April 2018

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Health News & Notes

A Publication of the Northwest Portland Area Indian Health Board

Policy

Indian Health Update

By Geoff Strommer,
Hobbs, Straus, Dean & Walker, LLP

This article provides updates on FY2018 appropriations and health program extensions, and an update on the Indian health legislative outlook as of April 2018.

Appropriations Update/Health Program Extensions
Significant developments have occurred on the federal appropriations front since our last newsletter. Following five FY 2018 Continuing Resolutions which provided funding at FY 2017 levels, final FY 2018 appropriations have finally been enacted and hearings have begun on FY 2019 funding.

FY 2018 Appropriations
FY 2018 enacted funding for the Indian Health Service is nearly $500 million over FY 2017, which is a 10 percent increase. This increase was in part made possible by the enactment in February 2018 of the Bipartisan Budget Act (P.L. 115-123) which raised the FY 2018 spending cap on domestic discretionary spending by $63 billion and the FY 2019 cap by $68 billion. That allowed Appropriations subcommittees to revise their earlier FY 2018 funding recommendations and provide increases in some areas. We note that the Congress, even in its pre-Bipartisan Budget Act recommendations, soundly rejected the Trump Administration's proposed large budget cuts for the IHS.

The President signed the Consolidated Appropriations Act, 2018 on March 23 (P.L. 115-141). IHS funding made available in that Act includes $93 million for pay cost increases and medical inflation which is $23 million over FY 2017 but does not fully meet built-in cost needs. There is $72 million for the Indian Health Care Improvement Fund, a program which has not received funding since 2012. The money is to address funding disparities that exist across the IHS system. Most of the increase over FY 2018 are in the areas of facility construction, staffing of new facilities, and accreditation emergencies. Contract support costs continue to be fully funded at "such sums as may be necessary" and House

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Northwest Portland Area Indian Health Board

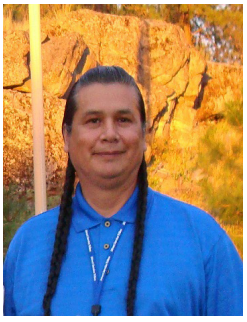
Executive Committee Members

Andy Joseph, Jr., *Chair*
Confederated Tribes of Colville Tribe
Cheryle Kennedy, *Vice Chair*
Confedrated Tribes of Grand Ronde
Greg Abrahamson *Secretary,*
Spokane Tribe
Shawna Gavin, *Treasurer*
Confederated Tribes of Umatilla
Kim Thompson, *Sergeant-At-Arms,*
Shoalwater Bay Tribe

Delegates

Twila Teeman, Burns Paiute Tribe
Dan Gleason, Chehalis Tribe
Leta Campbell, Coeur d'Alene Tribe
Andy Joseph Jr., Colville Tribe
Vicki Faciane, Coos, Lower Umpqua & Siuslaw Tribes
Eric Metcalf, Coquille Tribe
Sharon Stanphill, Cow Creek Tribe
Cassandra Sellards-Reck, Cowlitz Tribe
Cheryle Kennedy, Grand Ronde Tribe
Lisa Martinez, Hoh Tribe
Brent Simcosky, Jamestown S'Klallam Tribe
Darren Holmes, Kalispel Tribe
Gerald Hill, Klamath Tribe
Velma Bahe, Kootenai Tribe
Francis Charles, Lower Elwha S'Klallam Tribe
Nick Lewis, Lummi Nation
Nathan Tyler, Makah Tribe
Charlotte Williams, Muckleshoot Tribe
Sam Penney, Nez Perce Tribe
Samantha Phillips, Nisqually Tribe
Lona Johnson, Nooksack Tribe
Hunter Timbimboo, NW Band of Shoshone Indians
Karol Dixon, Port Gamble S'Klallam Tribe
Bill Sterud, Puyallup Tribe
Vacant, Quileute Tribe
Noreen Underwood, Quinault Nation
Joanne Liantonio, Samish Tribe
Cyntha Harris, Sauk-Suiattle Tribe
Kim Thompson, Shoalwater Bay Tribe
Ladd R. Edmo, Shoshone-Bannock Tribes
Sharon Edenfield, Siletz Tribe
Yvonne Oberly, Skokomish Tribe
Robert de los Angeles, Snoqualamie Tribe
Greg Abrahamson, Spokane Tribe
Bonnie Sanchez, Squaxin Island Tribe
Kevin D. Collins, Stillaguamish Tribe
Andrew Shogren, Suquamish Tribe
Cheryl Raser, Swinomish Tribe
Melvin Sheldon Jr., Tulalip Tribe
Shawna Gavin, Umatilla Tribe
Marilyn Scott, Upper Skagit Tribe
Janice Clements, Warm Springs Tribe
Frank Mesplie, Yakama Nation

Chairman's Notes



By Andrew Joseph, Jr.,
Colville Tribal Council
NPAIHB Chair

When I saw the FY 2018 Omnibus spending bill that was approved last month, I let out a deep sigh of relief. Congress had approved a 10% increase to the IHS budget for FY 2018, a strong statement opposed to the President's proposed 6% cut to the budget. Congress also appropriated $72 million to the Indian Health Care Improvement Fund (IHCIF) and $50 million to tribes and tribal organizations to address the opioid crisis. As to other HHS funding, I was also relieved when I learned that the Secretary's Minority AIDS Initiative Fund (SMAIF) was funded again. SMAIF dollars is the only source of funding to IHS for HIV and HCV prevention, treatment, outreach and education in Indian country. SMAIF supports "We R Native," Project ECHO and other important projects at the Board. So we faired pretty well this year but have work ahead of us for FY 2019.

For FY 2019, the President proposed an increase to the IHS budget but proposed to eliminate funding for Community Health Representative (CHRs) and Health Education. Outside of IHS, he also proposed no funding for the Low Income Energy Assistance Program (LIHEAP) and Supplemental Nutrition Assistance Program (LIHEAP). The President is not concerned that the lives of our poorest and sickest people are in jeopardy if they have no rides to medical care, no heat, and no food. Fortunately, we are lucky to have to have bipartisan representatives on both the House and the Senate that will listen to us and care about our people. I will be busy this year making sure our voice is heard to save these programs for our people.

Way límˈlímx (Thank you)
Yəx̌ʷyəx̌ʷúɬxn (Badger)

Andrew C. Joseph Jr.
HHS Chair
Colville Tribal Council
NPAIHB Chair
ATNI 3rd Vice Chair
NIHB Member

Congressional Efforts to Combat the Opioid Epidemic in Indian Country

Sarah Freeman Sullivan, MPH
Health Policy Analyst
Northwest Portland Area Indian Health Board

The opioid epidemic has disproportionately impacted tribal communities in the Northwest and has put a further strain on tribal healthcare resources. On March 14, Senator John Hoeven (R-ND), chairman of the Senate Committee on Indian Affairs convened an oversight hearing on solutions to combat the opioid abuse crisis in Indian Country. The Committee is dedicated to engaging with tribes to find ways to advance the federal government's role in combating opioids and other substance abuse disorders in tribal communities. The Committee heard testimony on efforts to prevent and treat opioid abuse from the Indian Health Service (IHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Justice for the District of New Mexico, the Port Gamble S'Klallam Tribe and the National Indian Health Board.

The Port Gamble S'Klallam Tribe testified on the numerous challenges that tribal communities in the Northwest experience with the opioid epidemic and the multifaceted response efforts that Northwest tribes have developed connecting prevention, treatment and interdiction. The Northwest Portland Area Indian Health Board (NPAIHB) submitted testimony for the record and made numerous requests of the Committee to include in legislation for tribes to utilize tribal best practices to combat the opioid epidemic. NPAIHB highlighted several culturally integrated continuum of care innovative model programs that Portland Area Tribes have developed without assistance from the federal government.

The opioid epidemic impacts scarce resources and funding priorities throughout all tribal government departments in tribal communities due to the lack of funding and resources from the federal government. Section 10003 of the 21st Century Cures Act provides grant funding for the State response to the opioid abuse crisis, however no grant funding was set-aside for tribes. Eligibility for the state targeted response to the opioid crisis grants (STR) was statutorily limited to single state agencies, thus tribes are not eligible to apply. The Board included comments in the testimony that highlighted the issue of forcing tribes to go through states and compete with states for funds, ultimately diminishing the federal trust responsibility.

The SAMHSA STR grant directed states to identify communities of focus at highest risk for opioid use disorder. States are also expected to address

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Northwest Portland Area Indian Health Board

Administration
Joe Finkbonner, Executive Director
Jacqueline Left Hand Bull, Administrative Officer
Mike Feroglia, Business Manager
Eugene Mostofi, Fund Accounting Manager
Nancy Scott, Accounts Payable/Payroll
James Fry, Information Technology Director
Chris Sanford, IT Network Administrator
Tara Fox, Grants Management Specialist
Andra Wagner, Human Resources Coordinator
Geo. Ann Baker, Receptionist

Program Operations
Laura Platero, Policy Analyst
Sarah Sullivan, Policy Analyst
Lisa Griggs, Program Ops & Exec. Assistant
Katie Johnson, EHR Intergrated Care Coordinator

Northwest Tribal Epidemiology Center
Victoria Warren-Mears, Director
Antoinette Aguirre, Cancer Prevention Coordinator
Birdie Wermy, EpiCenter National Evaluation Specialist
Bridget Canniff, PHIT/Injury Prevention Project Director
Candice Jimenez, Native CARS, T2T Research Coordinator
Celena McCray, THRIVE Project Coordinator
Chiao-Wen Lan, IDEA-NW Epidemiologist
Clarice Charging, IRB & Immunization Projects Coordinator
Colbie Caughlan, THRIVE Project Director
Danica Brown, Health Communications Coordinator
David Stephens, HCV RN Project Manager, PRT Media Specialist
Don Head, WTD Project Specialist
Eric Vinson, Cancer Project Coordinator
Erik Kakuska, WTD Project Specialist
Ethan Newcome, WEAVE-NW Project Assistant
Jenine Dankovchik, WEAVE Evaluation Specialist
Jessica Leston, STD/HIV/HCV Clinical Service Manager
Jodi Lapidus, Native CARS Principal Investigator
Joshua Smith, NWTEC Health Communicatoins Specialist
Kerri Lopez, WTDP & NTCCP Director
Luella Azule, PHIT/Injury Prevention Coordinator
Monika Damron, IDEA-NW Biostatistican
Nancy Bennett, EpiCenter Biostatistican
Vacant, WEAVE Project Director
Nicole Smith, Biostatistician
Nora Frank-Buckner, WEAVE Project Coordinator
Ryan Sealy, WEAVE Tobacco Project Specialist
Sarah Hatcher, CDC Epidemic Intelligence Officer (EIS), assigned to NWTEC
Stephanie Craig Rushing, PRT, MSPI, Project Director
Sujata Joshi, IDEA-NW Project Director
Tam Lutz, Native CARS, T2T Director
Tana Atchley, Youth Engagement Coordinator
Taylor Ellis, PHIT Project Specialist
Ticey Mason, Dental Project Manager
Tom Becker, NARCH Project Director
Tom Weiser, PAIHS, Medical Epidemiologist, assigned to NWTEC
Tommy Ghost Dog, Jr., PRT Coordinator

NPAIHB Projects
Christina Peters, NDTI Project Director
Pam Johnson, NDTI Project Specialist
Tanya Firemoon, NDTI Project Coordinator

Expanding Access to Hepatitis C Treatment



David Stephens, *BSN, RN*
HCV Clinical Services Manager, NPAIHB
Jessica Leston, *MPH HIV/STI/HCV Clinical Programs Director, NPAIHB*
Randy Blome*, MD,*
Grand Ronde

How Grand Ronde is Eliminating Hepatitis C Through Capacity Building, Collaborative Learning and Policy.
In September of 2017, family medicine physician Randy Blome, attended a free clinical training to provide a range of hepatitis C (HCV) services at the primary care level. Led by Dr. Jorge Mera, Director of Infectious Diseases for Cherokee Nation Health Service, the training paid special attention to the ECHO model of collaborative learning and how to replicate a Hepatitis C Elimination program at the tribal level. *"I saw an amazing opportunity to help our tribe in Grand Ronde,"* said Randy Blome, MD.

The First Barrier to Hep C Care. Knowing you have the disease.
There are 4 million people in the US with hepatitis C and half of them don't know they have the disease. In 2012, the CDC recommended ALL Baby Boomers (those born between 1945-1965) be screened for the virus. When Blome returned from the conference, he calculated the screening rate for Baby Boomers in Grand Ronde and found the clinic needed to increase awareness of hep C and increase the screening rate. They did this by encouraging and educating providers on screening, speaking to different departments, as well as sending letters and making phone calls to unscreened patients. Informational employee emails were sent and articles were written in the Tribal Newspaper. *"The newspaper is a great way to educate patients and the community",* said Blome.

With a concerted effort and focus, it took only 5 months - Grand Ronde improved their screening rate from 15% to 37%. The clinic now aims toward reaching 100%.

Building a Team. *"The most enjoyable part of this project has been building our Hep C Team. It all started with our administrator, Kelly Rowe. She has been supportive of whatever we need to be successful. We have assembled people from IT, Lab, Medical, and Pharmacy. Seeing everyone working together on a common goal and seeing the results of that has been awesome!"*

The Second Barrier to Hep C Care – getting medication for cure.
There are not enough specialists to treat all the people that have hep C and having to drive long distances to see a specialist can be a barrier to care. Grand Ronde is currently treating tribal and community members for hep C locally at their Health and Wellness Center.

"This is a huge benefit to our people,"
-Randy Blome, MD, Grand Ronde

Historically, hepatitis c treatment has been done by specialists, but with the new medications, ***"treating hepatitis C is now easier than treating toenail fungus",*** says infectious disease MD, Jorge Mera.

"I was taught by Dr. Mera how to work up patients and then present

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Expanding Access to Hepatitis C Treatment

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the cases to Dr. Mera via a monthly video conference called ECHO, which stands for Extensions for Community Healthcare Outcomes. He advises on how to best treat each patient. More primary care physicians and Tribes need to get involved in ECHO conferences. We have discovered this is a great tool to provide Hep C care," said Blome.

The Third Barrier to Hep C Care – State and Insurance limitations to Medication.

The new Direct-Acting-Antiviral medications for hepatitis C are miraculous, but when they first came out they were horribly expensive. States felt they couldn't afford to provide everyone with the medications so they wrote policies that allowed to only treat the sickest people. *"Now that we have done that these policies are outdated. Recently the price of the medications have dropped dramatically".*

"We have an epidemic and we need to aggressively treat people to limit this disease. The expert associations like the AASLD (American Association for the Study of Liver Disease) have recommend States drop limitations based on fibrosis scores, sobriety, and expensive diagnostic testing. If we are going to slow the epidemic and start the process of elimination, these limitations must be removed," said Blome.

The Northwest Portland Area Indian Health Board (NPAIHB) has made starting a Hepatitis C Elimination program easy. Blome says, *"There is a yearly training conference. They run the ECHO [Extension for Community Healthcare Outcomes] clinics and offer any support needed. NPAIHB also advocates for access to Hepatitis C medication for all and capacity building opportunities in Indian Country".*

Capacity Building in Indian Country.

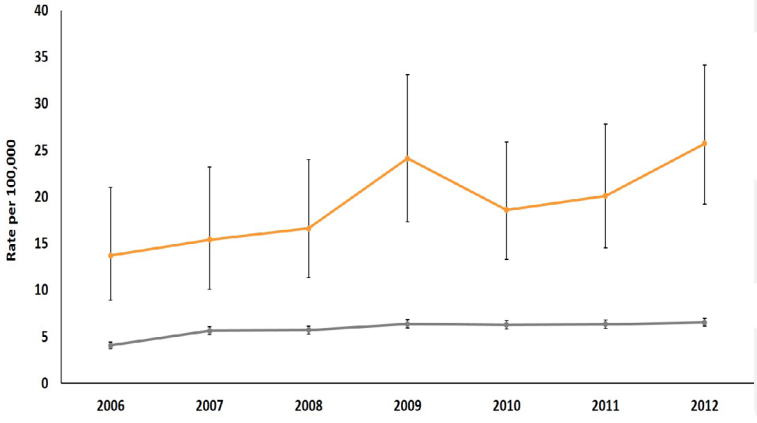
Each month, NPAIHB offers virtual teleECHO clinics with infectious disease specialist, Jorge Mera, focusing on the management and treatment of patients with hepatitis C. The 1 hour long clinic includes an opportunity to present cases, receive recommendations from a specialist, engage in a didactic session and become part of a learning community. Together, we manage patient cases so that every patient gets the care they need.

NPAIHB launched the teleECHO project in February 2017. The ECHO model is a collaborative model of medical education and care management that empowers clinicians to provide better care to more people, right where they live, an especially important attribute in Indian Country. ECHO increases access to specialty treatment by providing clinicians with the knowledge and support they need to manage patients with hepatitis C. To date, more than 35 clinical sites have joined and over 175 patients received recommendations for treatment. ECHO has been a way to democratize knowledge and NPAIHB will help to build the capacity for patients and providers to receive and give the best care possible.

NPAIHB plans to host a training Fall 2018. If you are interested in attending, or having the training team come to you, please email dstephens@npaihb.org.

Access to Hepatitis C Medication For All.

Hepatitis C is one of the deadliest infectious diseases for our tribal nations, yet many state Medicaid and other insurance programs have discriminatory restrictions that keep American Indian and Alaska Natives (AI/AN) from being cured and stop us from ending the epidemic. If HCV is left untreated, the virus slowly destroys the liver. The most recent national data show AI/AN people with both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any US racial/ethnic group. In the Northwest during 2006–2012, the AI/AN HCV-related death rate was over three times that of non-Hispanic whites. This disparity has persisted over time, demonstrating the need for access to treatment for AI/AN



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Expanding Access to Hepatitis C Treatment

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in the Northwest.

About 20,000 persons die from HCV each year, despite the availability of new medications that have a 95 percent success rate and can cure patients in as little as eight weeks. Improvements in new treatment options for HCV could have a major effect on the health of AI/AN. These new medications have high rates of achieving cure with few contraindications or adverse effects. These advances represent a major shift in treatment options for HCV and have the ability to reduce HCV-related deaths; yet state Medicaid programs are restricting access to cures for the virus, which kills more people each year than all other infectious diseases, including HIV, combined.

Restricting Access.

Due to cost concerns, many state Medicaid programs have limited access to new hepatitis c medications. In 2015, there were at least 34 states who had restrictions in place that limited access to treatment, based on

- Liver disease progression: Requiring that patients reach a certain stage of fibrosis (liver disease), which can be irreversible and cause cancer;
- Substance Use/Sobriety Requirements: Barring patients with a history of substance or alcohol abuse;
- Prescriber Restrictions: Only allowing certain specialists, who are not readily available, to prescribe a cure.

Currently in the Northwest:

- Idaho – Patients must have advanced liver scarring (referred to as Metavir stage F2-F4), and have no history of alcohol or substance abuse within 6 months prior to treatment; requires that a patient must be under the care of or in collaboration with an experienced hepatitis C practitioner. To learn more about Idaho's Medicaid policy and inclusion criteria for HCV medication, visit http://www.healthandwelfare.idaho.gov/Portals/0/Medical/PrescriptionDrugs/HepatitisCTherapeuticGuidelines.pdf
- Oregon – Patients must have advanced liver scarring (Metavir stage F2-F4), be enrolled in a treatment program under the care of an addiction specialist if they are actively using illicit drugs or abusing alcohol; requires that prescribers in care of patients with advanced liver scarring (F3-F4) the treatment must be prescribed by, or in consultation with, a hepatologist, gastroenterologist, or infectious disease specialist. To learn more about Oregon's Medicaid policy and inclusion criteria for HCV medication, http://www.oregon.gov/oha/healthplan/tools/Oregon Medicaid PA Criteria, January 2017.pdf
- Washington – Will approve payment for nearly every patient with chronic HCV (as of June 2016), including patients who are actively injecting drugs and/or using alcohol. To learn more about Washington's Medicaid policy and inclusion criteria for HCV medication, visit https://www.hca.wa.gov/assets/billers-and-providers/WA-Apple-Health-HepatitisC-Clinical-Policy.pdf

As of April 2018, Washington has the most open access to HCV medications for Medicaid patients, but this was not always the case. In 2015, the Washington Health Care Authority (HCA) approved guidelines restricting access to HCV drugs. A class action lawsuit ensued, claiming the restrictions violate federal law.

In response to the class action lawsuit, a federal judge ordered the state Health Care Authority to cover hepatitis C drugs for all patients with HCV, not just those who are sickest. The lawsuit was in response to a policy that restricted Medicaid patient's access to the medications based on the amount of liver scarring that was present. Only those with the most liver scarring were able to get the curative treatment.

After the federal judge's order, patients with less severe cases of HCV are now also able to access the medications. Unfortunately this is not the case in Oregon or Idaho, mainly due to the cost of the medication.

In Oregon, AI/AN reported cases of HCV are more than twice as high, cases of liver cancer are 50% higher, and HCV related deaths are twice as high compared to whites. These are deadly outcomes and expensive as well. Each hospital visit averaged over $25,000 and hospital visits associated with liver cancer averaged over $50,000. This cost could be avoided, but only those Medicaid patients in Oregon or Idaho who have advanced liver scarring are

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Expanding Access to Hepatitis C Treatment

given access to these curative drugs, and in some cases must be abstinent from alcohol and injection drug use. These criteria are not based on medical evidence, and in fact go against what national medical experts recommend. The American Association for the Study of Liver Diseases and the Infectious Diseases Society of America recommend HCV treatment as soon as possible rather than waiting for their liver to be heavily damaged.

From a public health perspective, rates of new infection will continue to rise unless a considerable number of people with chronic HCV who continue to inject drugs are treated. Many providers have therefore adopted a treatment-as-prevention approach when treating patients with HCV and finding ways other than getting reimbursed through Medicaid to cover the medications.

For more information about treating hepatitis C in your community, please contact Jessica Leston, 907-244-3888 or jleston@npaihb.org

Tribal Youth Delegate Program

By Tana Atchley (Modoc/Paiute/Karuk)
Youth Engagement Coordinator

The NPAIHB recently received a generous grant from the Administration for Native Americans. The Native Youth Initiative for Leadership, Empowerment, and Development (I-LEAD) Grant will allow us to expand our youth programs to prepare the next generation of health workers, through the newly created Tribal Youth Delegate Program. The primary goal of this program is to improve resilience and life skills among tribal youth by increasing their participation and success in leadership positions and by preparing them to join the public health workforce.

Program Description
The NPAIHB Youth Delegates are the official youth policy body to the Northwest Portland Area Indian Health Board Delegates. Youth Delegates will review

NPAIHB Creates Tribal Youth Delegate Program

NPAIHB programs and policies; and will provide advice about decisions that affect young people. The purpose of the Youth Delegates is to involve youth in all levels of community decision-making.

Skills & Knowledge
- Learn about health careers, governance structures, and policy
- Explore Indigenous Leadership styles by strengthening networking skills and sharing their personal story
- Enhance relationship building and team work skills
- Advocate for positive changes in healthcare and public health systems important to their Tribal communities

Application Criteria
- Must be an enrolled member or descendant of one of the 43 NPAIHB member tribes located in Idaho, Oregon and Washington.
- Must be between the ages of 14-24.
- Must have an interest in exploring a career in the health field.
- Must be able and willing to participate in delegate trainings, projects and activities.
- Must be prepared to represent themselves, their Tribe, NPAIHB, and the cohort of delegates with honor and respect at a regional and national level.
- Must have access to a phone and email account for regular communications.

Recruitment Process
On-line applications available via NPAIHB website
Available April – June 1, 2018
Text: DELEGATE to 97779

What are the NPAIHB Youth Delegates?
The Northwest Portland Area Indian Health Board's Youth Delegates are a group of Native youth who represent the tribes in Idaho, Oregon and Washington. They collaborate to share their voice on health programs and policies; and learn more about health and wellness careers.

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NPAIHB Creates Tribal Youth Delegate Program

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What do the Youth Delegates do?
Youth Delegates will meet in-person and attend virtual trainings throughout the year to develop leadership skills and learn more about health and wellness professions. During the meetings, Youth Delegates will **discuss health programs and policies that impact youth** in their tribal communities, write and pass resolutions, share their unique voice and perspective, and provide feedback to NPAIHB Delegates.

What is expected of a Youth Delegate?
Youth Delegates will meet 3 times in-person and have 5 virtual (recorded) trainings. They are expected to attend at least 1 in-person meeting and participate in all 5 virtual trainings throughout the year. Officers must attend at least 2 in-person meetings and participate in all 5 virtual trainings.

Who is Involved?
Participation is open to any tribal youth who is between the ages of 14-24, an enrolled member or descendant of one of the 43 tribal nations in Idaho, Oregon and Washington, and interested in learning more about health and wellness professions. Youth Delegates represent their tribal nation, so only one Youth Delegate will be selected per tribe.

How long can I be involved?
Terms are for 1 year (June 2018 – May 2019). Youth Delegates can reapply to participate another year, as long as they successfully met their obligations the year before and continue to meet the eligibility requirements.

When and how often do we get to meet?
We will meet several different times throughout the year, with 2 in-person meetings scheduled (June, July, and the option to attend the THRIVE Youth Conference in June 2019) and 5 virtual trainings (which will be offered live or as an online recording). In-person meetings will be at the *THRIVE Youth Conference* (5 days) in Portland, OR in June and at the NPAIHB Quarterly Board Meeting (3 days) hosted by one of the member tribes. Virtual Trainings will typically last 60 minutes and you can attend using your mobile phone or a computer.

Who runs the Youth Delegates?
Youth! Adult staff are involved to support programs and trainings and serve as mentors.

Can I get School Credit and treat this as an internship?
Yes. Since the NPAIHB is a nonprofit, your work as a Youth Delegate can qualify as an internship, which can fulfill community service hours.

Are there any other perks?
We will cover your travel costs to attend in-person meetings, hook you up with free We R Native gear, and provide new opportunities and experiences you can add to your resume.

How do I apply to be a Youth Delegate?
Fill out the application that can be found at:
http://www.npaihb.org/youth-delegate/

Or text "DELEGATE" to 97779. Your application will be reviewed by a selection committee composed of NPAIHB staff and We R Native Youth Ambassadors.

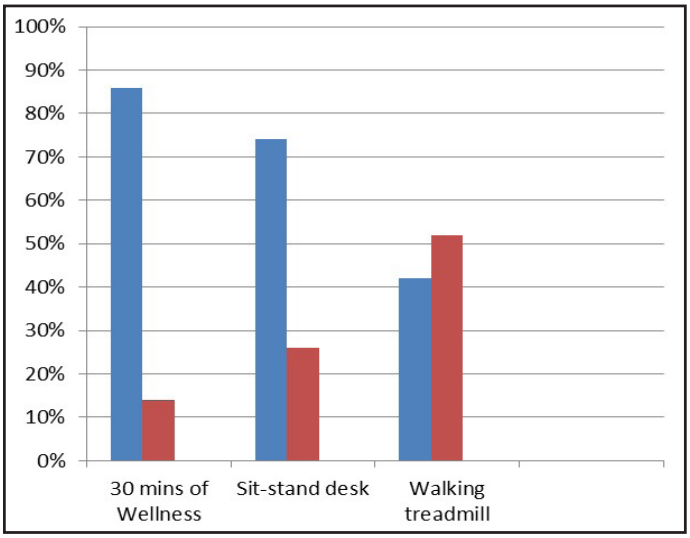
Who do I contact if I have questions?
You can contact our Youth Engagement Coordinator, Tana Atchley at tatchley@npaihb.org or (503) 416-3286.

NPAIHB Wellness Benefit

Northwest Portland Area Indian Health Board (NPAIHB) employees receive 30 minutes per day of paid Wellness time. The NPAIHB supports the goals set forth in the Healthy People 2020 with a fitness and wellness contract for each employee to use as they plan their wellness activity and time needed to complete the activity. Employees use Wellness time to participate in running, walking, lifting weights, cycling, yoga, CrossFit, and other activities. The health board supports the perspecitve wellness comes in many forms, some examples might include: hiking, chair activities, spiritual connection, as well as volunteering with local organizations such as the Oregon Food Bank. Our hope is that while the NPAIHB serves the 43 tribes of Oregon, Washington and Idaho there exists a framework within the organization that sustains and strengthens the physical, mental, emotional and spiritual health of its staff into the future.

The NPAIHB Wellness committee educates staff and supports wellness time through monthly wellness newsletters and wellness tips, opportunities throughout the year to access local wellness-minded employee stores such as Nike, Adidas and Columbia Sportswear. Additionally, there are 3-4 scheduled group workouts each week that are open to all Board employees. During the summer months there has been, on average, 5-7 people participating in these workouts, and the walking groups have included trips to the local Farmer's Market to stock up on fresh produce and healthy lunch bites. We have also acquired 5 treadmill desks, 3 of which are for all employees to use as well as a sit-stand Veridesks to add variety in the office environment. Additionally important to note is that the NPAIHB supports new families through an "Infants at Work" policy where employees may bring children up to six-months of age to work as well as housing a nursing and lactation room, which also doubles as a room to support all employees with a quiet space, as needed to support overall wellness needs.

Below are the results from our 2017 Wellness Survey:



Q1: Do you utilize the 30 minutes of wellness offered during the working day?
86% reported yes; 14% reported no.

Q2: Do you have a sit-stand desk (Veridesk)?
74% reported yes; 26% reported no.

Q3: Do you utilize the walking treadmill desks?
42% reported yes; 52% reported no.

Currently, the Board is supporting staff wellness activities by initiating our first "Spring Wellness Challenge" which began on April 2nd and will run for six weeks. Currently, we have 10 Board employees signed up to participate, and the goal is to utilize the 30 minutes of paid wellness time during the working day with a minimum goal of 90 minutes per week.

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NPAIHB Wellness Benefit

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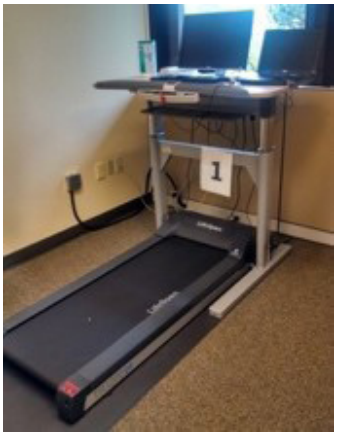
American Cancer Society: What to do if you have a "desk job" – or drive for several hours at a stretch every day? Here are helpful suggestions from our experts for adding bursts of activity to your daily routine.

- Take the stairs whenever possible.
- Exercise at lunch with colleagues or friends.
- Visit co-workers in person instead of e-mailing.
- Walk or bike when doing personal errands.
- In the office, stand up and stretch, walk or lift hand weights.
- When driving, stop every two hours for a walk or mini-workout.

We look forward to continually supporting our Northwest Tribes in Wellness as well as investing in the wellness of our staff!

"The Wellness Committee is committed to create & support opportunities for Wellness by promoting a safe & healthy workspace through a respect for ourselves & the organization."



Tribal Policy Guide:

Using a Tribal Perspective for Community-Level Policy Creation

a collaboration between WEAVE and NTCCP

Each tribal community is unique and the imbalances and needs of each community can also be very different. So, the approach to solving issues and restoring the balance must be community-driven and culturally relevant.

"I appreciate that there is a guide that teaches folks how to build policy and still be mindful for the tribal customary laws and protocols. Our communities are unique, but place a value on our traditional cultural teachings and practice that in a healthy decision making model."- Tribal reviewer

The Tribal Policy Guide was developed by the Northwest Portland Area Indian Health Board (NPAIHB) and National Indian Child Welfare Association (NICWA) to provide support to tribal leaders, employees, youth, and other community members with policy creation. The guide honors an indigenous approach by offering ideas, concepts and a tribal perspective that conveys how tribal communities may approach the policy process. NICWA's Relational Worldview Model[1] was adapted to develop a holistic and culturally informed approach that honors both culture and sovereignty. Use of this approach in policy may lead to improved health and well-being of tribal citizens and the surrounding community.

Why policy?

Policy can be defined as a plan or course of action designed to influence and determine decision making[2]. Policy can serve many purposes within a community. It can provide solutions to a problem, act as a preventative measure, inform how resources will be allocated and help create accountability.

When taking a holistic approach to developing policy you are honoring the voices of the entire

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Tribal Policy Guide:

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community, thus giving members more ownership and accountability to stand behind the policy that's being developed or updated.

What's included in the guide?

- Policy examples and templates
- Definition of policy and related terms
- Guidance on stakeholder engagement
- Definitions of various roles community members play in the process
- Checklist of policy phases: Identify Imbalance and Engage Stakeholders, Research and Planning, Writing, Implementation, and Evaluation.
- List of some potential challenges and how to address them
- Tools and resources: Environmental Scan Tool, Community Readiness Survey, and Tips on Writing Policy

Provide feedback!

Tribal community and leader feedback was important in the process of developing the guide. We continue to invite northwest tribal communities to provide feedback through a one day workshop with NPAIHB and/or NICWA staff.

Workshop includes:

- Training on policy phases and community engagement
- Ongoing technical assistance support after the workshop (including writing, evaluation, resources and templates)
- Follow-up evaluation
- Opportunity for feedback

If you are interested in this workshop please contact weave@npaihb.org .

Here in the Northwest many tribes have already done tremendous amount of work in tribal policy for their communities; ranging in tobacco, healthy foods, seatbelts and wellness in the work place. This guide can add value and help continue to move policies forward from where they currently are today

[1] Cross, Terry, (1997), Relational Worldview as an Organization Assessment and Technical Assistance Model, National Indian Child Welfare Association p.2, 4.

[2] Public Health Law Center. (2015, June). Drafting Tribal Public Health Laws and Policies. Retrieved from www.publichealthlawcenter.org: http://www.publichealthlawcenter.org/sites/default/files/resources/fs.tribal.health.policies.July2015.pdf

Workplace Policy to Support Breastfeeding Women

By Tam Lutz & Candice Jimenez
TOTS2Tweens Study

One of the most highly effective preventive measures a mother can take to protect the health of her infant and herself is to breastfeed. The World Health Organization (WHO) recommends that human infants have no other foods or liquids other than breastmilk for the first six months of their lives with breastfeeding to continue once solids are introduced for at least two years[1]. According to the National Immunization Survey, 69.8% of American Indian/Alaska Native (AI/AN) mother's initiate breastfeeding with 37.1% continuing onto at least 6 months and dropping off to only 19.4% at 12 months old[2].

However, breastfeeding is a personal decision. No mother should be made to feel guilty if she cannot or chooses not to breastfeed. But once a mother does choose to breastfeed her success rate can be greatly improved through support from her family, friends, health provider as well as her employer through their workplace policies and practices. While workplace breastfeeding policies are supportive of mothers it also important to note that breastfeeding programs may help to mitigate health care costs, lost productivity and absenteeism by reducing:

- Risk of some short and long-term health issues for women and children
- Decreasing employee absences associated with caring for a sick child
- Promoting an earlier return from maternity leave
- Increasing retention of female employees

In the United States, the Patient Protection and Affordable Care Act, enacted March 23, 2010, requires employers subject to the Fair Labor Standards Act (FLSA) – which is most employers – to provide unpaid, reasonable break time. The law states that employers must provide a "reasonable" amount of time and a

Workplace Policy to Support Breastfeeding Women

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private space other than a bathroom. They are required to provide this until the employee's baby turns one year old.

Former employee Liling Sherry and son Sam.

"Birthing the way of my Ancestors"
Artist Wakeah Jhane | www.wakeahjhane.com
Instagram @wakeahjhane

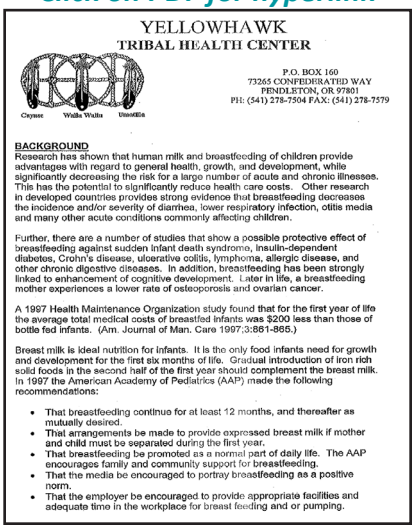
Section 4207 of the Patient Protection and Affordable Care Act (ACA), which amended Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) by adding at the end the following:

1. (r)An employer shall provide—
   (A) a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk; a
   (B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.
2. An employer shall not be required to compensate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.
3. An employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business.
4. Nothing in this subsection shall preempt a State law that provides greater protections to employees than the protections provided for under this subsection.

In Oregon State, legislation (HB 2372/SB618) was already enacted in 2005 and effective in 2008, requiring employers of 25 or more employees to provide unpaid breaks to express milk and provide private places for employees to express milk, unless doing so would cause undue hardship on business operations.
As sovereign nations, federally recognized tribes are not obligated to comply with state or federal statutes, such as those set above. However, the Prevention of Toddler Overweight and Tooth Decay Study (PTOTS) at the NPAIHB, found evidence in their qualitative data collection that workplace policy efforts may also be needed.

Focus groups conducted with Tribal mothers, fathers and elders found that breastfeeding was strongly influenced by external factors such as workplace policies and social environment and not as strongly influenced by internal factors such as perceived benefits. And while some felt breastfeeding was acceptable in the community, some mothers experienced negative reaction from community members when breastfeeding in public places such as work or school. When asked about what barriers mothers faced when trying to continue breastfeeding a key barrier was returning to work, lack of appropriate pumping location at work or school, along with lack of social support and resources in their community[3].

Click on PDF for hyperlink



YELLOWHAWK
TRIBAL HEALTH CENTER

Cayuse Walla Walla Umatilla

P.O. BOX 160
73265 CONFEDERATED WAY
PENDLETON, OR 97801
PH: (541) 278-7504 FAX: (541) 278-7579

BACKGROUND
Research has shown that human milk and breastfeeding of children provide advantages with regard to general health, growth, and development, while significantly decreasing the risk for a large number of acute and chronic illnesses. This has the potential to significantly reduce health care costs. Other research in developed countries provides strong evidence that breastfeeding decreases the incidence and/or severity of diarrhea, lower respiratory infection, otitis media and many other acute conditions commonly affecting children.

Further, there are a number of studies that show a possible protective effect of breastfeeding against sudden infant death syndrome, insulin-dependent diabetes, Crohn's disease, ulcerative colitis, lymphoma, allergic disease, and other chronic digestive diseases. In addition, breastfeeding has been strongly linked to enhancement of cognitive development. Later in life, a breastfeeding mother experiences a lower rate of osteoporosis and ovarian cancer.

A 1997 Health Maintenance Organization study found that for the first year of life the average total medical costs of breastfed infants was $200 less than those of bottle fed infants. (Am. Journal of Man. Care 1997;3:861-865.)

Breast milk is ideal nutrition for infants. It is the only food infants need for growth and development for the first six months of life. Gradual introduction of iron rich solid foods in the second half of the first year should complement the breast milk. In 1997 the American Academy of Pediatrics (AAP) made the following recommendations:

- That breastfeeding continue for at least 12 months, and thereafter as mutually desired.
- That arrangements be made to provide expressed breast milk if mother and child must be separated during the first year.
- That breastfeeding be promoted as a normal part of daily life. The AAP encourages family and community support for breastfeeding.
- That the media be encouraged to portray breastfeeding as a positive norm.
- That the employer be encouraged to provide appropriate facilities and adequate time in the workplace for breast feeding and or pumping.

At the Confederated Tribes of Umatilla Indian reservation, Yellowhawk Tribal Health Center, developed a workplace breastfeeding policy. To the right is Yellowhawks current breastfeeding policy used by Tribes. Followed by a

Workplace Policy to Support Breastfeeding Women

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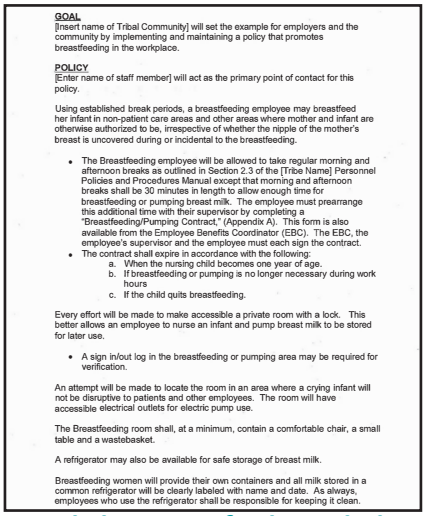

GOAL
[Insert name of Tribal Community] will set the example for employers and the community by implementing and maintaining a policy that promotes breastfeeding in the workplace.

POLICY
[Enter name of staff member] will act as the primary point of contact for this policy.

Using established break periods, a breastfeeding employee may breastfeed her infant in non-patient care areas and other areas where mother and infant are otherwise authorized to be, irrespective of whether the nipple of the mother's breast is uncovered during or incidental to the breastfeeding.

- The Breastfeeding employee will be allowed to take regular morning and afternoon breaks as outlined in Section 2.3 of the [Tribe Name] Personnel Policies and Procedures Manual except that morning and afternoon breaks shall be 30 minutes in length to allow enough time for breastfeeding or pumping breast milk. The employee must prearrange this additional time with their supervisor by completing a "Breastfeeding/Pumping Contract," (Appendix A). This form is also available from the Employee Benefits Coordinator (EBC). The EBC, the employee's supervisor and the employee must each sign the contract.
- The contract shall expire in accordance with the following:
  a. When the nursing child becomes one year of age.
  b. If breastfeeding or pumping is no longer necessary during work hours
  c. If the child quits breastfeeding.

Every effort will be made to make accessible a private room with a lock. This better allows an employee to nurse an infant and pump breast milk to be stored for later use.

- A sign in/out log in the breastfeeding or pumping area may be required for verification.

An attempt will be made to locate the room in an area where a crying infant will not be disruptive to patients and other employees. The room will have accessible electrical outlets for electric pump use.

The Breastfeeding room shall, at a minimum, contain a comfortable chair, a small table and a wastebasket.

A refrigerator may also be available for safe storage of breast milk.

Breastfeeding women will provide their own containers and all milk stored in a common refrigerator will be clearly labeled with name and date. As always, employees who use the refrigerator shall be responsible for keeping it clean.

Click on PDF for hyperlink

template for other tribes to use.

In an effort to support nursing employees and parent returning to work after the birth of their child, NPAIHB created an 'Infants at Work' policy that encourages employees to bring children up to six-months of age to work as well as housing a nursing/lactation room.

We would love to hear what other Tribes and Tribal organization are doing to support breastfeeding in their community? If you would like to share that information you can contact tlutz@npaihb.org or cjimenez@npaihb.org or call either of us at 503 228 4185.

What can employers do?

- Start and maintain high-quality lactation support programs for employees
- Provide clean places for mothers to breastfeed
- Work toward establishing paid maternity leave for employed mothers
- Adopt a workplace breastfeeding policy

What can policymakers do?

- Support the promotion of breastfeeding
- Increase funding of high-quality research on breastfeeding
- Support better tracking of breastfeeding rates as well as factors that affect breastfeeding

References

[1] "Exclusive Breastfeeding." World Health Organization, World Health Organization, 2018, www.who.int/nutrition/topics/exclusive_breastfeeding/en/.

[2] (Centers for Disease Control and Prevention. Racial and ethnic differences in breastfeeding initiation and duration, by state—National Immunization Survey, United States, 2004–2008. Morb Mortal Wkly Rep2010;59:327–334)

[3] Focus Group Summaries, Prevention of Toddler Overweight and Tooth Decay Study, 2008, NPAIHB

Act of Kindness – NPAIHB Employess Volunteer

Tam Lutz, NPAIHB Wellness Committee Member

April 3rd, sixteen NPAIHB employee volunteers participated in a NPAIHB Wellness Volunteer Activity at the Food Bank, which fittingly fell on April 3rd. Last year on April 3rd, the family of Haruka Weiser made a request to NPAIHB co-workers, friend and family to do small random Acts of Kindness on April 3rd as a tribute to their daughter and sister who was taken from the world too soon and became an angel on that day. Haruka is the daughter of IHS Medical Epidemiologist, Dr Tom Weiser. Dr. Weiser said that morning, "I'm counting this as one of those things that brings light and hope rather than darkness and fear."

Employees volunteered at two locations. Half went to the North Portland location and the other half went to the Beaverton location. In both locations, NPAIHB volunteers along with other community volunteers, repacked bulk frozen food into 2lb bags to be distributed to individuals who utilize the food bank for their meals. Volunteers doned hairnets, aprons and gloves and joined an assembly line were the food was scooped up, placed in bags, weight, sealed and boxed up for distribution. At Beaverton alone that day volunteers packed over 6,709 lbs of frozen carrots, with each volunteer creating the equivalent of 86 meals for the world today.

Maybe you will find an act of kindness to do today or tomorrow. Buy a stranger a cup of coffee. Push a grocery cart back to cart area for a harried mom. Visit with an elder. The possibilities are endless.

*"Life's most persistent and urgent question is, 'What are you doing for others?'" - **Martin Luther King, Jr.***

Indian Health Update

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report language encourages the IHS to pay contract support costs for its grant programs -- i.e., Substance Abuse and Suicide Prevention, Domestic Violence Prevention, Zero Suicide Initiative, aftercare pilots at Youth Regional Treatment Centers, and improvement of third party collection efforts.

FY 2019 Appropriations

The President released his proposed FY 2019 budget on February 12, 2018, but as of this writing the FY 2019 IHS Budget Justification book has not been published. What is available is a short description of the proposed IHS budget in the HHS "Budget in Brief" booklet. The proposal is $5.4 billion for IHS which is $100 million below the FY 2018 enacted level. Also included is the controversial proposal to change the funding for the Special Diabetes Program for Indians (SDPI) to a discretionary basis, as opposed to its current status of mandatory funding. If the funding is made discretionary the Interior Appropriations Subcommittee would have to take the $150 million the program currently receives out of its Subcommittee allocation. Also controversial is the proposal to eliminate the Community Health Representative and the Health Education programs.

The good news is that the FY 2019 IHS proposed budget would provide $150 million for addressing the opioid epidemic. Many Congressional committees, including the Senate Committee on Indian Affairs, have held hearings on the opioid crisis and there may be legislation considered to address myriad opioid issues involving several federal agencies. While legislation specific to Indian country and the opioid epidemic has not been enacted into law, the FY 2018 HHS budget provides $50 million under SAMHSA for tribes/tribal organizations to address opioid issues, a clear indication that the message has gotten across that tribes had been left out of opioid funding under the CURES Act.

Purchased/Referred Care would be funded at $955 million which is a decrease from $962 million in FY 2018. Contract Support Costs would remain as a separate account with an indefinite amount of "such sums as may be necessary".

The House Appropriations Subcommittee on Interior, Environment and Related Agencies will hold hearings May 9-10 on FY 2019 appropriations for public witnesses on Indian programs under its jurisdiction. For those tribes/tribal organizations submitting written testimony (not testifying in person) the deadline for receipt of testimony is May 18. The Senate Subcommittee on interior, Environment and Related Agencies has a deadline of April 27 for written testimony – that Subcommittee does not have a hearing for public witnesses.

Health Program Extensions

The Bipartisan Budget Act mentioned above also extended the authorization for a number of health programs. The SDPI was extended for FYs 2018 and 2019 at $150 million each year. The Children's Health Insurance Program (CHIP) was extended for an additional four years, through FY 2027, and the Community Health Centers authorization was extended for FYs 2018 ($3.8 billion) and 2019 ($4 billion).

Indian Health Legislative Outlook 2018

We are tracking two legislative efforts affecting Indian health that have seen recent movement in Congress. The first is legislation proposing solutions to address concerns about the ability of the IHS to deliver quality patient care in Indian Country. The second is a legislative effort to reform healthcare nationwide. As previously reported, attempts to completely repeal the Affordable Care Act (ACA) and cap and "block-grant" the Medicaid program were narrowly defeated last year in the Senate, but Congress did repeal the individual mandate to purchase health insurance in the tax reform bill (P.L. 115-97). This has led to a concern that insurance premiums will increase significantly in 2019. For the past several months, Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), the respective chairman and ranking member of the Senate HELP Committee, worked on a widely supported bipartisan solution to address the problem. However, the bill collapsed in heated partisan debate during deliberations for the Fiscal Year 2018 omnibus appropriations bill. It remains unclear how Congress will proceed with addressing rising insurance premiums and their inability to agree

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Indian Health Update

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on a solution indicates that comprehensive health reform legislation this year remains unlikely. Below is a more detailed discussion of these two legislative efforts.

Restoring Accountability in the Indian Health Service Act of 2017.

The first matter, specific to the Indian health system, is the "Restoring Accountability in the Indian Health Service Act of 2017," which was introduced on May 17, 2017 in both the House and the Senate (H.R. 2662 and S. 1250, respectively). On March 7, 2018, Representative Kristi Noem (R-SD), an original sponsor of the House bill, circulated a substitute amendment for the Senate version of the bill. The Senate Committee on Indian Affairs scheduled a markup of the IHS Accountability Act for March 21, 2018, but it was postponed due to weather and has not been rescheduled yet. In the House, the bill is under consideration by the House Committees on Natural Resources, Energy and Commerce, Ways and Means, and Oversight and Government Reform. The goal of the bill is to increase transparency and accountability within the IHS by providing for improved standards of care, increased congressional oversight of IHS activities, and staff recruitment and retention incentives.

Representative Noem's amendment makes edits based on significant input from tribes, tribal members, and medical experts across the country. Notably, it fixes the language of several provisions that had a problematic rule of construction. The amendment clarifies that certain requirements imposed on the IHS—in the areas of medical credentialing, liability protections for volunteers, and fiscal accountability—do not apply to tribes operating under self-determination agreements unless expressly agreed to by the tribe. Additionally, the amendment makes significant changes to personnel provisions, including changes addressing removal of personnel and adding whistleblower protections. Other changes include: removal of provisions regarding the timeliness of care; adding a section intended to correct an issue with low-volume hospital payments; and revising tribal consultation provisions.

Stabilization of Health Insurance Premiums

The second matter involves efforts by congressional leadership to enact a solution to stabilize the cost of insurance premiums in the individual insurance market. As previously reported, with the repeal of the individual mandate to purchase health insurance by the Tax Reform bill, there is concern that premiums may rise significantly if younger, healthier people decide to forego coverage. However, bipartisan efforts seem to be failing and prospects remain uncertain that a solution will be found before insurers the amount of their plan premiums for next year.

Recently, Congress failed to enact a republican-only bill, the "Bipartisan Health Care Stabilization Act of 2018," introduced during negotiations for the Fiscal Year 2018 omnibus appropriations bill. Sponsors included Senators Lamar Alexander and Susan Collins (R-ME), and Representatives Greg Walden (R-OR) and Ryan Costello (R-PA). Democrats opposed the bill because it would prohibit federal funding from being used for abortions and would codify the Department of Health and Human Services' proposed regulations for short-term insurance policies. Senator Murray's amendment, reflecting the previously supported bill, also failed.

The bills are primarily based on the negotiated "Bi-Partisan Healthcare Stabilization Act of 2017," sponsored by Senators Lamar Alexander and Patty Murray, and incorporate the "Lower Premiums through Reinsurance Act of 2017," sponsored by Senators Susan Collins and Bill Nelson (D-FL). The bills are designed to stabilize the individual insurance market and reduce increases in the cost of the premiums people have to pay in order to obtain coverage.

It is likely that new legislation will be introduced to stabilize the individual health insurance market but Congress has limited time to enact it before insurers begin finalizing rates for next year. We will continue to monitor these matters and other healthcare legislation, and keep you updated on any new developments.

Congressional Efforts to Combat the Opioid Epidemic in Indian Country

continued from page 3

differences in access, service use and outcomes for their population of focus. Of the 35 states that have federally recognized tribes, 16 states acknowledged tribes as a population of focus and/or specified actions being taken to combat opioids in tribal communities. In the Portland Area, only tribal clinics in Oregon applied to the state and received limited STR funds to combat the opioid epidemic and only the state of Washington included tribes as a high-risk population of focus for STR funds. The Oregon Health Authority has made $278,700 available to the nine Oregon tribes and the urban Indian health program for Year 1 of the STR grant money to be used for prevention and treatment activities. NPAIHB strongly recommended that Congress create direct funding sources for tribes to overcome the major resource barrier for tribal law enforcement, healthcare facilities, and social services programs. Direct funding will ensure that tribes receive adequate financial resources to combat the opioid epidemic through culturally responsive programs and the ability to integrate comprehensive behavioral healthcare into primary care. Additionally, the Board recommended that the Committee support, through legislation, tribal-specific approaches to treatment to effectively meet the healthcare needs of AI/ANs.

The Committee stated recognition of the need for Congress to appropriate direct funding to tribes in order combat the opioid epidemic. The FY 2018 Omnibus spending bill (H.R. 1625) includes $4 billion allotted to the Department of Health and Human Services (HHS), Department of Homeland Security (DHS), the Department of Justice (DOJ), and the Department of Veterans Affairs (VA) for prevention, treatment and law enforcement efforts to the opioid epidemic. The Omnibus contains a $50 million set-aside for tribes and tribal organizations out of $1 billion dispersed to HHS for prevention and treatment of opioid abuse under the SAMHSA STR grant funding. The FY 2018 appropriations also include $5 million specifically for tribes under the Medication-Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction program.

NPAIHB advocated for supporting pending legislation with direct benefits to tribes in the testimony. The Board is in support of the Mitigating Methamphetamine Epidemic and Promoting Tribal Health Act (METH Act) (S. 2270). This legislation would make tribes eligible for direct funding under the 21st Century Cures Act and would also allow for the funds to be used for prevention and response to other substances, such as methamphetamine. The Board is also in support of the Tribal Addiction Recovery Act of 2018 (TARA Act) (H.R. 5140). This bill also makes tribes and tribal organizations eligible for direct funding under the 21st Century Cures Act and extends the use of funds to address other addictive substances such as alcohol, heroin and methamphetamine, as well as providing mental health services.

In relation to the privacy of substance abuse treatment records, NPAIHB stressed that 42 CFR Part 2 is a barrier to coordinated medical care and prevents tribal primary care and mental healthcare providers from accessing patient records from dependency providers. The Board also expressed support for the Overdose Prevention and Patient Safety (OPPS) Act (H.R. 3545), which allows access by physicians to patients' full medical records with HIPAA safeguards.

Congratulations!

Congrats to David Stephens!
Employee of the Year 2017!

Save the Dates

Click on PDF for hyperlink

Native HOPE
3-Day Training Conference

2018
JUNE 4th-6th
8:30-4:00 PM
DOI Training Center
1011 Indian School Rd. NW - Bld #2
Rooms 270 & 271
Albuquerque, NM 87104

Training Themes:

Native HOPE is a culture and resilience based program endorsed by Tribal Leaders, state and federal agencies as an effective prevention model. The topics include suicide prevention, and the related risk factors, substance abuse, violence prevention, coping with stress-trauma and depression. The training includes strengthening facilitation and group process skills.

Who Should Attend:

Prevention Specialists, Domestic Violence Advocates, Social Workers, Mental Health Professionals, Substance Abuse Counselors, MSPI-DVPI workers, school-youth workers, Tribal Leaders, and Community Members.

2 CEU's have been requested through the University of New Mexico - Continuing Education

Hotel: **Holiday Inn Express** 2300 12th Street NW • Albuquerque, NM 87104
Phone: **505-842-5000** Single/Double **$102** *includes breakfast, plus tax.*
mention rate code: **Native Pride**

Registration: www.nativeprideus.org
Contact: Maha Small, PhD—505-897-7968 or Clayton Small, PhD—505-321-2808
Cost: $200/per person includes a copy of the Native HOPE curriculum
Pre-registration deadline: **May 18th 2018** • Late registration is $250.00
If participants are unable to attend, refunds will not be available after May 28, 2018

NATIVE PRIDE

Benefits: An awesome opportunity to address personal wellness and strengthen your training skills regarding suicide prevention and related risk factors as you enjoy charming Albuquerque. Please join us!

The Native CARS Atlas shares the successes the Native CARS Study had with six northwest Tribes. The Atlas course materials include downloadable media materials, data collection protocols, suggestions for community engagement, step-by-step plans for building your awareness campaign, strategies for measuring car seat use, and methods for evaluating outcomes in your community.

THE ATLAS OFFERS THE FOLLOWING COURSE MODULES.

- **Module 1** Build and Organize Your Coalition
- **Module 2** Check Your Community's Readiness
- **Module 3** Find Data to Support Your Campaign
- **Module 4** Collect Your Own Child Passenger Safety Data
- **Module 5** Use Qualitative Methods to Understand How Beliefs and Culture Shape Desicions
- **Module 6** Make Data-Driven Plans to Improve Car Seat Use
- **Module 7** Create a Data-Driven Awareness Campaing
- **Module 8** Provide Child Passenger Restraint Education
- **Module 9** Got Seats? Child Safety Seat Distribution Programs
- **Module 10** Develop an Electronic Health Record System Alert for a Tribal Clinic or Hospital
- **Module 11** Develop Policy and Law Enforcement Interventions

For more information visit us at nativecars.org

Save the Date
June 5th & 6th, 2018

Wellness is Life is Culture is Prevention is Treatment

Please Join us for the
Oregon Tribal Summit on Opioids & other Drugs

Hosted by the
Confederated Tribes of Warm Springs
at Kah-Nee-Ta Resort, 6823 Oregon 8, Warm Springs, OR 97761

In parternship with
lines for life
Oregon Health Authority

Artwork by Tanya Blackhorse

For more information contact, Asa Wright at 971.247.9072 or asaw@linesforlife.org

Registration Open!
8th Annual THRIVE Conference
June 25-29, 2018

WHO: For American Indian and Alaska Native Youth 13-19 years old
- 1 Chaperone for every 4 youth attending. **Background checks are required for all adults facilitating or attending who did not attend in 2017.
- Activities, materials, lunch and snacks Mon-Thurs. will be provided.
- Travel, parking, lodging, breakfast and dinners are not included.

WHERE: Native American Youth & Family Center (NAYA)
5135 NE Columbia Blvd., Portland, OR

Register at:
https://www.surveymonkey.com/r/2018THRIVE

LODGING: Howard Johnson Portland Airport, 8247 NE Sandy Blvd, Portland, OR 97220
Call 503-256-4111 for group rate under "THRIVE" at $89/night + tax dbl occupancy, $99 for four
*A hot breakfast, airport shuttle, parking, and free wifi is included.

WHY: Build protective factors and increase your skills and self-esteem, connect with other young Natives, learn about healthy behaviors (suicide prevention, healthy relationships, etc.) and how to strengthen your nation through culture, prevention, connections, and empowerment!

WHAT: This conference will be made up of FIVE workshop tracks and at registration each youth will need to rank their preference for which workshop they want to be in. Tracks include: Gen-I Bootcamp (stop motion film w/ special guest), Beats Lyrics Leaders (song writing and production), We Are Native youth Ambassadors (youth leadership), science and medical track sponsored by the Oregon Health and Science University, and the **NEW** track - Native Fitness and Traditional Foods (physical fitness and nutrition).

#WeNeedYouthere

Contact Information:
Northwest Portland Area Indian Health Board's project THRIVE
Celena McGray, project coordinator
Ph: 503-228-4185 x 270
Email: cmcgray@npaihb.org
Website: http://www.npaihb.org/epicenter/project/thrive

THRIVE

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SUMMER RESEARCH TRAINING INSTITUTE 2018
For American Indian & Alaska Native Health Professionals

Save the Dates
June 11-29, 2018

Location
Northwest Portland Area Indian Health Board
Portland, Oregon

Sponsored by
Northwest Portland Area Indian Health Board, Native American Research Centers for Health, Oregon Health & Science University - Center for Healthy Communities, & Indian Health Service.

For more information
Visit: www.npaihb.org/training/narch_training
Email: summerinstitute@npaihb.org

Upcoming Events

Click on date for hyperlink

APRIL

April 22-26
Tribal Self-Governance Annual Conference
Albuquerque, NM

April 23-26
Hands on Health Conference
Loleta, CA

April 24-25
NW Tribal Cancer Coalition Meeting & NW Tribal Clinical Update
Tigard, OR

April 25-26
NW Tribal Energy Efficiency & Conservation Conference
Suquamish, WA

April 27-28
2018 Contemporary NW Tribal Health Conference
Portland, OR

April 30-1
IHS Direct Service Tribes Adivisory Committee Quarterly Meeting
Albuquerque, NM

MAY

May 2-3
Health Data Literacy & Applications for Tribal Health Workshop
Anacortes, WA

May 7-11
Tribal Forensic Healthcare: Sexual Assault Examiner training
Portland, OR

May 16-18
2018 Tribal Emergency Preparedness Training & Conference
Suquamish, WA

May 17-18
IHS/Tribal Indian Health Care Improcvemtne Fund Workgroup Meeting
Denver, CO

May 21-24
ATNI Midyear Convention
Toppenish, WA

May 21-25
Alaska Tribal Health Conpact Final Negotiations
Anchorage, AK

May 22-23
NW Tribal Tobacco Prevention Conference
Suquamish, WA

May 23
Idaho Tribes/Idaho Medicaid Quarterly Meeting
Plummer, ID

May 22-24
NIHB 2018 National tribal Public Health Summit
Prior Lake, MN

Upcoming Events

Click on date for hyperlink

JUNE

June 3-6
NCAI 2018 Mid Year Conference & Marketplace
Kansas City, MO

June 4-6
Native HOPE Training Conference
Albuquerque, NM

June 5-7
Diabetes Management System (DMS) Training - WTDP
Portland, OR

June 5-6
Oregon Tribal Summit on Opioids & other Drugs
Warm Springs, OR

June 11-29
Summer Research Training Institute
Portland, OR

June 26-28
2018 NCUIH Annual Leadership Conference
Arlington, VA

June 25-29
8th Annual THRIVE Conference
Portland, OR

June 26-28
13th Women Are Sacred Conference
Scottsdale, AZ

JULY

July 11-12
IHS Direct Service Tribes National Meeting
Minneapolis, MN

July 18-19
Tribal Self-Governance Advisory Committe
Washington, DC

July 26-29
47th Annual Meeting & Health Conference
Scottsdale, AZ

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

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

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JANUARY 2018 RESOLUTIONS

RESOLUTION #18-02-01
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RESOLUTION #18-03-01
Medication Access_Federal