA and the Bureau of Indian Education—has so far entered just two. But Indian Affairs recently released a 105(*l*) negotiation "framework" and is gearing up to engage in this process more actively.[2]

[2] See https://www.bia.gov/as-ia/raca/regulations-development-andor-under-review/section-105l-leases.

New Faces

Amy Franco
Grants Management Specialist

My name is Amy Franco, I'm a Panamanian from the Midwest. I grew up in Illinois, lived in Chicago for ten years, and moved to Portland in 2016. I have a decade of experience in health research grant administration including prior positions at University of Illinois at Chicago (UIC) and Oregon Health & Science University. I attended UIC for undergrad (Anthropology) and grad school (Urban Planning & Policy). I'm delighted to be at NPAIHB to support proposal development and submissions and grant administration in my role as a Grants Management Specialist.

Ashley Hoover, MPH
Communicable Disease Epidemiologist

Ashley Hoover recently moved to Portland to work at the Board as a Communicable Disease Epidemiologist. She grew up in the Florida Keys but most recently lived in New Orleans, Louisiana, where she received her MPH at Tulane University with a focus in maternal and child health, and interned at the Board in 2014 as a maternal and child health epidemiologist. After graduation, she spent the past five years working at the Louisiana Department of Health STD/HIV/Hepatitis Program as the Perinatal Surveillance Supervisor overseeing all maternal/perinatal exposures to HIV and syphilis. She is excited to bring her skillset to the Board in her new role and spend some time in the beautiful and newish-to-her Pacific Northwest!

Barbara Gladue
(Little Shell and Turtle Mountain Bands of Chippewa Indians)
Oregon Tribal Public Health Improvement Manager

Hello, my name is Barbara Gladue hired as the Oregon Tribal Public Health Modernization Manager. I am an enrolled member of the Turtle Mountain Band of Chippewa Indians and Caucasian. I grew up in Great Falls, Montana, next to the Blackfeet's buffalo jumps.

I moved to Portland in 2000. I attended PCC and PSU earning an AA and then a BA degree. I am a mother to three amazing girls, Tristan 24 years old, Milagros 12 years old, and Esperanza 6 years old. My hobbies include volunteer coaching basketball (last year was my fifth year coaching my daughter team at NAYA) and sometimes volleyball, rafting, hiking, and crafting. I love anything outdoors, but my real love is FOOD! I love to cook and to eat.

I bring to the NPAIHB a lifetime of traditional and spiritual knowledge. A decade of family engagement, advocacy, case management, training, and technical assistance. I hope to cross paths real soon.

Miigwech,
Barbara Gladue

Celeste L. Davis, REHS, MPH
(Chickasaw Nation)
Environmental Public Heath Program Director
NARCH Asthma Management Project Director

Hi friends! My name is Celeste Davis and I am excited to join the Northwest Portland Area Indian Health Board/ Northwest Tribal Epi-Center as the Environmental Public Health Program Director and NARCH Pediatric Asthma Management Research Project Director for the in Portland, OR. I retired after a 20-year service career in February 2017 from the US Public Health Service (USPHS) Commissioned Corps, with my last assignment as the Director for the Division of Environmental Health Services (DEHS) and the Emergency Management Coordinator for the Indian Health Service (IHS), Portland Area. During my career, I've had the privilege to serve over 130 Tribes and Alaska Native Villages through a variety of environmental public health positions in the southeastern U.S., Alaska, New Mexico, and the Pacific Northwest, having risen through the ranks from the field to management. I hope my broad work experience in public health includes assessment and inspection, environmental and epidemiological investigations, training, policy development, program and project management, and evaluation will be valuable to the Tribes of the Pacific Northwest.

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New Faces

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I am a citizen of the Chickasaw Nation, and was born in Alaska and grew up in Oklahoma. She is a Registered Environmental Health Specialist who earned a Bachelor of Science degree in Environmental Health Science from East Central University in Ada, Oklahoma, and a Master of Public Health degree in Occupational and Environmental Health from the University of Oklahoma. Ms. Davis is currently pursuing a PhD in Health Systems Management and Policy at the OHSU-PSU School of Public Health. In my spare time, I enjoy traveling all over the world, going to rock concerts, reading, playing and watching sports, anything outdoors - hiking and fishing, and hanging out with my family, friends, and cats. My favorite color is purple. My drink of choice is a crisp, refreshing lager or pilsner.

Lael Tate
(Navajo)
THRIVE Project Coordinator

"Hello! My name is Lael Tate and I am joining the Board as a THRIVE project coordinator. I am Navajo and grew up in NE Portland. I just graduated from Columbia University with a Bachelor's degree in Ethnicity and Race Studies. I interned at the Board last summer and am very happy to be back and to be working with familiar faces. I am eager to learn how to best support the mental health of our Native communities, especially during this time of loss, grief and heightened attention to racial injustice. I look forward to seeing you all in person soon."

Melino F. Gianotti
Oregon Tribal Public Health Improvement Analyst

Melino joined the NPAIHB in March and has been loving her time here ever since. She is from Douglas County, OR. Before joining the NPAIHB, Melino was serving as a Peace Corps Volunteer. She worked as a Community Health Educator in Cambodia for two years, coordinating with local schools and clinics. She then transferred to Liberia to work as a Community Health Outreach Specialist and trained within her local community. She is very thankful for the opportunity to serve tribal communities.

Chronic Disease and COVID-19: What You Need to Know

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Tips and information to protect yourself and your family

What is COVID-19?

COVID-19 is a new kind of illness caused by a virus. People can carry and spread the virus without feeling sick. It causes fever, coughing, and trouble breathing.

What should people with chronic diseases know about COVID-19?

Anyone can get sick from COVID-19, but people who are older than 65 and people of any age who have a serious chronic disease are the most likely to become very ill or die.

People who have one or more of these chronic conditions should be extra careful to protect their health from COVID-19:

- Asthma and lung disease
- Heart disease
- Unmanaged diabetes
- Severe obesity (BMI>40)
- Weakened immune systems because of diseases like HIV or because people are going through cancer treatment.

What can people with chronic diseases and their families do to protect themselves from COVID-19?

Making healthier choices every day can help people prevent and improve their chronic disease as well as their well-being, overall. Some of the most important healthy choices include quitting tobacco use, getting more physical activity, and eating nutritious meals and snacks.

People with chronic diseases must be sure to:

- Take regular medications on time and as directed (reach out to your healthcare provider to ask about obtaining an extra supply of medications in case you cannot get to the pharmacy or clinic).
- Make time to keep measuring your blood pressure if you have hypertension or take your blood sugar if you have diabetes.
- Use the telemedicine/telehealth option for a regular medical visit (your healthcare provider can tell you if your insurance company offers this option).

Everyone should follow CDC's recommendations to prevent COVID-19:

- Avoid crowded places and stay at home.
- When you are outside your home, stay at least two arms' length away from other people.
- Wash your hands often with soap and water for at least 20 seconds (or the time it takes to sing "Happy Birthday" twice). If you don't have soap and water, you can use hand sanitizers that contain at least 60% alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your cough or sneeze with the inside of your elbow.
- Clean objects or surfaces in your home that people touch a lot, such as door knobs, elevator buttons, and key pads.

! If you or a family member starts to get a fever, cough, or shortness of breath, it may be because of COVID-19. Here is what you should do next:

- Take steps to protect your family members from getting sick (read the CDC fact sheet on how to keep your family safe: www.cdc.gov/coronavirus/2019-ncov/prepare/get-your-household-ready-for-COVID-19.html).
- Call your healthcare provider and follow their advice on what to do next. Do not go to the Emergency Room unless your provider tells you to do so.
- If you have a job or go to school, let them know that you are sick. You should not go to work or school.

Managing Your Chronic Disease to Prevent COVID-19

▶ I have... diabetes

When people with diabetes do not manage their blood sugar levels well, they can have more trouble fighting off illnesses like COVID-19. Because of this, people with poorly controlled diabetes are more likely to become very ill or die if they get COVID-19.

What you can do:

- Make sure to monitor your blood sugar regularly and to take your medications as directed. Contact your provider to help you get an emergency supply of medications.
- Follow your healthcare provider's advice about healthy eating and increasing physical activity.
- Stop smoking, as smoking can make it more likely that you have heart attack or stroke.

▶ I have... asthma

Both asthma and COVID-19 can harm your lungs. If you have asthma and get ill with COVID-19, it could lead to life-threatening lung conditions.

What you can do:

- If you have one, follow your Asthma Action Plan (www.cdc.gov/asthma/actionplan.html).
- Take your medications as directed. Talk to your doctor and pharmacist to be sure you have an emergency supply of prescription medications.
- Stop smoking and using e-cigarettes, which can cause lung damage.

Quitting tobacco use now can help you improve your health. People with chronic diseases who use tobacco are most likely to have life-threatening health issues. If you use tobacco, make the commitment today to quit. Call the free quitline today to get started at 1-800-QUIT-NOW (1-800-784-8669).

▶ I have... heart disease

COVID-19 can strain all of the systems in the body, which puts additional stress on your heart. In patients with heart disease, COVID-19 can make it more likely that your heart won't be able to keep up with the needs of your body.

What you can do:

- Ask your doctor about telehealth visits to manage your condition so that you don't have to go into the clinic, where you could catch COVID-19.
- Maintain the medications and treatment plan that you and your doctor created.
- Keep up the healthy habits that your doctor recommends, including healthy eating, exercise, getting enough sleep, and managing stress.
- Stay up-to-date on other vaccinations that can protect you from diseases that stress your heart, including pneumonia and the flu.

For more information, please visit:
- **NACDD webpage for COVID-19 resources:** www.chronicdisease.org/news/496967/NACDD-Resources-to-Support-States-Response-to-COVID-19.htm
- **CDC website for COVID-19 resources:** www.cdc.gov/coronavirus/2019-ncov/index.html

▶ I have... cancer

Some types of cancer and cancer treatments can weaken people's immune systems and can make them more likely to get very ill from COVID-19.

What you can do:

- Before going into your appointments for cancer treatment, ask your doctor how you can help protect yourself from catching COVID-19.
- Check if any oral medications that you are taking can be sent directly to you so that you don't have to go to the pharmacy or the clinic.
- Your doctor may recommend other things that you should do to isolate yourself from others to help make sure that your treatments have the best chance of working.

"Whether you make the decision to quit smoking, choose fruit instead of your regular snack, or take some light exercise during TV commercial breaks, it's never too late to try something new to improve your well-being."

– John W. Robitscher, MPH, CEO,
National Association of Chronic Disease Directors

Upcoming Events

Dates Hyperlinked

JULY

July 17 - August 21
Native American Pathways Program
Mayo Clinic, Office of Diversity

July 21-23
IHS Partnership Meeting
IHS

AUGUST

August 3-7
OCPS Conference
IHS

August 3-7
2020 Health Disparities Research Institute
National Institutes of Health

August 6-7
IHS Direct Service Tribes National meeting
IHS

August 11-12 (Postponed 8/8/2021)
Region 10 Opioid Summit
Portland, OR

August 17-21 (Postponed 8/1/2021)
National Indian Council on Aging Conference
Reno, NV

August 25-27 (Postponed May 2021)
3rd Biennial World Indigenous Suicide Prevention Conference
Winnipeg, MB, Canada

SEPTEMBER

September 14-18 (Postponed April 26-17, 2021)
NW Tribal Public Health Emergency Preparedness Training
Shelton, WA

September 22-24
Diabetes RPMS Training (DMS)
ZOOM Platform

OCTOBER

October 20-22
NPAIHB Quarterly Board Meeting
NPAIHB

We welcome all comments and Indian health-related news items.
Address to:

Health News & Notes/ Attn: Lisa Griggs or by e-mail at lgriggs@npaihb.org
2121 SW Broadway, Suite 300, Portland, OR 97201
Phone: (503) 228-4185 FAX: (503) 228-8182

For more information on upcoming events please visit www.npaihb.org

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD APRIL 2020 RESOLUTIONS

RESOLUTION #20-03-01
NARCH 6.5.2020

RESOLUTION #20-03-02
HRSA Opioid-Impacted Family Support

RESOLUTION #20-03-03
PUBLIC HEALTH RECOMMENDATIONS FOR A PHASED APPROACH TO REOPENING

RESOLUTION #20-03-04
BOLD Resolution 6.5.2020

RESOLUTION #20-03-05
Oppisition to 100% FMAP_Non_IHS-Tribal Agreements

RESOLUTION #20-03-06
NW Tribal Juvenile Justice

RESOLUTION #20-03-07
ANA-Social and Economic Development Strategies

Photo credit: E. Kakuska - Dancing in the Square Powwow 2018