HEALTH NEWS & NOTES

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Nation to Nation: Deb Haaland

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On March 15, 2021, Deb Haaland became the first Native American Cabinet Secretary. As the Senate confirmed Ms. Haaland to lead the Interior Department, congratulations and praise soared over Native social and news media. Tribal members, communities, and Native organizations across the nation have rallied behind her confirmation since President Biden announced her as his nominee on December 17, 2020. The Northwest Portland Area Indian Health Board sent a **letter of unequivocal support** of Haaland's nomination on February 17, 2021.

Haaland sat before the Senate Committee on Energy and Natural Resouces during her two days of confirmation hearings in February. At times during **the hearings**, Haaland defended her position of support for aggressive action on climate change and even one accusation that she is anti-hunting. Montana Senator Danes asked, "Why should congress believe you will expand and protect our shooting opportunities on public lands?" I'm a Pueblo woman," Haaland answered. "We've been hunting on public lands for centuries. My dad and grandparents and brother, they all hunt. I myself was fortunate to harvest an oryx from the White Sands Missile Range, which fed my family for about a year. I respect the sportsmen and the anglers."

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Nation to Nation: Deb Haaland (continued)

Ms. Haaland, a Laguna Pueblo tribal member and former U.S. representative for New Mexico's 1st congressional district (2019-2021), has her work cut out for her. The Department of Interior will have many other challenges under Haaland, including taking a central role in President Biden's ambitious plan to get to 100% clean electricity by 2035. There's the review of the many Endangered Species Act protections rolled back by the Trump administration. In addition to the management of American Indian affairs and wildlife conservation, the Department of Interior manages 507 million acres of public land, 476 dams, 348 reservoirs, and the seabed and submerged land off of the American coastline (Outer Continental Shelf) rich in marine wilderness and oil resources.

Since her confirmation, Secretary Haaland has issued a new Secretarial Order to prioritize action on climate change. She has also revoked orders of the former administration that she called "inconsistent with the department's commitment to protect public health; conserve land, water, and wildlife; and elevate science" **in a recorded statement**.

"A voice like mine has never been a Cabinet secretary or at the head of the Department of Interior," Haaland wrote on her Twitter account. "**Growing up in my mother's Pueblo household made me fierce. I'll be fierce for all of us, our planet, and all of our protected land. I am honored and ready to serve**."

"The historic confirmation of Secretary Deb Haaland is not only monumental for Indian Country, but shatters the glass ceiling for Native women legal professionals, like myself. Mich gayis Secretary Haaland for your fierceness that has paved the way for Native women in leadership."

Elizabeth J. Coronado, JD (Chukchansi)
NPAIHB Health Policy Specialist

"This is an unprecedented and monumental day for all first people of this country. Words cannot express how overjoyed and proud we are to see one of our own confirmed to serve in this high-level position. It's a wonderful feeling that we can now refer to her as Madam Secretary. Today's historic confirmation sets us on a better path to righting the wrongs of the past with the federal government and inspires hope in our people, especially our young people. It gives us a seat at the table to offer a new and different perspective from a person that has experienced the reality of adversities and challenges of growing up on what federal officials refer to as 'Indian' reservations."

Jonathan Nez,
President of the Navajo Nation

Chair's Notes

Nickolaus D. Lewis
Lummi Nation
NPAIHB Chairman

I think we are seeing the light at the end of the tunnel, and I am hopeful for what the future brings for our communities. The last 13 months have been hard, yet through all of the challenges we have seen people pull together and support each other over and over again. Thank you for all you do for our people. So much has happened since our January 2021 meeting, I want to focus first on the unprecedented funding to Indian Country by President Biden's administration with the additional $6 for the Indian Health Service (IHS) under the American Rescue Plan Act of 2021. This almost doubles our FY2021 budget, the funds are available until they are spent and includes:

- $2 billion for lost third-party revenue
- $500 million for additional health care services, including Purchased/Referred Care
- $140 million for information technology, telehealth, and the IHS Electronic Health Record
- $420 million for mental health and substance abuse prevention and treatment activities
- $600 million for construction, maintenance, equipment, and other related activities for COVID-19 response
- $240 million for public health workforce and other related activities
- $600 million for necessary expenses to plan, prepare for, promote, distribute, administer, and track COVID-19 vaccines and other related activities
- $1.5 billion for COVID-19 testing, contact tracing, and other related activities
- $10 million for the delivery of potable water
- No less than $84 million for Urban Indian Organizations

While we are waiting for the results of the consultation on these funds, we have another financial proposal to analyze as President Biden just released his FY 2022 budget. It includes an additional $2.2 billion for the Indian Health Service. This proposal takes IHS up to approximately $8.4 billion, which is $4.4 under the National Tribal Budget Workgroup's FY 2022 recommendation. We have started virtual visits with our representatives recently, and we will continue our advocacy. One of the things I have noticed in working with the Biden administration is that senior leadership is showing up at the table to talk, and they seem to be listening to tribal voices. I am encouraged to learn that HHS Secretary Xavier Becerra showed up at the National Tribal Budget Formulation Workgroup consultation in April, and that Acting HHS Director Norris Cochran and CDC Director Rochelle Walensky attended the HHS Secretary's Tribal Advisory Committee (HHS-STAC) meeting in February.

I am humbled to report that I have been given the opportunity to serve our people at the national level as the Vice-Chair of the National Indian Health Board (NIHB), and I will be the national at-large rep for NIHB on SAMSHA TTAC and CMS TTAG. These opportunities are meaningful to me because I believe that our work at the national level brings to light the good work that is going on at the local level. Your work in responding to COVID-19, the strong work that your health programs and the Board are doing in expanding the CHAP program to the lower-48, innovations that we see in your clinics in addressing prevention, intervention, treatment, and after care of substance use disorder, and the focus on traditional and cultural ways in healing and health that we see in our communities, all serve as examples we can share when we advocate for additional resources at the national level. Thank you for all you do to take care of our people. Please always know that I am available to listen, and help where I can.

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

Biden Administration Undertakes Consultation With Tribal Nations

Elizabeth J. Coronado, JD (Chukchansi)
Health Policy Specialist

Within the first week of office, President Biden issued Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships directing his executive departments and agency heads to develop a plan of action to implement the directives of Executive Order 13175.[1] This Presidential Memorandum reaffirms the federal government's commitment to fulfil the trust and treaty obligations to Tribal Nations and to conduct regular, meaningful, and robust consultation.[2] Although this Memorandum reaffirms the policy directive in Presidential Memorandum of November 5, 2009, President Biden further directs his Executive Branch to not only "includ[e] Tribal voices in policy deliberation that affects Tribal communities" but to listen to Tribal Leaders.[3]

Since the execution of the Presidential Memorandum in January, the Biden Administration has conducted tribal consultation across the many agencies of the federal government, including Department of Health and Human Services (HHS) and Office of Management and Budget (OMB).

HHS Tribal Consultation Policy Background

The HHS Tribal Consultation Policy was initially developed with Tribal input in 2004, and signed in 2005. The most recently revised Tribal Consultation Policy was signed in 2010 by Secretary Kathleen Sebelius as a result of President Obama's 2009 Executive Memorandum. Tribal Leaders agreed to put on hold further revisions to the Policy under the Trump Administration.

HHS Tribal Consultation

HHS conducted tribal consultation for Region 10 on March 25, 2021. Through a pre-recorded video, Secretary Becerra committed to advancing American Indian and Alaska Native health priorities, honoring tribal sovereignty, and including tribal voices in policymaking. Tribal leaders on behalf of the Northwest Portland Area Indian Health Board (NPAIHB) urged HHS to honor tribal leaders requests in order to advance the health status of American Indian and Alaska Native people; to hold HHS' Agencies, Offices, Centers, Operating Units, and Regional Offices accountable to the provisions of the HHS Tribal Consultation Policy; and to mandate that states hold sincere and effective consultation with Tribal Nations. The HHS Office of Intergovernmental and External Affairs (IEA) is collating comments received during consultation and will issue a report on HHS plan of action to implement the directives of EO 13175 by the end of the month. IEA will collaborate with the Secretary's Tribal Advisory Committee (STAC) on comments received on the Tribal Consultation Policy.

Historical OMB Tribal Consultation

Because of their role in implementing and overseeing the President's agenda and budget, OMB is a crucial partner to Tribal Nations. The OMB has five main functions including, budget development, oversight of agency performance and financial management, federal regulatory coordination and review, clearance of agency testimony and legislative proposals, and clearance of Presidential Executive Orders and memoranda.[4] Tribal Leaders have been stalled in their policy efforts and funding requests by OMB without any true and effective government to government consultation.

On April 2 and April 5, 2021, OMB engaged in consultation for the first time with Tribal Nations. OMB acknowledged Biden's commitment to honor tribal sovereignty and to fulfill the federal trust and treaty obligations. In addition, OMB recognized that there is much work that needs to be done to rectify the type of engagement with Tribal Nations that historically has not happened. Tribal Leaders had a number of requests to OMB, including a dedicated Indian desk within OMB; a tribal advisory committee; a detailed cross for federal funding that specifies whether grant funding reaches Tribal Nations; and commitment to ongoing, meaningful consultation. The comments received during tribal consultation will help inform OMB's plan of action to engage in meaningful tribal consultation.

This initial consultation with OMB is the first step towards this Administration truly honoring tribal sovereignty by Tribal Leaders having a voice with senior leadership and participating with the highest levels across the Executive Branch.

HHS Annual Tribal Budget Consultation – FY 2023

The HHS agencies heard consistent requests from Tribal Leaders, such as the need to fully fund the Indian Health Service at $48 billion, non-competitive funding opportunities across the agencies, exempting the one-time COVID-19 funds from indirect cost rate negotiations, and the challenges of recruiting Indian Health Care Providers across the Indian health care system. Councilman Joseph and Councilwoman Sampson specifically addressed NPAIHB policy priorities, including but not limited to, increased funding for Community Health Aide Program expansion and Purchased Referred Care and the need for additional services and supports for tribal elders living in their homes and communities.

On the last day, Secretary Becerra conducted a roundtable discussion on Tribal Leaders' policy priorities. Councilwoman Sampson spoke to Secretary Becerra on a handful of NPAIHB's policy priorities, including reversing Medicaid policies that are inconsistent with the objectives of the Affordable Care Act, honoring Tribal Leaders' requests, and expansion of self-governance and self-determination models across HHS agencies.

"Final word . . . test me" stated Secretary Becerra during his address to Tribal Leaders at the Annual Tribal Budget Consultation on April 7, 2021.

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[1] *Presidential Memorandum On Tribal Consultation and Strengthening Nation-to-Nation Relationships, Daily Comp. Pres. Docs., DCPD No. 202100091 (JAN. 26, 2021).*

[2] *Id.* | [3] *Id.*

[4] *Office of Mgmt. and Budget,* **https://www.whitehouse.gov/omb/** *(last visited Apr. 9, 2021).*

Brief Summary of Mental & Behavioral Health Legislation (Northwest & National)

Candice Jimenez, MPH
Confederated Tribes of Warm Springs
Health Policy Specialist

In understanding the landscape of mental and behavioral health resources in the Northwest, and across the nation, is to know that there exist historic and systemic impacts on tribes and communities of color; a chasm between meeting needs and current resources that are sustainable, accountable, responsive and appropriate for each community they serve. When appropriate and consistent health interventions are brought together in a people first approach, there is less need for more intensive services or even hospitalization that can further harm youth, adults and families in those experiences. Further, the challenge may not exist in accessing services rather in how the services are being engaged with the people they are meant to serve, and how it benefits them in the long term across generations from youth to elders. As we collectively continue forward during a global pandemic, we are beginning to see positive changes that recognize the need for behavioral and mental health services that call on systemic reform which acknowledge the ongoing under-resourced nature of the system and recognizes expertise from the communities themselves, such as those who offer peer support, lead with traditional and cultural knowledge along with the healing nature of ceremony for one's mental and behavioral health. In this light, here we will take a brief look at local and federal legislation that focuses on these areas as we move forward in 2021 during a time where the current national administration seeks to build better relationships with tribal nations via tribal consultation, and for many agencies, a first-time occurrence.

Here's a brief look at current and pending legislation impacting mental and behavioral health services in the Northwest:

Idaho

- SB 1125 – To establish provisions regarding recognized state crisis care and suicide hotlines, to provide for mobile response teams, to provide for a suicide and mental health crisis access fund, to provide for a suicide and mental health crisis access fee, to provide for the use of the fee, to provide auditing and reporting requirements, and to provide a fee implementation deadline.
- HB 233 – Seeks to add a new section to the Child Mental Health Services Act; the addition would prevent parents from losing custody of children for seeking services for children in mental health facilities under certain conditions.

Oregon

- HB 2086 – Appropriates moneys to Oregon Health Authority to undertake specified steps to address needs of individuals with behavioral health disorders for services, treatment and housing. Declares emergency, effective on passage.
- HB 2314 – Requires Oregon Health Authority to study and make recommendations to interim committees of Legislative Assembly, no later than September 15, 2022, for legislative changes needed to increase access to behavioral health services for all Oregonians and particularly to Oregonians in rural areas and to medically underserved populations.
- HB 2381 – Modifies laws relating to youth suicide intervention and prevention to include children under 10 years of age and creates a Youth Suicide Intervention and Prevention Advisory Committee to advise the Oregon Health Authority on the development and administration of strategies to address suicide intervention and prevention for children and youth [10 through] who are 24 years of age or younger.

- HB 2949 – Requires Mental Health Regulatory Agency to establish program to improve Black, indigenous and people of color mental health workforce, including pipeline development, scholarships for undergraduates and stipends for graduate students, loan repayments and retention activities.
- HB 3377 – Establishes Addiction Crisis Recovery Fund. Prescribes uses of fund. Establishes Office of Intervention and Engagement in Oregon Health Authority to oversee expansion of substance use disorder treatment and peer services. Establishes Office of Behavioral Health Workforce Development in Oregon Health Authority to oversee recovery workforce development. Requires Oregon Health Authority to increase payments for reimbursement to addiction treatment providers for services provided to medical assistance recipients.
- Learn more about these bills and more at the OR House Committee on Behavioral Health led by Representative Tawna Sanchez (Shoshone-Bannock, Ute, Carrizo), Chair at https://olis.oregonlegislature.gov/liz/2021R1/Committees/HBH/Overview

Washington

- SB 5195 – Concerning prescribing opioid overdose reversal medication.
- SB 5412 – The authority shall conduct its oversight of the community behavioral health system in a manner that is aware of, nurtures, and protects significant relationships in the life of behavioral health system clients. These relationships may involve family, friends, and others who play a significant role.
- SB 5328 – An act relating to clubhouses and peer-run organizations for persons with mental illness; a clubhouse is a member organization where people living with mental illness can find fellowship, hope, opportunity, and recovery. Clubhouse programs offer vocational training, wellness programs, employment opportunities, participative community, and an end to isolation for persons whose lives have been severely disrupted by mental illness.

Recent Federal legislation (American Rescue Plan)

With President Biden's March 11 signing into law of the American Rescue Plan Act of 2021, a $1.9 trillion COVID-19 relief package emerged, there includes a number of provisions that affect health systems and provisions including across Indian Country. The law allocates $3.5 billion for block grants addressing behavioral health disorders and several million more for other behavioral health programs and workforce issues. Specifically, the law allocates:

- $1.5 billion for mental health block grants
- $1.5 billion for substance use disorder block grants;
- $420 million in grants to clinics participating in the Certified Community Behavioral Health Clinic program;
- $100 million in behavioral health workforce education and training grants;
- $80 million for grants to health professional schools, academic medical centers, local government and other nonprofits for training in evidence-based strategies to decrease behavioral health disorders among health care personnel;
- $40 million in grants to health care providers for programs promoting good behavioral health among their personnel;
- $30 million in grants for local governments, nonprofits, and health organizations for overdose prevention and harm reduction programs, including needle exchanges and naloxone distribution;
- $20 million for an education campaign directed at health care personnel and first responders to encourage identification and prevention of behavioral health disorders; and
- Over $100 million to programs addressing community-based and child and adolescent mental health.

In addition, the law creates a new optional Medicaid covered service. For the five years following enactment, states can cover mobile crisis intervention services for individuals experiencing a mental health or substance use disorder crisis. The law provides $15 million for planning grant funds for states to develop a mobile crisis service program, and provide enhanced FMAP for states that implement such a program. The law also directs $80 million to pediatric mental health services.

If you have any questions on current federal legislation related to mental and behavioral health, please reach to Candice Jimenez at cjimenez@npaihb.org – thank you!

Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group – 2021 Medicaid Priorities

Veronica Smith, MBA
Health Policy Consultant

Is Your Clinic Properly Reimbursed for Services by Medicaid Managed Care?

Tribes across the country have reported challenges being properly reimbursed by Medicaid Managed Care Organizations (MCOs). These reports have led the CMS Tribal Technical Advisory Group (CMS-TTAG) to add a recommendation its 2021 priorities. CMS-TTAG has recommended that CMS issue a State Health Official (SHO) letter informing all 50 states that compliance with the Indian provisions of the Medicaid Managed Care Rule (42 C.F.R. § 438.14) is a condition of approving any State Plan Amendment or waiver, and a condition of payment in state contracts with MCOs. CMS-TTAG is also recommending that MCO's deem all Indian health care providers as in-network providers, regardless of whether or not they have entered into a network provider agreement.

The National Indian Health Board is partnering with CMS-TTAG and hosting a MCO roundtable on May 19, 2021 from 9:30am – 2pm. The draft agenda includes:

- Overview of the Indian Provisions of the Medicaid Managed Care Rule
- Best practices in implementing managed care in Washington State
    - Presenters: Vicki Lowe (Jamestown S'Klallam, AIHC) and Jessie Dean (WA HCA)
- Overcoming challenges in implementing Medicaid Managed Care with CA, MS, and TX
    - Presenters: Tribal and state representatives
- Developing an Indian Managed Care Entity
    - Presenters: Michael Collins (Warm Springs), Sharon Stanphill (Cow Creek) Jason Stiener (Oregon Health Authority), Casey Cooper (CEO, Cherokee Indian Hospital Authority), and North Carolina Department of Health Services

Attendees to the roundtable will include tribes, state Medicaid Directors, and MCOs. Please share this meeting information with your office staff, your ideas and experiences make a significant contribution to moving this policy priority forward.

What is the Status of the 4-Walls Limitation?

The 4-Walls Limitation prohibits Indian Health Care Providers (IHCPs) from billing the Medicaid program for services provided outside the physical four walls of a health care facility. This includes many services that have been provided for years at off-site locations as a part of wraparound services. Tribes had been given a grace period until January 31, 2021 to work with their states and enroll in state Medicaid programs as Tribal Federally Qualified Health Centers (T-FQHCs), and for state governments to submit State Plan Amendments (SPAs) and agree to pay tribes at the all-inclusive rate (or encounter rate) for services provided by T-FQHCs. To date, only nine states have filed SPAs. Tribes were given an **11th hour extension** to the 4-Walls Limitation grace period on January 15, 2021, and enforcement is now scheduled to begin after October 31 2021. CMS-TTAG has advocated for a legislative fix to the 4-Walls Limitation, and recent legislation (**H.R. 1888, Improving Access to Indian Health Services Act**) provides that fix, along with providing 100% FMAP for Urban Indian Health Programs.

If you have questions about the upcoming MCO roundtable or the 4-Walls Limitation, please feel free to contact me at **vsmith-contractor@npaihb.org**

Administration's FY 2022 Budget Request Includes Funding Increases for Tribal Programs

Cindy Darcy
DC Policy Strategist

The Biden-Harris Administration released the outline of their discretionary spending priorities in the FY 2022 budget request. (Mandatory spending and details will be forthcoming.) The overview is available here: **https://www.whitehouse.gov/wp-content/uploads/2021/04/FY2022-Discretionary-Request.pdf**

Following the document's overall summary, the summaries of federal agencies' requested funding are listed by department, with the Department of Health and Human Services beginning on page 10. The budget request reads in most relevant part, "To begin redressing long standing health inequities experienced by American Indians and Alaska Natives, the [Administration's FY 2022] discretionary request includes an increase of $2.2 billion in the Indian Health Service."

Given the $6.1 billion increase to IHS that was included in the American Rescue Plan Act (Public Law 117-2), that essentially doubled funding for IHS, on top of the $6.236 billion that was enacted in the final FY 2021 omnibus appropriations and COVID-19 relief Act (Public Law 116-160), we may be looking at a requested FY 2022 funding level of $14.5 billion for IHS!

The Administration's FY 2022 budget request puts the emphasis on discretionary spending for domestic programs like education, health care and environmental protection, while essentially maintaining funding for defense spending. The discretionary request proposes $769 billion in non-defense discretionary funding in FY 2022, which is a 16% increase over the FY 2021 enacted level. A total of $753 billion is requested for national defense programs, which is a 1.7% increase.

The budget request also recommends the following:

- a total of $133.7 billion, a 23.1% increase over the FY 2021 enacted level, for the Department of Health and Human Services.
- $6.5 billion for a proposed Advanced Research Projects Agency for Health within the National Institutes of Health to pursue research in cancer, diabetes, Alzheimer's and other diseases.
- $10.7 billion, an increase of $3.9 billion over the FY 2021 enacted level, to address the opioid epidemic through support research, prevention, treatment, and recovery support services to populations with unique needs, including Native Americans, older Americans, and rural populations.
- $670 million within HHS to help reduce the number of new HIV cases, while increasing access to treatment, expanding the use of pre-exposure prophylaxis (also known as PrEP), and ensuring equitable access to services and supports.
- $7.4 billion for the Child Care and Development Block Grant program, an increase of $1.5 billion over the 2021 enacted level.
- $11.9 billion for Head Start, a $1.2 billion increase.
- increases of more than $600 million over the FY 2021 enacted levels for a range of tribal programs in the Department of the Interior, including for education, clean energy development, tribal law enforcement and tribal court programs.
- $3.6 billion to advance water infrastructure improvement efforts for community water systems, schools, and households, and to improve drinking water and waste water infrastructure, including in tribal communities.
- $153 million for CDC's Social Determinants of Health program to support states and territories to improve health equity and data collection for racial and ethnic populations.
- $900 million to address poor housing conditions in tribal areas.
- $1 billion for Department of Justice Violence Against Women Act programs, which is nearly double the FY 2021 level.

As noted above, the Administration's proposals for mandatory spending programs and tax policies, as well as more details about domestic discretionary spending, are not expected until late spring. However, with the submission of today's FY 2022 discretionary spending request, House and Senate Appropriations Subcommittees may begin writing their appropriations bills.

2020 Trans and Gender-Affirming Care Strategic Vision and Action Plan

Itai Jeffries, PhD (Yèsah/Occaneechi)
they/them/ya'll
Co-Manager
Paths (Re)Membered

Jessica Leston (Tsimshian)
she/her/hers
Clinical Programs Manager

Morgan Thomas
they/them
Co-Manager
Paths (Re)Membered

Prior to colonization, concepts of gender identity in Native communities were diverse and the acceptance of gender diversity was high. Two Spirit people, "whose behaviors or beliefs may be interpreted by others to be uncharacteristic of their sex," were often expected to take on roles as medicine people, mentors, teachers, and healers.[1] This practice of diverse gender acceptance in Native communities has been dramatically altered through colonization and the forced assimilation process. However, the history of Native acceptance of Two Spirit and LGBTQ identities remains in the teachings and wisdom of Native ancestors and Two Spirit Elders living today.

Over the past year, the Paths (Re)Membered Project has worked on a variety of projects to support the health of Two Spirit and LGBTQ+ (2SLGBTQ+) people. (We use Two Spirit and LGBTQ+ or 2SLGBTQ+ throughout this briefing to refer to individuals who identify as gender-diverse (not cisgender) or have a minority sexual orientation.) Paths (Re)Membered activities have included founding a **Trans & Gender-Affirming Care ECHO**, publishing monthly **podcasts** and blog posts, hosting regular community events and trainings for staff and partners, working with northwest tribes to build capacity for affirming environments in clinics and community spaces, and completing a 2SLGBTQ+ Pride and Connectedness Online Survey.

In a Pride and Connectedness Survey, completed in September 2020, we observed a number of widely reported barriers to healthcare access experienced by 2SLGBTQ+ people, with gender-diverse people reporting greater barriers than their cisgender peers. The most commonly reported barriers include lack of healthcare providers (especially behavioral healthcare providers) adequately trained to offer gender-affirming care and fear that providers would find out clients were 2SLGBTQ+. [2] The 2015 U.S. Transgender Survey also found that 37% of AI/AN transgender individuals postponed necessary healthcare appointments because they were afraid of mistreatment by healthcare providers.[3] However, advances in gender-affirming care and our knowledge of affirming clinical environments make it possible for all clinics to offer 2SLGBTQ+ clients the care they deserve. [4] [5]

In January of 2020, NPAIHB Delegates approved the resolution "Support for Quality Care and Improved Health Outcomes for Two Spirit and LGBTQ+ People." In response, the NPAIHB Paths (Re)Membered Program founded the Native Advocacy Workgroup for Trans Health and worked with them to collectively create a Strategic Vision and Action Plan focused on Trans & Gender-Affirming Care in Indian Health Service, Tribal and Urban Clinics (I/T/U).

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[1] Jacobs, S.E. (1997). Two-Spirit People: Native American Gender Identity, Sexuality, and Spirituality. University of Illinois Press.
[2] Jeffries, Itai, Leston, Jessica,Thomas, Morgan, and Kaylee Trottier. "Two Spirit and LGBTQ+ Pride and Connectedness Survey." Unpublished. 2020.
[3] 2015 U.S. Transgender Survey: Report on the Experiences of American Indian and Alaska Native Respondents. National Center for Transgender Equality (2015): https://transequality.org/sites/default/files/docs/usts/USTS-AIAN-Report-Dec17.pdf
[4] UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at transcare.ucsf.edu/guidelines.
[5] Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. The Journal of adolescent health : official publication of the Society for Adolescent Medicine, 63(4), 503–505. https://doi.org/10.1016/j.jadohealth.2018.02.003

In its role creating the **Strategic Vision and Action Plan**, NPAIHB listened and consulted with stakeholders including 2SLGBTQ+ community members, healthcare providers, policymakers, and community and program leaders. The authors of the 2020 Trans and Gender-Affirming Care Strategic Vision and Action Plan upheld principals to ensure that:

1. Initiatives are integrated with Indigenous Traditional Understandings and Practices
2. Initiatives are led by gender-diverse people
3. Initiatives recognize Indigenous diversity in gender conceptions, roles and practices

Gender-affirming care refers to healthcare that affirms a person's gender identity and allows gender-diverse people to live more authentically. To be gender-affirming, providers must create positive and optimistic medical care systems, inclusive clinic environments, and patient support through effective and compassionate social gender transition. With appropriate planning and support, gender-affirming healthcare can be highly successful at all levels of the medical system, including primary care, behavioral health care, pharmaceutical care, Traditional Indigenous Medicine, and various other specialties. If effectively applied, gender-affirming care becomes integrated throughout all clinical services. Incorporating holistic and affirming care with respect to both gender and culture, and welcoming clinical spaces for all patients ensures gender-diverse patients have access to the care they medically need and that they feel safe accessing that care.

This strategic plan supports the I/T/U clinics as they begin to provide gender-affirming care to their patients by emphasizing the following four goals:

1. Develop and pass protective policies at the federal, tribal, and local levels;
2. Ensure affirming clinical environments for gender-diverse patients;
3. Ensure best practice care for Indigenous gender-diverse patients; and
4. Improve I/T/U health systems support for initiatives focused on the wellness of gender-diverse community members.

These recommendations are not individual-level interventions. They are structural and community-level interventions to ensure the wellbeing of gender-diverse patients. We hope that the NPAIHB, various tribal nations in the US Pacific Northwest, and partnering agencies use this plan to guide program planning, catalyze community outreach efforts, and foster a coordinated response to the health and wellbeing of gender-diverse members of our tribal and urban communities. The dissemination of this strategic plan will guide I/T/U clinics, ensuring they have the strategies and support they need to fully implement these guidelines and to offer 2SLGBTQ+ clients a welcoming space and the care they need to be healthy. It will further guide policy and tribal leaders as they work to ensure programs and policies developed in Indian Country are affirming for 2SLGBTQ+ clients and community members.

For more information about the Strategic Vision and Action Plan or to learn more about the NPAIHB Paths (Re)Membered Program, please contact Morgan at **mthomas@npaihb.org** or 850-748-3458.

Environmental Health Policy in Indian Country

Celeste L. Davis, REHS, MPH (Chickasaw)
Director

Ryan Seely, MPH (Chickasaw)
Environmental Health Scientist

Shawn Blackshear, RS, MS
Sr. Environmental Health Specialist

Antoinette Aguirre, BA (Navajo)
Environmental Health Specialist

Holly Thompson Duffy, MPH
Environmental Health Science Manager

Environmental Health Policy in Indian Country

Cultural practices, laws, and policies related to the intersection of the environment and people have ancient origins with written documentation. Environmental health policy arose through the era of industrialization with an emphasis on sanitation and worker safety. Early practitioners' work profoundly influenced our understanding of environmental-related illness, none more influential than Dr. John Snow in his 1854 epidemiological investigation of the cholera outbreak in London and the implication of the Broad Street water pump as the source of disease. We can trace the modern field of environmental health back to the mid-20th Century and the 1962 publication of Rachel Carson's "Silent Spring." The advent of the EPA in 1970, the energy crisis in the 70s, visible smog in cities, and a series of deadly environmental disasters – the 1969 Cuyahoga River fire, Love Canal, the Exxon Valdez Oil Spill, and others - resulted in monumental environmental health legislation such as the Clean Air Act, Clean Water Act, and more. The increased public awareness of the intersection between the environment and health ignited the modern-day environmental justice movement, exemplified by the Dakota Access Pipeline protest movement to protect significant cultural and ecological resources for the Standing Rock Sioux Tribe. Weaved throughout the Pacific Northwest, laws associated with salmon, shellfish, and waters have long been a battle for Tribal rights and environmental health. Presently, environmental regulation and public health protection are fundamentally integrated and inseparable.

The Environmental Public Health (EPH) Program at the NPAIHB started in February of 2020 after the program's assumption from the Portland IHS under P.L. 93-638. Since that time, the EPH Program has secured additional funding from the CDC and the EPA and is actively funding tribal environmental health projects. The major approaches for addressing tribal environmental health issues include assessment, monitoring, providing training, health education, advocating for equitable environmental health policies, and assisting tribes with policy development.

Because environmental health involves the natural environment and the built environment, there are a multitude of laws, policies, and jurisdictions that may be involved in addressing issues and services. Environmental health services associated with the natural environment can include environmental quality monitoring of air, water, soil; pollution control; land use, zoning, and permitting; environmental hazards from natural disasters; and climate change. The majority of governmental environmental health work is associated with the built environment, which includes the following operations: retail and institutional food safety, drinking water quality, sanitary waste management, indoor air and indoor environmental quality, safety and emergency preparedness in facilities, school and child care health and safety, environmental infection prevention in health care, and occupational health and safety.

Environmental Health Policy in Indian Country

Due to the complexity of laws and jurisdictions associated with environmental health, we have adopted a collaborative governance model that involves shared responsibility and decision-making across organizations to include Tribes, NPAIHB, and appropriate federal agencies. Our ultimate goal is to develop and strengthen tribal public health capacity and infrastructure to support tribal environmental health programs' development and management.

Environmental health policy is often fractured and can be overwhelming. Many codes and regulations may be rightfully or wrongfully applied and enforced in Indian country. The table below is not exhaustive but includes the primary list of federal agencies and laws that define environmental public health policy on tribal lands:

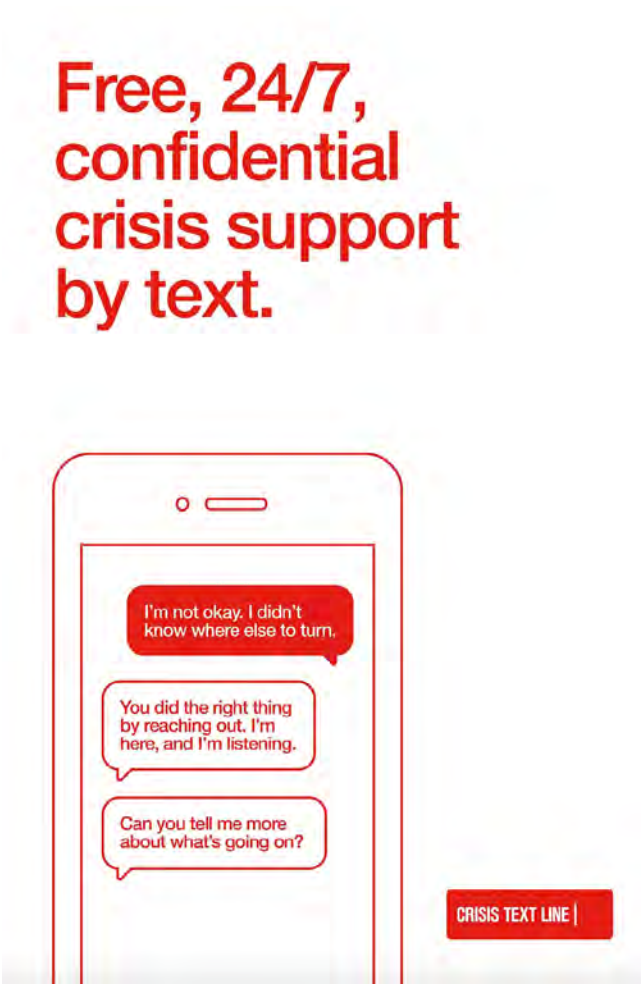
Agency	Code or Law	Role	Regulatory Authority for Tribes	Tribal Authority
IHS	25, 42, & 45 CFR	Responsible for providing direct medical and health services to federally recognized Tribes	No Regulatory Authority	Tribes have the authority to regulate health and safety, including licensing and permitting of businesses.
CDC	42 CFR	Supporting tribal public health capacity building to reduce disparities, prevent the spread of infectious disease, conduct investigations, and research	No Regulatory Authority	Tribes have Public Health Authority (quarantine, infectious disease control).
FDA	21 CFR	To safeguard public health by ensuring food safety, security and preventing the spread of foodborne illness through retail food establishments	No Regulatory Authority on Tribal Lands	Tribes have the authority to regulate retail food and manufacturing/processing on tribal lands.
NIGC	25 CFR	Regulations to ensure the construction and maintenance of the gaming facility, and the operation of that gaming, is conducted in a manner that adequately protects the environment and public health and safety, pursuant to the Indian Gaming Regulatory Act	Yes	Tribes adopt codes according to their license and have the authority to ensure compliance through attestation.
OSHA	29 CFR	Assures safe and healthful working conditions to prevent occupational health and illness through inspections and application of standards	Yes	Tribes can enact policies, but the Federal OSHA retains primacy
EPA	40 CFR	Covers all environmental protection laws to protect the land, water, and air; includes the SDWA, CWA, CAA, TSCA, RCRA, FIFRA, and many other laws	Yes	Tribes can enact policies and seek primacy through EPA; otherwise, EPA has primacy.
BIA	25 CFR	To understand, protect and improve the integrity and security of the land, human health and safety, and cultural resources	Yes	Tribes can assume authority through P.L. 93-638. BIA land leases and environmental regulations are complex and can involve multiple parties.

Environmental Health Policy in Indian Country (continued)

Environmental health practitioners may be involved in other policy arenas in Indian Country such as health care accreditation surveys based on CMS policies, HUD-NAHASDA policies for healthy housing, and ACF health and safety policies for Head Start and child care centers.

While the environmental health political and regulatory landscape in Indian Country is saturated with many agencies often having vague and politically focused intentions, the ultimate regulatory authority for environmental public health in tribal communities resides with each Tribe itself. We encourage all Tribes to adopt and enforce their own policies to protect and enhance environmental health, retaining the legal protection of their lands, resources, and people. After all, who would you prefer to have the ultimate legal authority: the ever-rotating Rolodex of federal employees that shifts at least every four years with the changing political tides or the people who have been stewards of the land consistently and responsibly since the beginning of time?

The EPH team is available to work with Tribes on anything related to environmental health policy. Please email us at ehteam@npaihb.org should you have any questions, concerns or needs that we can assist you with.



FAQ: Washington Youth Sexual Healthcare (WYSH) Grant

Celena McCray, MPH
(Navajo)

WYSH Project Manager

NPAIHB's WYSH project is recruiting 4-6 federally-recognized Washington State tribes to fund youth sexual health services, strengthen linkages and referrals to youth sexual health services, and educate youth about sexual health services.

WYSH GRANT FAQ

Who is eligible for WYSH funding?	*Local I/T/U (Indian Health Service, Tribal and Urban) clinics, Tribal Health Departments, school-based health programs and youth engagement programs who have a bi-directional impact on youth and their access to and experience with sexual healthcare. Recipients must represent and/or provide services to one or more of the 29 federally-recognized Tribes in Washington.*
Can only federally-recognized tribes apply?	*The entity applying doesn't have to be a Tribe, if they can show partnership/collaboration with an I/T/U.*
Can multiple programs under one tribe/organization apply?	*One application will be funded per WA Tribe/Organization.*
What does the application entail?	*There are 3 sections of the application, a brief project narrative (no more than 2 pages), detailed budget justification, and workplan description.*
How long is the funding?	*Subcontracts can be extended for up to 2 additional one-year periods; up to 3 years total, contingent on available funding. The total term of the contract shall not exceed three (3) years.*
What is the total amount available for this grant?	*$65,000 - $100,000 per year, including indirect costs.*

Who should I contact if I have any questions?

WYSH Project Manager: Celena McCray at cmccray@npaihb.org or 503-416-3270. TA available every Tuesday and Thursday from 11 AM-12 PM until May 24th.

A Call for Targeted Suicide Prevention Interventions during the COVID-19 Pandemic – Trends in Suicide-related Emergency Department Visits during the COVID-19 Era

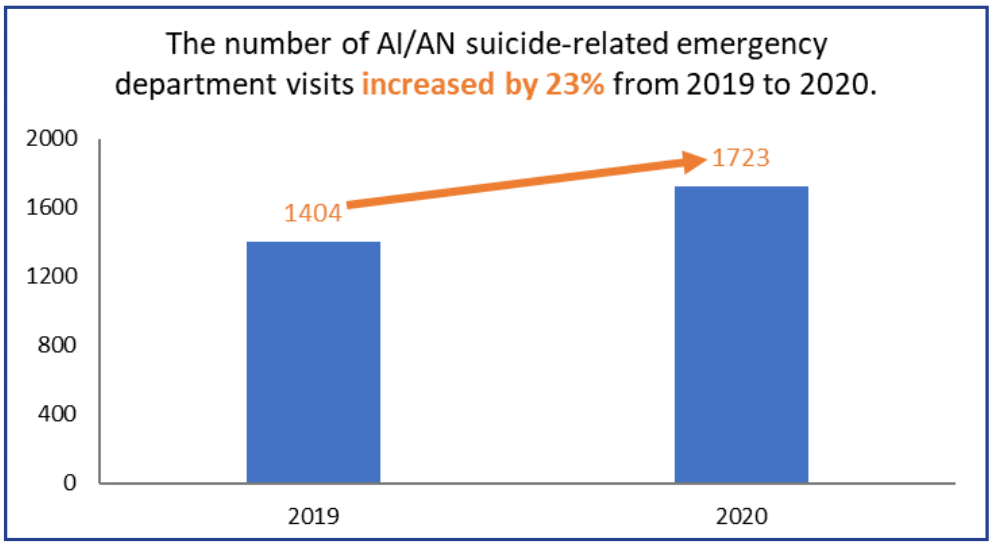
Chiao-Wen Lan, PhD, MPH

Improving Data & Enhancing Access (IDEA-NW) Epidemiologist

Sujata Joshi, MSPH

Improving Data & Enhancing Access (IDEA-NW) Project Director

The COVID-19 pandemic has resulted in negative mental health impacts among adults and children, including increases in anxiety and fear, loss, sense of isolation, and disrupted access to mental health services. American Indian and Alaska Native (AI/AN) communities in our region experienced a higher burden of suicide before COVID-19, and there are concerns that this burden has worsened during the pandemic. This article examines trends in suicide-related emergency department (ED) visits among Washington AI/AN communities during the first year of the COVID-19 pandemic.



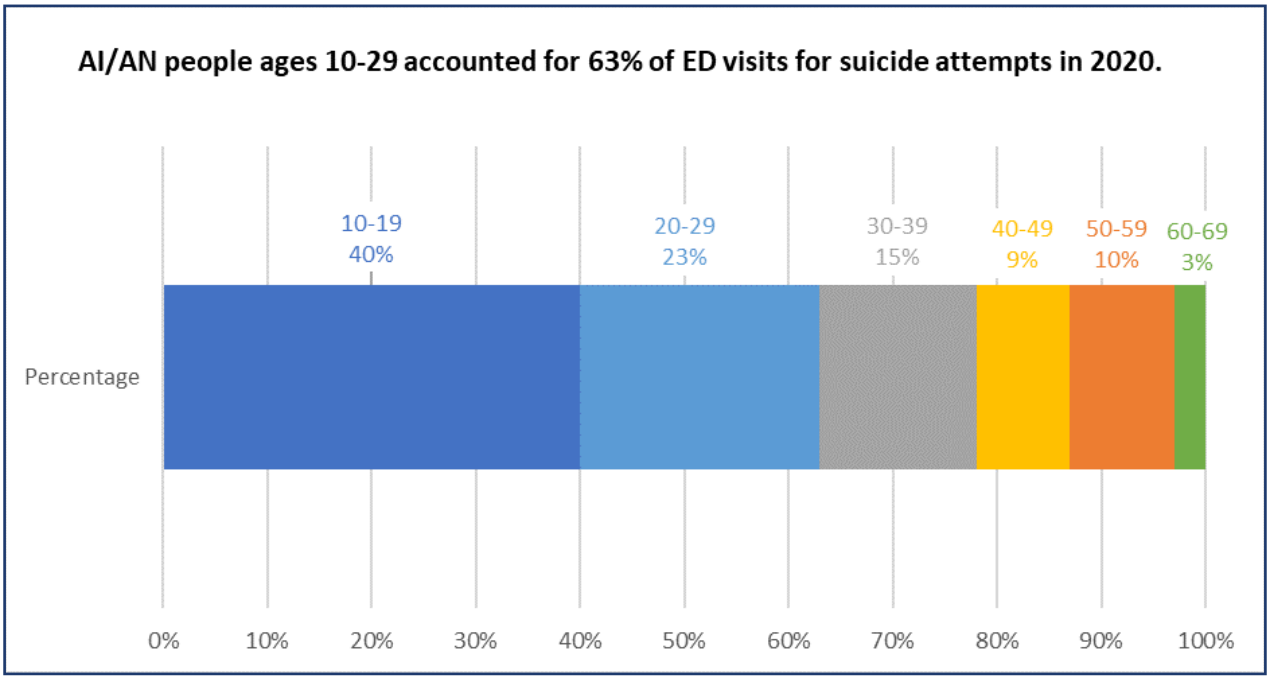
In Washington, the total number of **suicide-related ED visits** **among AI/AN people went up by 23% during the COVID-19 pandemic in 2020 compared to pre-pandemic** in 2019.

AI/AN **suicide ideation ED visits** **increased by 24% in 2020** compared to 2019. The ED monthly rate of suicide ideation for AI/AN reached its highest in May 2020, which was over 24% higher than the pre-pandemic monthly average.

The number of **suicide attempt ED visits** **among AI/AN increased by 17% in 2020** compared to 2019. The rate of suicide attempt ED visits reached its highest in September 2020, which was 45% higher than the previous year monthly average in 2019.

In Washington, AI/AN people ages 10 to 29 accounted for 63% of suicide attempt ED visits in 2020. The highest increase between 2019 and 2020 was seen in three age groups: ages **10-19, 30-39, and 50-59**. **The number of suicide attempt ED visits among AI/AN adults ages 50-59 doubled from 2019 to 2020.**

There was a higher percent increase for suicide ideation seen among AI/AN women compared to AI/AN men (7% vs. 2%). Alarmingly, there was a 29% increase in ED visits for suicide attempts among AI/AN women between 2019 and 2020. The data presented do not represent the full burden of suicide-related health care visits among AI/AN in Washington, but only those that presented at emergency departments in 2019 and 2020. Further, these data may undercount suicide-related ED visits by roughly 28% due to the misclassification of AI/AN people in emergency department data.



Key Considerations

There is a pressing need for innovative and age-appropriate mental health support for adults and youth. The extent of the pandemic's impact on mental health among adults and youth may depend on many vulnerability factors. These data suggest that AI/AN females in particular need tailored and targeted prevention interventions, especially among those10-39 and 50-59 years of age.

- Data Source: Analyses are based on information reported to the Rapid Health Information NetwOrk (RHINO), the syndromic surveillance program at the Washington State Department of Health.

Suicide-related, suicide ideation, and suicide attempt ED records were identified using validated CDC definitions for syndromic surveillance data. For more information or additional data, please contact the IDEA-NW project at ideanw@npaihb.org.

COVID-19 Mental Health Resources:

- Text NATIVE to 741741 for free, 24/7 crisis counseling from the Crisis Text Line
- Lines for Life: 24/7 free, confidential, and anonymous help get help https://www.linesforlife.org/get-help-now/
- National Suicide Prevention Lifeline Coping during COVID-19 https://suicidepreventionlifeline.org/current-events/supporting-your-emotional-well-being-during-the-covid-19-outbreak/
- American Foundation for Suicide Prevention: Mental health and COVID-19 https://afsp.org/mental-health-and-covid-19
- Approved Suicide Prevention Apps:
  - Stay Alive: Grassroots Suicide Prevention App
  - ReMinder Suicide Safety Plan on the App Store
  - My3 application

OHSU and NPAIHB Team up to Create Powerful PSAs in Response to COVID

COVID Communications Team

OHSU and NPAIHB Team up to Create Powerful PSAs in Response to COVID

We know films are a powerful tool to tell Indigenous stories and communicate important teachings to tribal people. To address the disproportionate impact of COVID-19 on tribal communities, the Northwest Native American Center of Excellence (NNACoE) and the Northwest Portland Area Indian Health Board (NPAIHB) teamed up to limit the spread of COVID-19 in tribal communities through innovative digital health technologies and tribal expertise.
The partners produced a series of Public Service Announcements (PSAs) to help keep Indigenous people safe during the pandemic, focusing on the informational needs and cultural values of Native people. According to Jonas Greene, Communications Manager at the NPAIHB, "It is imperative that we prevent, prepare, and respond to the pandemic in ways that meet the unique needs of our NW Tribes."

While our communities have been deluged with COVID-related messages, to truly resonate with our people, they must reflect the nuances of AI/AN culture and feature AI/AN subjects. Together, in partnership with A Twilight Dawn Productions, Buffalo Nickel Creative, and NW Tribes, we are producing powerful PSAs to help share those teachings:

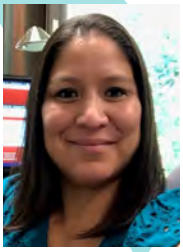
- Clinical perspectives on protecting ourselves and our communities through vaccination: **https://www.youtube.com/watch?v=ypdIV7OdI1Y**
- Protecting our children through vaccination: **https://youtu.be/uSG_h7UGVxs**
- Traditional practices and COVID-19: **https://youtu.be/npsIO7OhdEM**
- Staying connected while being physically distant: **https://youtu.be/TunV6AUFs-g**
- Exercising safely: **https://youtu.be/Dr8EJUZ_c1M**
- Importance of wearing masks, even after vaccination (in production)
- Resilience and strength of Tribal communities during the pandemic (in production)

As Indigenous people, it is our role to learn from those who came before us and nurture those who come next. We dance, we pray, we share, we adapt, we protect. We thrive and carry on for those who came before us. Thankfully, we can now vaccinate adults and elders with confidence, knowing that getting vaccinated is the best way to protect our community and the quickest way to end the pandemic!

Until we return to normal: Get vaccinated when it's your turn. Continue to practice masking and social distancing outside. Avoid crowded settings and wash your hands regularly.

The Northwest Portland Area Indian Health Board is a non-profit tribal advisory organization that serves the forty-three federally recognized tribes of Oregon, Washington, and Idaho. **www.npaihb.org**
Follow the Northwest Native American Center of Excellence's Visual Stories page for future PSAs in the series. The NNACoE works to sustainably address the health care needs of all people by increasing the number of AI/ANs in the U.S. health professions workforce.
See: **https://blogs.ohsu.edu/researchnews/2020/11/20/ohsu-center-and-partners-release-first-native-health-psa-with-cares-act-funds/**

NPAIHB Health & Wellness During the Pandemic



Birdie Wermy, MPH
(S. Cheyenne)

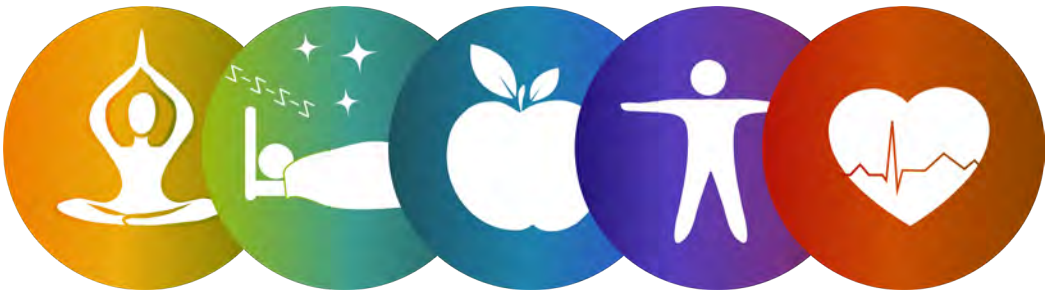
Behavioral Health Project Manager &
Wellness Committee Co-Chair

We can all agree 2020 was a hard and challenging year. Our world and daily life as we once knew it, was shut down in the blink of an eye. Our favorite restaurants were closed, the movie theaters were shut down and the gyms were closed – to avoid the spread of the Coronavirus. We all had to adjust to working from home, teaching our children from home and in some cases, becoming an in-home daycare for our children while trying to maintain a household and normal schedule. For some of us, this was a blessing in disguise. No more driving and sitting in traffic, more time with our families and children, more home cooked meals and more time to focus on our health and wellness.

The Northwest Portland Area Indian Health Board (NPAIHB) employees receive 30 minutes per day of paid Wellness time, and a full hour if combined with their lunch break. Employees use Wellness time to participate in running, walking, lifting weights, cycling, yoga, CrossFit, and other activities.

During the pandemic the Wellness Committee came up with ideas on how to engage staff virtually through weekly Craft Circle meetings, Wellness Wednesday Workouts with Erik and most recently Yoga w/ Ashley on Thursdays. A few of these activities included participation from our member Tribes as well as our family, children and friends. Our goal was to engage with others the same way we would've if we were in the office. We had a number of participants ranging from 5 -10 staff, family and friends on any given night. We also held our very first Virtual Summer Challenge which began on June 21st 2020 and extended through to the end of the year to reach a goal of 2,121 minutes (our address). We had a total of 26 staff participate in the Summer/Fall/Winter challenge and received positive feedback from this virtual challenge. We wanted to encourage ALL employees to take advantage of the 30 minutes of paid wellness time that you get every workday. This was a self-care approach to help with the physical, mental, spiritual, and emotional health which is especially important during this time. Consistently taking care of yourself in all these areas can help build your immune system, promote clear thinking to make decisions and overall physical wellbeing.

A few of our member Tribes also held their own virtual challenges and invited health board staff and family to participate. A few of the health tracking apps, include inKin, Strava, MapMyRun and the Nike Plus app. If you have a Garmin or Apple watch, there are certain apps that can track your workouts, heart rate and other health information. For our virtual challenges, we used a Google doc and staff would log their weekly activities and minutes. At the end of each month, we sent out monthly updates on the minutes and activities we participated in along with encouraging words and slogans to get folks going on their health and wellness. During our check-in meetings, staff would share their activities with one another, allowing for other staff to engage with one another by sharing HOW they were using their wellness time during the week.



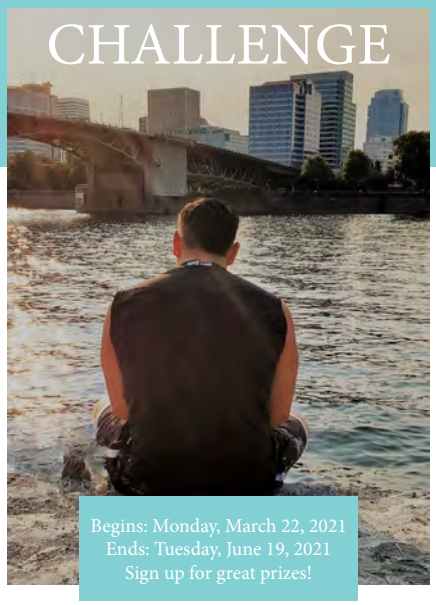
During the summer, we also held our 2020 Virtual Picnic and all staff were gifted a wellness bag from Native Preserve filled with Sweet Grass from Sakari Farm (Tumalo, Oregon), a Sweet Grass candle, sunscreen, chap stick, hand sanitizer and thermometer. Staff and family were invited to meet at the 12 o'clock hour and enjoy lunch together.

Going outside each day for 15 minutes of fresh air and sunshine helps the body make vitamin D. Vitamin D deficiency can create vulnerability to the common cold (Source: John's Hopkins Medicine). It's also important to keep in touch with friends, especially the ones who uplift you, and give people the benefit of the doubt during this challenging time. Practicing mindfulness and gratitude promotes your well-being. Spending time each day to say positive affirmations for yourself can improve your mental health and mood (Source: John's Hopkins Medicine).

61 Top Self Care Tips During the Coronavirus Pandemic updated 3.23.21

- Prioritize Sleep – Your Mood and Immune System Are Counting On It
- Work. It. Out – Test Ride A Workout You've Never Done Before
- Skip, Jump, Hop and Get Silly
- Play A Game
- Avoid Mindless Snacking, Eat Intuitively Instead
- Enjoy the Healing Power of Baking
- Practice Kindness and Gratitude
- Practice Positive Self Talk
- Practice Diaphragm Breathing
- Stand Up and Stretch
- Reap the Health Benefits of Laughter by Watching YouTube Videos

SPRING FITNESS CHALLENGE



Spring begins March 20th! Time to get out and about.

Safety Note: Check with your medical provider before starting any exercise plan.

Begins: Monday, March 22, 2021
Ends: Tuesday, June 19, 2021
Sign up for great prizes!

NPAIHB has been Challenged!

The Burns Wellness Center has asked us to join their Spring Fitness Challenge.

Simply keep track of your physical activity minutes by using the link provided. Wellness committee will compile and send to Burns.

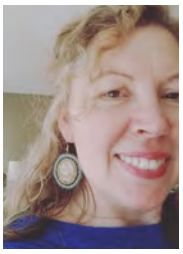
https://docs.google.com/spreadsheets/d/1B0V27VVDare4D8_Lmaun0dit-wr9aRXXPCwbiLWdPKI/edit?usp=sharing

Most health organizations recommend at least 150 minutes of any kind of physical activity. (30 minutes a day, 5x a week)

NW Portland Area Indian Health Board
2121 SW Broadway, Ste. 300
Portland, Oregon 97201
www.npaihb.org

Currently NPAIHB staff are participating in a Spring Wellness Challenge with the Burns-Paiute Tribe (3.22-6.19) and we have a total of 20-24 staff participating each week.

Have a Healthy Mother's Day!



Tyanne Conner, MS

Native Boost
Project Coordinator

Mother's Day is coming up soon! In honor, we want to share with you what we know about pregnancy, breastfeeding, and vaccines in the era of COVID-19. We wish for all* people to be safe and healthy in these uncertain times. To that end, we want to provide useful vaccine-related information so that each person may make the best and most informed decision for themselves and their families.

American Indians and Alaska Natives have been negatively affected by COVID-19 at **disproportionate rates** compared to non-Natives, and while Tribes have done great work to reduce the spread and to distribute vaccines, there is still work to be done to safeguard our communities. To protect the most vulnerable including mothers, babies, elders, and others with serious health conditions, we must make sure we reach **community immunity.** The safest and best way to do that is by making sure that all people eligible to receive vaccines, including those who are pregnant and breastfeeding have the opportunity to do so.

Vaccines are one of the **most studied,** regulated, and safest medical interventions ever created. Increased **safety monitoring** has been put into place for all COVID-19 vaccines including monitoring for those who are pregnant. The **FDA** has stated that for the three currently available COVID-19 vaccines, there are no contraindications for those who are pregnant or breastfeeding. In fact, antibodies generated from the vaccine have been found in both breast milk and umbilical cord blood. This means that immunity from the vaccine is **passed** from mother to baby, giving baby the best possible chance at good health.

Pregnant people are more prone to severe illness if they get COVID-19 and though it is rare, it is possible for babies to get COVID-19 through the placenta, during birth, or after via what is called vertical transmission. For this reason, it is especially important to provide accurate vaccine information so that those experiencing pregnancy can make informed decisions.

Understanding how vaccines work arms us with the information we and our communities need. Messenger RNA or mRNA vaccines DO NOT contain the live virus so CANNOT give someone COVID-19. Viral vector vaccines like the Johnson & Johnson (J&J) vaccine also DO NOT contain the COVID-19 virus and thus cannot make us sick with COVID-19. In response to questions whether Moderna vaccine was safe for those who are pregnant, the World Health Organization (WHO) has updated its stance: "Based on what we know about this kind of vaccine [mRna], we don't have any specific reason to believe there will be specific risks that would outweigh the benefits of vaccination for pregnant women." Pfizer is currently in clinical trials with healthy pregnant people over 18 years and once those results are available, we will provide updates.

V-safe, a smartphone-based tool that prompts an online health check-in by answering simple questions after vaccination helps us gather more information on safety of vaccines. Pregnant people who have been vaccinated are highly encouraged to participate. Vaccinated pregnant people also may choose to enroll in a registry that gathers more information about their experiences. Currently more than 69,000 people have enrolled in the registry and the more who register, the more safety information can be gathered. MotherToBaby, a trusted source of information about medications and other exposures during pregnancy and breastfeeding, includes information regarding COVID-19 exposure, and vaccine safety during pregnancy. More information from the FDA on vaccines currently available can be found here.

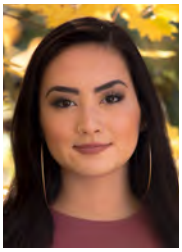
New Faces

Dawn Bankson,
PHN, MSN, ARNP/CPNP

Oregon Tribal and Urban
Testing Liaison

My name is Dawn Rae Bankson. It is an honor to be a part of the Northwest Portland Area Indian Health Board and Northwest Tribal Epidemiology Center. I received a Bachelor of Science degree in Nursing at Loma Linda University and a Master of Science/Pediatric Nurse Practitioner Certification at California State University Fresno in 1997. My love for science/medicine may have been influenced by my father's work as a medical research engineer. His involvement in science and medicine started before I was born and included his work in developing the first positive pressure mechanical ventilator, called the Puritan-Bennett Ventilator, which replaced the iron lung.

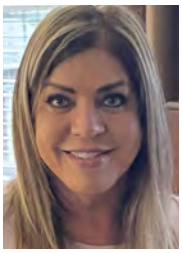
In my early years, I had the opportunity to work in public health with the Riverside-San Bernardino Tribes in California. After moving to Washington, I was privileged to work for the Quinault Indian Nation as their Pediatric provider and cherished my years working with the Tribe. I feel very fortunate to now have this opportunity to put on a new hat by serving the many Northwest Tribes. I am humbled and excited to be a part of this wonderful NPAIHB team!



Asia Brown
(Choctaw)

Sexual Health
Communications Specialist

Halito! My name is Asia Brown (pronouns: she/her/hers) and I am a member of the Choctaw Nation of Oklahoma. I was born in Tulsa, OK but consider Skiatook my hometown. At a young age my parents and I moved to Florida where I spent most of my childhood, then made our way out here to Oregon where I completed high school and college. I graduated from OSU in spring 2020 with a B.S. in Public Health, minor in Ethnic Studies, and emphasis on Microbiology. Shortly after, I joined the board in October 2020 as the Communications Intern for the Native Dental Therapy Initiative (NDTI), then switched gears to coming on full time as the Sexual Health Communications Specialist on the Washington Youth Sexual Health (WYSH) project. I am so grateful to be a part of this work and to continue being in community with you all.



Tammy Cranmore

Finance Director

I've been a CFO for the last 15 years, with 25 years working in Finance & Accounting. I graduated from PSU with a degree in Finance. I live in Battle Ground, WA and have 2 kids, 17 & 20. I am a people person that loves to mentor my team and embrace new ideas. I have extensive experience specializing in Finance and Accounting and serving as an expert on senior executive teams. I have experience with leadership of multi-million-dollar entities and I deliver quantifiable profitability through cost management, analytical reasoning, training, and technology. I have a track record of raising profitability, uncovering high-impact issues, and rolling out new technologies. I am very excited for this new opportunity and I look forward to working with all of you in my new position at the Board.

New Faces (continued)

Jane Manthei

Healthy Native Youth
Outreach Specialist

My name is Jane Manthei and I'm from Winslow, Arizona. My family largely resides in the Midwest and in Russell County, Alabama. I am the new outreach specialist for Healthy Native Youth and I am excited to help educators deliver culturally relevant curricula for AI/AN youth. I have a BS in Biology from the University of New Mexico with a focus on immunology. After college, I taught high school science in McLaughlin, SD in a small public school in Standing Rock. Prior to accepting this role, I was working as a policy journalist in Northeast Arizona for a small radio station with an emphasis on Navajo Nation, Hopi tribal, and city/county government.

I like science fiction and hockey, I read a lot, and I've never turned down a fried egg sandwich. I'm thrilled to be in the Pacific Northwest and I am delighted to sign on with the Project Red Talon team!

Holly Thompson Duffy, MPH

Environmental Health
Science Manager

Holly Thompson Duffy spent the past year as an Environmental Health Consultant working to assist the NPAIHB Environmental Public Health staff carry out immediate activities in response to the COVID-19 public health emergency. Prior to this she served for nine years as an Environmental Protection Specialist with the Portland Area Indian Health Service, Division of Environmental Health Services, managing an interagency agreement with the EPA to reduce the environmental health risks of pests and pesticides by educating and empowering communities to adopt Integrated Pest Management (IPM). While there she also served as the technical lead on a project with the EPA to collect valuable data on children's exposures to lead, allergens, pesticides, and PCBs in Tribal childcare facilities, utilizing a comprehensive data collection strategy which included environmental sampling. Holly came to IHS from Chicago where she spent four years as an Environmental Health Programs Manager at a small nonprofit working with schools, childcare facilities, residents, property managers and municipalities to reduce toxic exposures in the built environment and improve environmental health outcomes. She initiated programs targeting refugee and Spanish speaking populations, as well as a series of pollinator protection projects. She received her undergraduate degree from Trinity College in Hartford, Connecticut. She will be graduating this spring from the University of Alabama at Birmingham with an MPH in Environmental Health and Toxicology.

988 and the National Suicide Prevention Lifeline

30 Percent

The percent the suicide rate has climbed since 1999

1 in 5

people above the age of 12 has a mental health condition

280

For every one person that dies by suicide, 280 people seriously consider suicide but go on to live

Why Do We Need 988?

America is experiencing a mental health crisis. But the crisis is not irreversible.

- The suicide rate has climbed nearly 30% since 1999 – and the rate has increased in 49 out of 50 states over the last decade.
- From 2016-2017 alone, there was a 10% increase in suicides of young people between 15-24 years old in the US.
- Approximately one in five people above the age of 12 has a mental health condition in the US.
- Suicide is the second leading cause of death among young people, and the tenth leading cause of death in the US.
- **More Americans died from mental health crises and substance abuse in 2018 alone than have died in combat in every war combined since World War II.**
- However, suicide is most often preventable. For every person who dies by suicide, there are 280 people who seriously consider suicide but do not kill themselves.
- Over 90% of people who attempt suicide go on to live out their lives.

For too long, our system for mental health crisis services has been underfunded and undervalued. We will now meet this challenge with the evidence-based crisis intervention that the 988 crisis line will provide.

What Is 988?

A direct three-digit line to trained National Suicide Prevention Lifeline counselors will open the door for millions of Americans to seek the help they need, while sending the message to the country that healing, hope, and help are happening every day.

In 2020, the Lifeline received over 2.6 million calls, chats, and texts. **With an easy to remember and dial number like 988, the Lifeline hopes to reach many more people in emotional crisis.**

A 988 crisis line that is **effectively resourced and promoted** will be able to:

- Connect a person in a mental health crisis to a trained counselor who can address their immediate needs and help connect them to ongoing care.
- Reduce healthcare spending with more cost-effective early intervention.
- Reduce use of law enforcement, public health, and other safety resources.
- Meet the growing need for crisis intervention at scale.
- Help end stigma toward those seeking or accessing mental healthcare.

When you've got a police, fire or rescue emergency, you call 911.
When you have an urgent mental health need, you'll call 988.

V!brant Emotional Health · RI International · ABHW · American Foundation for Suicide Prevention · BHL Behavioral Health Link · Centerstone · lines for life · Mental Health America · NAMI · National Council for Behavioral Health · American Association of Suicidology · The Trevor Project

Lifeline Crisis Centers are Effective

The National Suicide Prevention Lifeline provides 24/7, free and confidential emotional support to people in suicidal crisis or emotional distress across the United States. The Lifeline is administered by the nonprofit Vibrant Emotional Health and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). **The Lifeline is effective in reducing suicidal and emotional distress.**

- Evaluations and caller feedback show that Lifeline counselors are effective in reducing caller distress and suicidality, and help tens of thousands of people get through crises every day.
- Since launching in 2005, the Lifeline call volume has increased approximately 14% annually.
- In 2005, the first year of the Lifeline, it answered over 46,000 calls. In 2020, the Lifeline received over 2.6 million calls, chats, and texts.

The Lifeline is a network of over 180 accredited crisis call centers.

- Crisis centers are local and connected to their community resources, community mental health, hospitals, social service and first responders.
- All Lifeline centers are accredited, provide extensive training in crisis intervention and suicide prevention, and must apply Lifeline's best practices on calls.
- These same crisis centers continue to answer more than 12.1 million additional non-Lifeline crisis calls on their local, city, county and state crisis lines.

The current Lifeline grant is not designed to fund the centers answering local Lifeline calls. The Lifeline and Vibrant Emotional Health currently provide the following support to the national network for local crisis call centers:

- Routes calls through the network to a local crisis center or national backup center and pays for incoming call charges.
- Sets clinical standards and sector-wide best practices, and provides constant quality assurance, training, assessments, and guidelines to ensure quality, effective help for people in crisis.
- Runs state-of-the-art technology to ensure responsiveness, including online 24/7 chat platform technologies.
- Provides specialty national services for the network, such as: national backup centers; Lifeline's crisis chat centers; and Lifeline's Spanish-speaking subnetwork, translation services and accessibility options for individuals who are deaf or hard of hearing.
- Provides grants to temporarily support some states to answer more Lifeline calls until they can sustain their own funding, and one-time planning grants to help state agencies and centers plan and prepare for 988.
- Lifeline and its partner, the National Association of State Mental Health Program Directors, work closely with state officials to promote awareness and approaches for successfully funding local Lifeline crisis centers.

How Does 988 Improve Health Care and Public Safety Costs?

When 988 is fully implemented, Lifeline call centers could potentially divert many calls from 911, resulting in substantial cost-savings for health and safety crisis and emergency systems nationally.

- Reducing the dispatch of law enforcement to persons in non-emergency mental health crises frees more resources to respond to public safety needs, and reduces the hesitation associated with reporting mental health crises.

Call centers in the Lifeline divert hundreds of thousands of calls from 911 every year.

- The Lifeline dispatches emergency services for only 2% of calls.
- People in crisis who call the Lifeline have better health outcomes than people in crisis who are triaged with emergency services personnel.

What Is Next?

Vibrant Emotional Health, the administrator of the Lifeline, has identified three key themes to guide 988 implementation:

1. **Universal and Convenient Access**, including omnipresent public awareness and varying modalities for individuals to access 988 through their preferred method of communication.
2. **High Quality and Personalized Experience** that is tailored to the unique needs of the individual while also in line with identified best practices.
3. **Connection to Resources and Follow Up** to ensure all persons contacting 988 receive additional local community resources as needed.

In keeping with these themes, Vibrant has several key recommendations:

It is critical that **appropriate funding** for the network, individual crisis centers, and the crisis continuum be allocated to serve more people in crisis. States should exercise their authority to implement a 988 fee, similar to the current 911 fee, that would be restricted to crisis center and service provider expenses, to ensure a robust infrastructure. In 2018, fees for 911 generated $2.6 billion to support that service; similar investment is needed for mental and behavioral health crises. The fee revenue should supplement, not supplant, funding from diverse sources, including federal, state and local governments.

Increased **collaboration between 911 and 988** can provide more options for those in crisis, such as dispatching mobile crisis teams to individuals in mental health or suicidal crisis rather than police or EMS, and greater coordination of care options like crisis stabilization units. Such collaborations can reduce the burden on the costly use of hospital emergency departments.

We must also seek to optimize and support services that ensure **access and inclusion** within 988 to meet the unique needs of at-risk groups, including youth, rural populations, BIPOC communities, and LGBTQ+ individuals.

We encourage stakeholders, crisis centers, telecommunications agencies, mental health providers, and people with lived experience to work together to help build this public health safety net for all.

For source materials for any part of this document, please contact communications@vibrant.org.

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

2121 SW Broadway • Suite 300 • Portland, OR 97201

Return Service Requested

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD OCTOBER 2020 RESOLUTIONS

21-02-01 Support for Legislation to Amend Lease Compensation Provisions of the Indian Self-Determination and Education Assistance Act

21-02-02 Environmental Protection Agency Region 10 General Assistance Program (GAP) Proposal

21-02-03 TI- 21-007 Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Opioid Response (TOR) Grant

21-02-04 Behavioral Health Aid Training and Support Project

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