Health News & Notes

Our Mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality health care.

January 2013

A Publication of the Northwest Portland Area Indian Health Board

WILL THERE BE MENTAL HEALTH PARITY?

Jim Roberts, NPAIHB Policy Analyst

Beginning in 1996, Congress began to enact several laws that were designed at improving access to mental health and substance abuse services. These laws aimed at addressing parity issues in the lack of available behavioral health services compared to medical care services in health insurance plans.

The Mental Health Parity Act of 1996 (MHPA; Pub. Law 104-204) addressed aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits offered by group health plans. Shortly following passage of the MHPA, the Balanced Budget Act of 1997 (BBA, Pub. Law 105-33) added sections 1932(b)(8) and 2103(f)(2) of the Act to apply certain aspects of MHPA to Medicaid managed care organizations (MCOs) and CHIP benefits.

More recently, Senators Paul Wellstone and Pete Domenici introduced, and Congress passed, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA; Pub. Law 110-343). This law establishes requirements to make insurance coverage of mental health conditions and substance use disorders comparable to coverage of other medical conditions. This law prohibits some insurance plans from charging higher deductibles or co-payments or limiting the number or frequency of provider visits for mental health or substance use disorder treatment unless – and to the same extent that – those limitations are also imposed on medical/surgical benefits. This critical mental health services law was extended by the Affordable Care Act of 2010 (ACA; Pub. 111-148). As a result, coverage of mental health conditions and substance use disorders should become mandatory for most insurance providers by 2014.

The new health reform law extends the MHPAEA to require that behavioral health benefits be provided at parity with medical service benefits. Specifically, the ACA mandates that all qualified health plans provide an "essential health benefits" package, which must include mental health and substance use disorder services. The ACA requires that a health insurance issuer that offers health insurance coverage in the individual or small group market provide an essential health benefits package. The ACA further prohibits insurance plans from refusing to cover people with a history of mental illness or substance abuse, or from charging higher premiums based on having such a history. Beginning on January

continued on page 4

OUR MENTAL HEALTH ISSUE CONTAINS:

Northwest Portland Area Indian Health Board

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NPAIHB CHAIR REPORT

Andy Joseph, JR., NPAIHB Chair

I am pleased that this edition of our newsletter is focusing on behavioral health issues. These issues are very important to all Tribal leaders. We are especially concerned for those warriors who are returning from Afghanistan and Iraq. Caring for our Indian veterans—not just physically—but for their emotional and spiritual well-being is very important. Given the fiscal climate this need will be harder to meet and I hope we can do more to help our veterans. I also hope the articles in this edition are helpful to you all in caring for our Indian people.

Over last year the Board joined with Tribes nationally to help develop the IHS-VA memorandum of agreement for reimbursing services provided to eligible Indian veterans in IHS and Tribal health facilities. This was not an easy task to get done and has taken almost four years since the enactment of the Indian Health Care Improvement Act. The Act included this requirement for IHS and VA to develop a reimbursement process to assist veterans to get care at IHS facilities. During the NIHB's Annual Conference, I attended a VA listening session and met with the HHS Office of Inspector General to discuss this agreement. I am glad that many of the Board's recommendations were adopted in the final agreement. It's been a difficult issue to work on, but I am pleased to report that we now have an agreement that Tribes can live with.

This last quarter had me attending the National Congress of American Indians (NCAI) annual conference held in Sacramento, California. There were many key sessions that I attended and participated. The most important item was a meeting that the Board worked with NCAI to set up with Jodi Gillette from the Whitehouse. The purpose of this meeting was to address the Indian definition issues in the Affordable Care Act and how this would affect our families. I feel we made good progress on this and it resulted in another meeting the following month at the Whitehouse. While the Administration has indicated that they will issue new rules to address this issue we have made good progress and will continue to work hard on this item.

Last December, we also conducted the Portland Area FY 2015 Budget Formulation meeting in Seattle, Washington. The meeting was well attended with over 50 people in attendance. Past year's meetings only saw 10-15 people attend and I was glad to see the good turnout. Our overall

continued on page 13

INFLUENZA ACTIVITY WIDESPREAD!

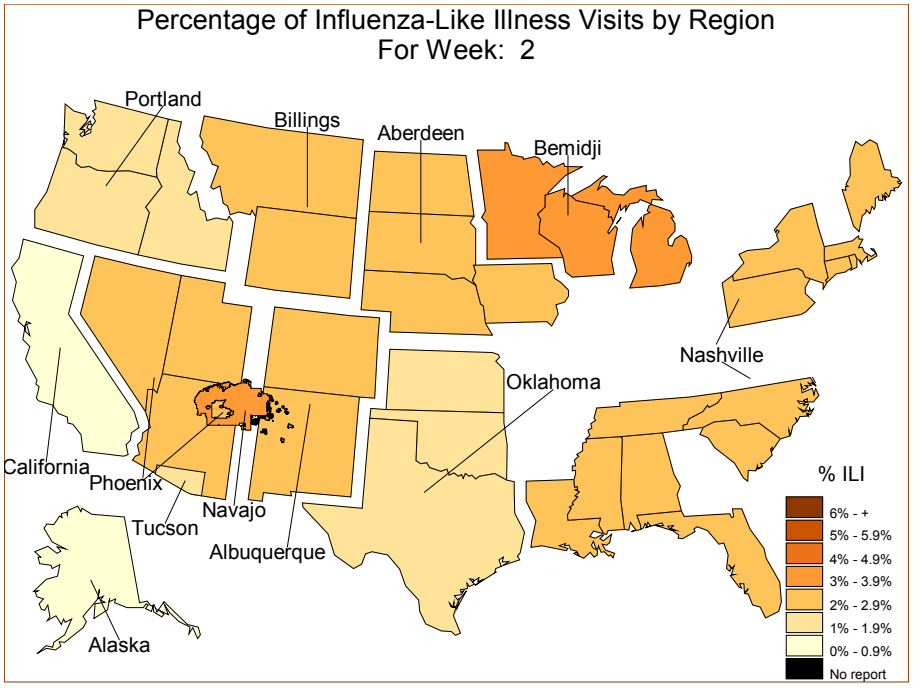
The Centers for Disease Control and Prevention (CDC) reported on 1/10 that seasonal influenza activity had become widespread in 47 states including the Pacific Northwest, and making this one of the earliest flu seasons in the last decade.

To learn more about the flu and what you can do to prevent influenza and keep your community healthy, visit these websites:

www.flu.gov
www.cdc.gov/flu
www.ihs.gov/Flu

Surveillance

The CDC, State Health Departments and IHS all have influenza surveillance systems in place, and each system is measuring flu activity in different ways. This information helps public health officials track the spread of influenza across the US. The Indian Health Service has maintained a robust Influenza-like Illness Awareness System (IIAS) since 2009 and posts weekly reports at: www.ihs.gov/Flu. Currently, 27 sites from the Portland Area contribute data to this system. In addition to tracking the number and percentage of patients seen with influenza-like illness, the IIAS also collects information on immunization coverage, giving the best ongoing estimate of flu vaccination coverage available.



continued on page 11

Northwest Portland Area Indian Health Board

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Northwest Tribal Epidemiology Center
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Amanda Gaston, IYG Project Coordinator
Birdie Wermy, Comprehensive Cancer Tribal BRFSS Director
Bridget Canniff, TECC, TEC Evaluation Project Director
Clarice Charging, IRB & Immunization Project
Colbie Caughlan, Suicide Prevention Coordinator
David Stephens, Multimedia Project Specialist
Don Head, WTD Project Specialist
Elizabeth Viles, WTD Project Assistant
Eric Vinson, Cancer Project Coordinator
Erik Kakuska, IDEA-NW Project Coordinator
Jenine Dankovchik, Biostatistician IDEA-NW
Jessica Leston, Multimedia Project Coordinator
Jodi Lapidus, Native CARS P.I.
Erik Kakuska,, WTD & Epi Project Specialist
Kerri Lopez, Western Tribal Diabetes Director
Kristyn Bigback, IDEA-NW Project Support
Linda Frizzell, Nak Nu Wit P.I.
Luella Azule, Injury Prevention Coordinator
Nancy Bennett, EpiCenter Biostatistican
Vacant, IDEA-NW/Tribal Registry Director
Nicole Smith, Biostatistician
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Stephanie Craig Rushing, PRT, MSPI, Project Director
Suzanne Zane, MCH Epidemiologist
Tam Lutz, PTOTS, Native CARS Director
Ticey Casey, Project Manager
Tom Becker, Medical Epidemiologist
Tom Weiser, Medical Epidemiologist
Wendee Gardner, VOICES Project Coordinator

Northwest Projects
Rachel Ford, Public Health Improvement Manager
Carrie Sampson, Preventing Sexual Assault Project Coordinator

WILL THERE BE MENTAL HEALTH PARITY?

Continued from page 1

1, 2014, all plans available in the new health insurance exchanges are required to comply with the MHPAEA. In addition, all Federal Employee Health Benefits Plans, all state employee health plans, and health maintenance organizations will be subject to these requirements.

On its face these laws and requirements would give you the impression that mental health parity will be achieved and that such services will be offered on an equal basis as medical care services. However, full implementation of these laws has not gotten much traction in the insurance markets nor in Medicaid program. Many behavioral health advocates have been extremely critical of the Obama Administration because of the endless work to implement other aspects of the ACA and focus on promulgating regulations associated with establishing the health insurance exchanges. As a consequence key details about the MHPAEA have been missing. "It's been our understanding that they've just been so bogged down with ACA rules coming out that it's been delayed," said Sarah Steverman, director of state policy for Mental Health America.

The Administration has also been criticized for the method in which it determined essential health benefits (ESB) for mental health and substance use disorder services. To develop the ESB services, The NIH Institute of Medicine (IOM) surveyed a number of "typical employer plans" based on the coverage provided by small employers (currently defined as up to 50 or 100 employees). This resulted in a health benefit package supposedly based on the national average premium cost for a typical small employer plan. The challenge of this methodology is the limitation that insurance plans put on health benefits due to costs. Although IOM may have found that the small group products and State and Federal employee plans cover similar services within most of the ten categories of EHB, coverage in some of the statutory EHB categories is limited, including behavioral health treatment, and habilitative services.

An examination of benefits covered in employer-sponsored insurance in the small group market and State and Federal employee plans found that behavioral health treatment (separate from mental health and substance abuse services) was not frequently mentioned in plan booklets. [1] This concludes that the level of behavioral services varies widely and using employer sponsored plans to develop a baseline for essential health benefits is not the most effective manner to develop a benefit structure.

Another concern is how health plans select benchmarks compared with other plans on the basis of patient satisfaction, measures of quality of care, and covered services (e.g. mental health, substance abuse, behavioral health)? The concern is that small businesses may be selecting the least expensive plan without regard to quality of care and comprehensiveness of services, and that plan may not be the best basis for improving health in our country. Thus, if current small group plans are used to develop a baseline for EHBs than they most likely disregard any parity for mental health.

On January 16, 2013, the Administration finally announced, along with a national response to the Sandy Hook tragedy, guidance on the requirements under the MHPAEA for Medicaid managed care organizations, the Children's Health Insurance Program (CHIP), and alternative benefit (benchmark) plans. This is welcome news for mental health advocates who believe these guidelines should have been issued long ago. A summary of some of these requirements include:

- Financial requirements applied to mental health or substance use disorder benefits may not be more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits.
- There are no separate cost-sharing requirements that apply only to mental health or substance use disorder benefits.

1. Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans. ASPE Research Brief, Office of the Assistant Secretary for Planning and Evaluation, Office of Health of Health Policy, U.S. Department of Health and Human Services, December, 2011.

WILL THERE BE MENTAL HEALTH PARITY?

- Treatment limitations applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- The criteria for medical necessity determinations for mental health or substance use disorder benefits are made available to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits is made available within a reasonable timeframe to participants and beneficiaries upon request.
- If a plan or coverage provides out-of-network coverage for medical/surgical benefits, it must provide out-of-network coverage for mental health or substance use disorder benefits.

As you can see, the jury is still out on whether there will be true mental health parity under the Affordable Care Act. Because individuals with mental health disorders are more likely to be uninsured, they will disproportionately benefit from the ACA's coverage expansions. One estimate suggests that these insurance expansions will result in an additional 1.2 million new mental health service users.[2] However, it remains unclear how all this will unfold and what mental health services will be covered by qualified health plans in the insurance exchanges. Many are awaiting the selection of exchange qualified health plans and how the requirements for EHB mental health services will be carried out.

2 Garfield RL; Zuvekas SH; Lave JR; Donohue JM: The impact of national health care reform on adults with severe mental disorders. Am J Psychiatry 2011; 168:486–494

AFFORDABLE CARE ACTS MENTAL HEALTH HIGHLIGHTS

In general. The *Patient Protection and Affordable Care Act* offers significant opportunities to begin to ameliorate the impact of mental illness and drug abuse (here after referred to as "Behavioral Health" as a summary term) upon the lives of American Indians and Alaska Natives (AI/AN). Behavioral health issues have been profoundly underestimated and culturally undefined in the AI/AN population. Most troubling is the fact that much of the personal and societal burden of behavioral health conditions and issues could be prevented or alleviated if people at-risk for experiencing these conditions had access to and received appropriate prevention and treatment care and services.

AI/ANs face significant access barriers for effective behavioral health prevention and treatment care and services. Access to and the availability of behavioral health professionals, such as psychiatrists, psychologists, drug counselors, and social workers are seriously lacking. Poverty, geographic location, and cultural differences further limit the amount and quality of services available. Research confirms that limited insurance coverage, scarce availability of services, excessive travel distances, weather hazards, increased personal monetary costs, and stigma related to behavioral health needs additionally contribute to poor access. Finally, for those who do receive treatment, many find that the care provided is not intensive enough, not long enough, and/or lacking in important follow-up health and social services.

Much work needs to be done to better understand the breath and scope of behavioral health issues affecting Indian Country. This legislation has the potential to begin to develop much needed services that are driven by the stakeholders.

continued on page 7

NORTHWEST TRIBAL FETAL ALCOHOL SPECTRUM DISORDER

By Jacqueline Left Hand Bull, FASD Project Director

If you have ever wondered how you could best assist a loved one who is affected, directly or indirectly, by a Fetal Alcohol Spectrum Disorder (FASD), the Northwest Tribal FASD Project may be of particular interest to you. It is well known that FASD is entirely preventable. The Project continues to gather information as the spectrum of disorders is better understood, and it actively works with tribal communities to learn and develop prevention education opportunities and accommodation strategies, sharing their learning, and materials on the NPAIHB website project page. The project has three primary areas of endeavor: prevention education, intervention action and referral, and training and technical assistance to American Indian community service providers toward development of informed tribal community programs and family practices that serve those with FASD. To carry out these endeavors, the NPAIHB contracts with two FASD specialists, Carolyn Hartness and Suzie Kuerschner, and with the University of Washington's Fetal Alcohol and Drug Unit (FADU).

Both of the FASD Specialists are seasoned grass roots trainers who are deeply committed to assisting tribal communities to succeed in preventing FASD, and to develop community based responses that use existing resources to accommodate those who have been directly affected by exposure to alcohol in utero. Their efforts focus on education of key personnel in the community to develop appropriate prevention education, provide interventions as needed, and accommodate considerations for those community members that live with FASD. The Specialists also are in continual collaboration with the U of W FADU regarding education, intervention and diagnosis advances, and participate in training provided by FADU. Although the FASD Specialists work intensively with only a few tribal communities, materials used are freely shared and the Specialists are available to all NPAIHB member tribes for technical assistance and staff training.

The NPAIHB contract with the U of W FADU supports services of the Parent-Child Assistance Program (PCAP) that includes working with high-risk, substance-abusing pregnant and parenting women in several tribal communities in Washington State. PCAP case managers work intensively with the women, providing assistance directly through home visits. The Unit also works with a local network of community service providers to connect clients with an array of services and to assure that clients actually receive services intended, including diagnosis as appropriate. Many of the PCAP staff are American Indian/Alaska Native (AI/AN). Reports indicate that the intervention outcomes of AI/AN "graduates" of PCAP are similar to those among non AI/AN clients.

In addition to prevention of sustained alcohol exposure before birth due to pregnant women using alcohol and other drugs, development of strategies to improve the outcome of addiction treatment and the acquisition of crucial life skills for those mothers in PCAP who also have or are suspected of having FASD is ongoing. All PCAP advocates receive extensive training on FASD as well as on effective interventions and communication approaches that can result in improved life outcomes for the mothers. FADU also has provided training directly upon request of tribal communities on issues such as the effects of poly-drug exposure on the unborn baby; medical management of the exposed newborn; early interventions with exposed babies and children and adolescents; early diagnosis and mental health issues and treatment of babies, children, and adolescents; and interventions with mothers with addiction problems to prevent future exposed pregnancies.

continued on page 7

NORTHWEST TRIBAL FETAL ALCOHOL SPECTRUM DISORDER

Continued from page 6

Highlights for the Northwest Tribal FASD Project in 2012 include:

- The Project presented a participatory workshop on forming community-based diagnostic teams at the national HHS Behavioral Health Conference in Minneapolis in June
- The American Bar Association unanimously passed a resolution regarding consideration of FASD in legal matters, after intense educational and shepherding efforts of FADU's Kay Kelly
- PCAP was named a Best Practice by AMCHP (Association of Maternal and Child Health Programs)
- The FASD Specialists and FADU collaborated on a full-house, three-day training for Northwest tribal representatives and health care providers; the agenda included a broad range of considerations

The FASD Specialists (Carolyn Hartness and Suzie Kuerschner) sit on SAMHSA's FASD Expert/Native Expert Panels. FADU and the FASD Specialists were asked to present on aspects of FASD at conferences, and regularly interact with Canadian First Nations efforts. Independent of the Project, this past year Carolyn also spent three months providing training and TA relative to FASD for an aboriginal community in Australia.

New activity scheduled for 2013:

- FADU will provide quarterly webinars, using the Indian Health Service webinar network, available to NPAIHB member tribes
- The Project key personnel will participate in quarterly conference calls with IHS PAO Behavioral Health Specialist and IHS HQ Program officers.

AFFORDABLE CARE ACTS MENTAL HEALTH HIGHLIGHTS

Continued from page 5

The *Patient Protection and Affordable Care Act* has specific language for government to government relations, tribes, tribal organizations, urban Indian programs, and the Indian Health Service. Additionally, there are public sector sections that would be available, often working with a state, but also directly with federal departments. Please find the following selected listings extracted out of the *Act* that relates to behavioral health.

Details for each Section can be obtained by contacting Dr. Linda Bane Frizzell, Ph.D. lfrizzell@npaihb.org

THE BOARD'S HOLIDAY PARTY

Holiday Feast

Candice Brings Plenty and family

Stephanie and Finley Craig-Rushing, Bishop & Lisa Griggs

Shawna Gavin and brother Michael Ray

Colbie and Sidney Caughlan

THE BOARD'S HOLIDAY PARTY

Rowan and Jo Lutz and baby Sidney

Tanya Firemoon and Chris

Bobby Puffin, baby Amlie and mom Megan Hoopes and Luella Azule

Victoria Warren-Mears and Bridget Canniff

Aunt Berta and Brenda Nielson

GOOD NUTRITION IN 2013: CONSUMER TRENDS

Unfortunately, in the United States, many individuals are overweight or obese. We live in a food environment where foods are "up-sized" or "super-sized" from traditional portion sizes. Over time our minds are retrained to think these large sizes are "average".

So what do consumers say that they are doing? How does this compare to what you, your family or your community is doing?

Are you doing all you can do to achieve a healthy diet? The Academy of Nutrition and Dietetics has conducted surveys since 1991, respondents have been asked: "Are you doing all you can to achieve balanced nutrition and a healthy diet?" The percentage who said yes has remained relatively constant at just under half since 2002.

People who report that they are making dietary changes are more likely to fit the following profile:

- Be female
- More likely to obtain nutrition information from magazines
- Most likely to say nutrition is "very important" to them personally
- Most likely to live in a household where a person is on a diet for medical reasons

People who "know they should change" fit the following profile:

- Be between the ages of 35 to 54
- Want more practical tips to eat better
- Be more likely to use organic foods and products
- Be more likely to use the Internet for nutrition information

Do you fall into one of these groups or are you more likely to fall into the "don't bother me group?"

Women are much more likely than men to believe diet and nutrition are important to them personally – though men have closed the gap in recent years, according to the Academy of Nutrition and Dietetics' Nutrition and You: Trends survey.

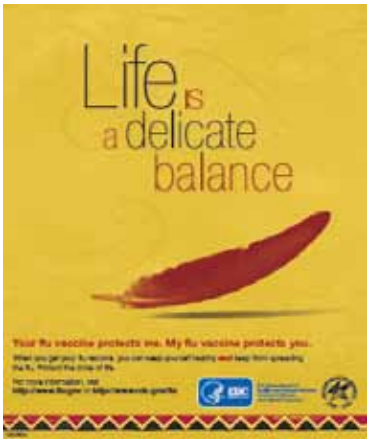
Meanwhile, long-term trend data show many Americans "got the message" about the importance of diet during the decade of the 2000s, and the message has stuck.

This is good news. We have work ahead, in light of increases in overweight and obesity.

INFLUENZA ACTIVITY WIDESPREAD!

Continued from page 3

Preventing Influenza Vaccination



Vaccination is the most effective way to prevent influenza. Each year, influenza vaccine is produced based on the expected influenza strains. For the 2012-2013 influenza season, the vaccine protects against 99% of the influenza A strains identified and 67% of the influenza B strains identified so far. The overall efficacy to prevent influenza infection is estimated to be 62%. The vaccine may be less effective for those who are very young (under 2 years of age), the elderly (over 65 years of age) and those with weakened immune systems because of other medical conditions, including Diabetes. Many of these same groups are also at increased risk to have severe illness or complications from the flu, including hospitalization and death. For this reason, it is important that family members who live with those at high risk of getting the flu receive the influenza vaccine.

Clinics usually place their orders for the following year's flu vaccine in February and base their orders on past experience and cost. American Indian/Alaska Native children are all eligible for free influenza vaccine through the CDC Vaccines for Children (VFC) program which is administered by State health departments. Adult vaccines are purchased by the clinic, the costs of which can be reimbursed by billing private insurance, Medicare or Medicaid. Providing flu vaccine for free to clinic employees is a recognized best practice to help vaccinate Health Care Personnel.

Community-based, mass vaccination clinics, including school-based vaccination campaigns and drive-through vaccination campaigns have been very successful in Portland Area communities. For example, At the Chemawa BIE School near Salem, OR, public health and clinic staff from the Western Oregon Service Unit have vaccinated 92% of the student population. Increasing these efforts in other communities will be an important part of future influenza plans in the Portland Area.

Other measures to prevent the spread of influenza:

Symptoms of the flu

People who have the flu often feel some or all of these signs and symptoms:

- Fever* or feeling feverish/chills
- Cough
- Sore throat
- Runny or stuffy nose
- Muscle or body aches
- Headaches
- Fatigue (very tired)
- Some people may have vomiting and diarrhea, though this is more common in children than adults.

- **Practice good hand hygiene**: wash your hands using soap and water, rubbing the soap in for at least 30 seconds (try singing Happy Birthday twice while you do this!);
- **Cover your cough**: cough into your sleeve or use a tissue or handkerchief to avoid spreading influenza virus to others when you cough or sneeze;
- **Stay home if you are ill**: don't go to school or work if you develop symptoms of the flu. Stay home, rest and drink plenty of fluids.

continued on page 15

PUBLIC HEALTH IMPROVEMENT PROGRAM: YEAR 2 GOALS ACHIEVED!

By Rachel Ford, MPH
Public Health Improvement Manager

Public Health Improvement Program Overview

The Northwest Portland Area Indian Health Board (NPAIHB) was one of 8 tribal grantees chosen to participate in the Centers for Disease Control and Prevention's National Public Health Improvement Initiative (NPHII) efforts. The aim of the NPHII grant is to systematically increase performance management capacity and improve the ability to meet national public health standards. NPAIHB's Public Health Improvement program is meeting the goals of the NPHII grant by facilitating education and technical support to increase the organizational capacity and Quality Improvement (QI) efforts of its 43 member tribes, as well as promoting the integration of a "QI culture" and linking QI with public health accreditation of tribally-based health departments.

Public Health Improvement Program Year 2 Goal: Series of 3 Public Health Accreditation Trainings

The primary goal for Year 2 of the Public Health Improvement program was to bring a series of 3 public health accreditation trainings to the tribes. The trainings were chosen based upon data collected from a Public Health Improvement survey conducted in Year 1 of the program. Training and travel costs were covered for all tribal participants. 24/43 tribes participated in one or more of the trainings. The 3 trainings offered were:

1. Tribal Public Health Accreditation 101
2. Tribal Public Health Accreditation Readiness and Self-Assessment
3. Tribal Public Health Accreditation Prerequisites

Tribal Public Health Accreditation 101

The first training of the series, Tribal Public Health Accreditation 101, was held February 9, 2012 and April 6, 2012. Tribal Health Directors, Clinic Managers, Health Board Delegates, Public Health Nurses, and other persons involved in public health leadership and delivery were all encouraged to attend. There were 33 participants at the February training and 11 at the April training.

Participants learned about the new national voluntary public health accreditation and what it means for tribes. They were given an overview of the accreditation process, including costs, benefits, opportunities, and recommendations and considerations for application.

Tribal Public Health Accreditation Readiness and Self-Assessment

The second training in the series, Tribal Public Health Accreditation Readiness and Self-Assessment, was conducted June 6 and 7, 2012. There were 25 people in attendance.

Training participants learned about the public health accreditation process and preparation, as well as the 3 prerequisites. They became familiarized with the Public Health Accreditation Board domains, standards and measures, and learned how to use the Accreditation Readiness Self-Assessment Tool.

Tribal Public Health Accreditation Prerequisites

The third training in the series, Tribal Public Health Accreditation Prerequisites, was conducted September 18, 2012. There were 13 participants in attendance.

Training participants learned about the elements, scope, process, and outcomes of the 3 accreditation prerequisites: Community Health Assessment, Community Health Improvement Plan and Department Strategic Plan. They also learned implementation strategies for their communities.

Year 3 Training Opportunities

For Year 3, there will be 4 trainings: QI Basics will be

continued on page 13

PUBLIC HEALTH IMPROVEMENT PROGRAM...

Continued from page 12

taught by Marni Mason, Cherokee Nation: Best Practices will be taught by Laura Sawney-Spencer, and two additional Public Health Accreditation trainings. Emails will be sent to all Tribal Health Director, Delegates, prior training participants, and also posted in the Weekly Mailout and on the NPAIHB website.

Questions? Please contact Rachel Ford at 503-416-3282 or rford@npaihb.org.

NPAIHB CHAIR REPORT

continued on page 2

recommended increase for the IHS budget was to add 17% to the overall program. As in past years, our number one recommendation was to fund current services followed by additional funding of $200 million for the Contract Health Service program. In February, Steve Kutz (Cowlitz Tribe) and I will attend the national budget meeting in Rockville, Maryland.

Finally, in November the Executive Committee and I trekked to Washington, D.C. for a lobbying trip to prepare for the lame duck session. Our work focused on the sequestration issues and federal deficit. We advised Congressional leaders that IHS funds are not discretionary but are resources provided by the United States Congress to carry out its responsibilities of the federal trust relationship. My impression is there is broad support for IHS and BIA programs with our Congressional delegation. We will have to keep up this advocacy work with the new Congress and prepare for more hill visits during the Winter Session of NCAI.

I hope you enjoy this edition of the newsletter and look forward to our work in the New Year!

2012 ALFRED P. SLOAN AWARD FOR EXCELLENCE IN WORKPLACE

Recently, NPAIHB received the ***2012 Alfred P. Sloan Award for Excellence in Workplace Effectiveness and Flexibiliy*** at an award ceremony and banquet at The Benson Hotel in downtown Portland. The award is sponsored by the Families and Work Institute (FWI) through their "When Work Works" project. FWI is a national nonprofit, nonpartisan research organization that studies the changing workforce, family, and community.

The award will be displayed in the front lobby. The following is what was said of our organization:

"As a recipient of this prestigious award, Northwest Portland Area Indian Health Board has distinguished itself as a leader in the movement for more forward-thinking, family-friendly workplaces. Your organization ranks in the top 20% of employers nationally in terms of the programs, policies and culture that create an effective and flexible workplace. In addition, what makes this honor so special is that your employees have affirmed that in their day-to-day experience, your workplace is indeed as flexible and effective a place to work as it looks on paper. We envision a day when flexible, family-friendly workplaces are the norm, and we want to thank you personally for your leadership in Oregon toward this goal."

Photo of Jacqueline Left Hand Bull, NPAIHB Administrative Officer; Victoria Warren-Mears, EpiCenter Director and Cassandra Sellards-Reck Cowlitz Tribal Delegate receiving the award.

Upcoming Events

JANUARY

January 28-31
ATNI 2013 Winter Convention
Grand Mound, WA

FEBRUARY

February 5th
Cover Oregon Workgroup
Salem, OR

February 13-15
IHS National Budget Formulation
Worksession
TBD

February 18
Federal Holiday
Presidents Day

February 19-22
MMPC/TTAG Meeting
Washington, DC

MARCH

March 4-7
NCAI Winter Session
Washington, DC

March 5th
Cover Oregon Workgroup
Salem, OR

March 25-28
Youth Conference

March 27-28
8th Annual Native Caring
Lincoln City, OR

APRIL

April 2nd
Cover Oregon Workgroup
Salem, OR

April 7-10
31st Annual Protecting Our Children
Conference on Child Abuse & Neglect
Tulsa, OK

April 9 - April 10
IHS Tribal Self-Governance
Advisory Committee
Meeting
Washington, DC

April 15 – 18
NPAIHB Quarterly Board Meeting
Swinomish, WA

April 23-24
Lifestyle Counseling Training
Portland, OR

April 29- May 2
2013 Annual Tribal Self-Governance
Conference
Anaheim, CA

INFLUENZA ACTIVITY WIDESPREAD!

Continued from page 11

Treatment

Treatment oseltamivir (Tamiflu) or zanamivir (Relenza) is available for those who get the flu. It helps prevent serious illness or complications, such as pneumonia. Those who need it most include those at greatest risk for developing complications from the flu or who live with those at increased risk, including:

- Children younger than 5, but especially children younger than 2 years old
- Adults 65 years of age and older
- Pregnant women
- American Indians and Alaskan Natives seem to be at higher risk of flu complications
- People who have medical conditions including:
    1. Asthma (even if it's controlled or mild)
    2. Chronic lung disease (such as chronic obstructive pulmonary disease [COPD] and cystic fibrosis)
    3. Heart disease (such as congenital heart disease, congestive heart failure and coronary artery disease)
    4. Diabetes mellitus

Medication Supplies

Oseltamivir is readily available from the IHS National Supply Service Center in Oklahoma. **Supplies of pediatric suspension are not available** because of national supply shortages. Pediatric suspension can be compounded following the manufacturer's FDA approved instructions.

NEW FACES AT THE BOARD

Congratualtions to Birdie Wermy and Alex and big sister Alicia on the birth of their daughter April Millaruby Gudino-Wermy born October 30, 2012 weighing in at 6 lbs and 19.25 inches

Greetings! My name is Nancy Bennett; I am very excited to join the Northwest Portland Area Indian Health Board Epidemiology Center. I will be providing support to all programs within the Epi-Center as the new floating Bio-statistician. I received my Bachelors of Science degree in Information Technology from University of Phoenix. Prior to moving to the Portland area, I spent 7 years at the Great Lakes Inter-Tribal Epidemiology Center (located in the north woods of Wisconsin) as their MIS Analyst and RPMS trainer as well as my many other "hats" at GLITC some of which include SAS programming, Bio-Statistician, Database creator and administrator. Until now I have always lived in the Midwest (majority of the time in the western suburbs of Chicago) and I look forward to the culture and climate the West Coast has to offer.

I have two children; one moved here with me and is finishing high school. My other child just finished college and is in a contract as a research assistant at University of WI, Stevens Point. She will join us here in the summer.

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S OCTOBER 2012 RESOLUTIONS

RESOLUTION #13-01-01
MATERNAL AND CHILD HEALTH RESEARCH PROGRAM SECONDARY DATA ANALYSIS

RESOLUTION #13-01-02
NIMHD COMMUNITY-BASED PARTICIPATORY RESEARCH (CBPR) INITIATIVE IN REDUCING AND ELIMINATING HEALTH DISPARITIES: DISSEMINATION PHASE

RESOLUTION #13-01-03
EXEMPT IHS & BIA APPROPRIATIONS FROM SEQUESTRATION REQUIRED UNDER THE BUDGET CONTROL ACT OF 2011

RESOLUTION #13-01-04
SUPPORT DENTAL HEALTH AIDE THERAPIST AND ADVANCED DENTAL THERAPISTS' EDUCATIONAL AND SCOPE OF PRACTICE REQUIREMENTS

RESOLUTION #13-01-05
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) EPIDEMIC INTELLIGENCE OFFICER

RESOLUTION #13-01-06
SUPPORT NPAIHB CONTRACT SUPPORT COST LITIGATION