HEALTH NEWS & NOTES

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Motor Vehicle Injury Emergency Department Visits during the COVID-19 Pandemic for American Indian People in Oregon and Washington

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American Indian/Alaska Native (AI/AN) people experience a disproportionate burden of motor vehicle injuries and fatalities. Unlike other motor vehicle injury-related data sources, Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) contains near real-time data. Emergency Department (ED) and urgent care facilities in both Washington and Oregon states participate in this reporting program, and the Northwest Tribal Epidemiology Center will soon have access to Idaho data as well.

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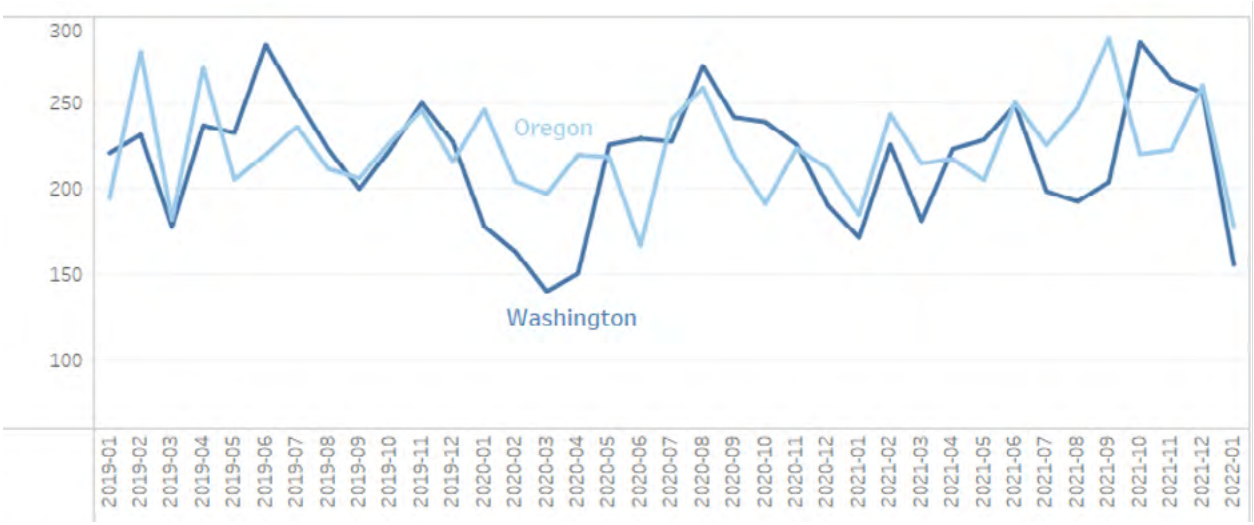
Motor Vehicle Injury Emergency Department Visits during the COVID-19 Pandemic for American Indian People in Oregon and Washington

To assess motor vehicle injury-related ED visits (MVIs), we used the built-in syndrome query "All Traffic Related v2," which includes motor vehicle, pedestrian and non-car motorized vehicle injuries. To specifically analyze pedestrian injuries, we used a query developed by the Washington Traffic Safety Commission. We downloaded and analyzed Oregon and Washington state syndromic surveillance data from January 1, 2019 through January 31, 2022.

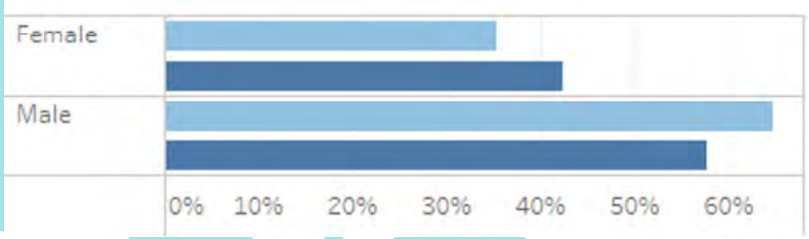
American Indian motor vehicle traffic (MVT) Emergency Department visit rates for Washintgon and Oregon

Rate per 10,000 Emergency Department visits



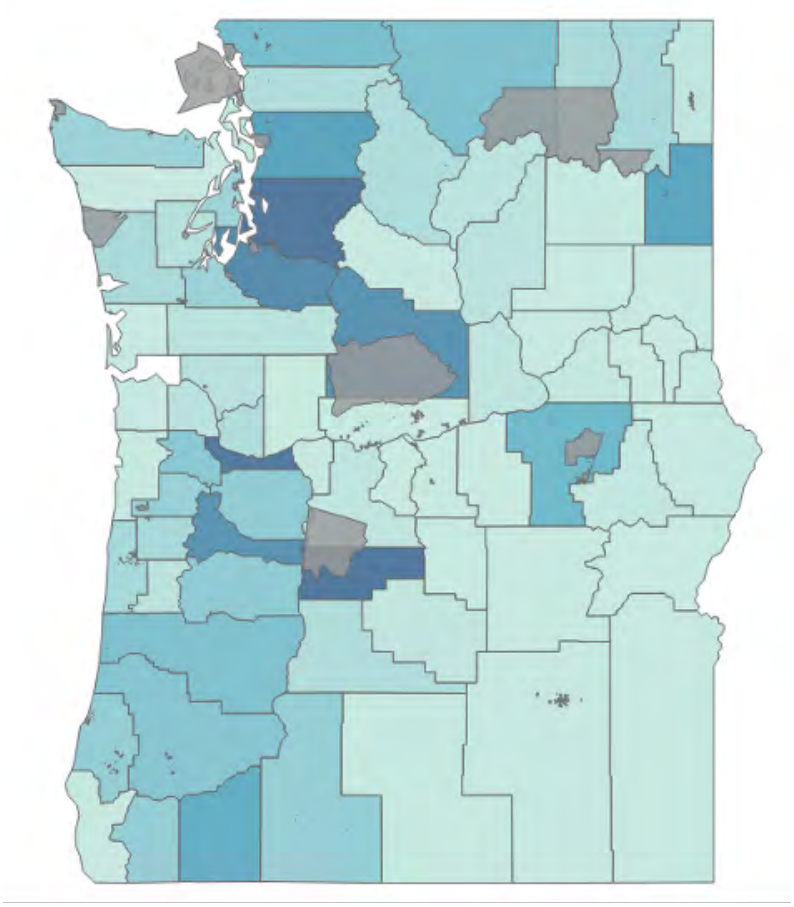
AI/AN in both Oregon and Washington had very similar patterns in rates of MVT ED visits. We found that the pandemic affected the rate of all visits to EDs, including MVIs, with visit counts and rates being very low in March and April 2020. AI/AN people had similar seasonal patterns of MVI visits as White people, though visit rates were consistently higher for AI/AN. Elders age 70+ had the lowest MVI visit rates of any age group, but the highest rate ratio compared to White. AI/AN people had higher rates of MV pedestrian injuries than White. The number of MVI visits among AIANs vary between counites in both Washington and Oregon depending on the population density and rurality.

A higher proportion of AI/AN men were injured as pedestrians in both for Washington and Oregon



Number of American Indian Motor Vehicle Traffic Emergency Department visits by county, Washington and Oregon States, 2019-2021.

Darker color means higher counts within state . American Indian lands layer in gray.



The Syndromic Surveillance data was very useful in assessing the most recent trends of MVI visits in both Oregon and Washington. As seen with other race groups the rates of MVI visits to ED and urgent care facilities among AIANs were lower in early periods of the COVID-19 pandemic, however it is concerning to see the rates go up immediately. We will wait for more data to compare with the pre-pandemic trends. Just as seen with the ESSENCE data, higher rates of AIAN pedestrian injuries and fatalities are persistently observed in various other MVI data sources such as death certificate, hospital discharge & Fatality Analysis Reporting System (FARS) data. This indicate the need for traffic intervention priorities towards pedestrian safety.

For questions about the Syndromic Surveillance data please contact Nicole Smith at nsmith@npaihb.org.

Chair's Notes

Nickolaus D. Lewis
Lummi Nation

NPAIHB Chairman

We have crossed the halfway point of 2022 – welcome everyone as we continue to pull together!

There is an old Lummi saying that says 'we are not alone – that when you walk, wherever you walk – the ancestors are walking behind you.' It is important to remember that today, as we continue to walk, rest, run, and sometimes climb that this time has given us the opportunity to spend time with our kids, and our young people. It has offered us space to show how nature supports our traditions and our cultural ways. For example, gathering berries or bark and wood in the mountains. Or, dropping a crab pot, fishing off the islands and waterways of our people that our ancestors have fished since the beginning of time. In the mountains, we may also be preparing to pick huckleberries and welcome them through ceremony as the new seasons arrive.

Returning to the places and spaces that our ancestors once gathered or singing the same songs that they once sung brings us a sense of strength that we all need during this transition time. It has given me the energy to travel physical distances to meet and gather on behalf of NW Tribes to places like Washington D.C. where we advocated on the healthcare priorities of our communities – from supporting funding for dental health aide therapy education, addressing Indian Health Service funding to prioritizing the role of contract support costs in our tribal health programs. And, sharing those experiences – cultural, traditional and in advocacy – with our young people can help guide them during the tough times. Times like now. Taking the time to teach and listen to the young people is really an act of love and care, a healing time for all of us. We are resilient people. Our ancestors have persevered and we can, too. They are walking with us and beside us. And, will continue to guide us for the generations to come.

This month's issue of Health News and Notes is focused on injury prevention and maternal child health. In that light I encourage everyone to be mindful of the safety of all generations as you enter this summer season, physically and culturally – to gather. If you're traveling in a vehicle, remember the safety of each person in the car, from the youngest little one to our elders. During the summer months, our people may also spend more time on the water – whether it's on boats or shores, fishing or for recreation. Beware of issues like weather, condition of your vessel, and overloading. I encourage to be safe so you can bring your catch ashore, your wood or pick your berries, and return home to your families. Always be prepared!

Hy'shqe

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

Supreme Court Overturns Roe v. Wade | Policy Updates

Geoff Strommer

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On June 24, 2022, the U.S. Supreme Court issued its decision in Dobbs v. Jackson Women's Health Organization and overturned Roe v. Wade, the 1973 case that established that a state's authority to prohibit abortion is restricted by the U.S. Constitution's protection of the right to privacy. In addition, on June 29, 2022, the Court decided Oklahoma v. Castro-Huerta in which it extended state criminal jurisdiction to include crimes committed by non-Indians against Indians in Indian Country. Prior to Castro-Huerta, States only had criminal jurisdiction over crimes committed by non-Indians against non-Indians in Indian Country. Based on these two decisions, states could now attempt to apply their criminal prohibitions on abortion to non-Indian providers working in tribal health facilities.

Even before Dobbs, tribal health programs operating under Indian Self-Determination and Education Assistance Act (ISDEAA) agreements already had very limited authority to perform abortions. The annual appropriations legislation for the Department of Health and Human Services (HHS) contains language known as the "Hyde Amendment," which limits the extent to which federal funds may be used to cover abortion services. The current version of the Hyde Amendment provides that no federally-appropriated funds may be "expended for any abortion" except when: (1) "the pregnancy is the result of an act of rape or incest"; or (2) "in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."

The Hyde Amendment restrictions apply not only to funds that tribes receive from the Indian Health Service (IHS) but to other program resources as well. For self-governance tribal health programs, operating under Title V agreements with IHS, "[a]ll Medicare, Medicaid, or other program income … shall be treated as supplemental funding to that negotiated in the funding agreement." 25 U.S.C. § 5388(j). This means that the Hyde Amendment applies to all program income for such Title V programs, and as a result, the Hyde Amendment restrictions would apply regardless of the source of funds used to provide the service. For tribal health programs operating under Title I ISDEAA agreements with the IHS, all program income must "be used by the tribal organization to further the general purposes of the contract." Id. § 5325(m).

Because of Hyde Amendment restrictions, state-law abortion prohibitions are only likely to be of concern to tribal health programs to the extent that their exceptions to abortion prohibitions are narrower than those in the Hyde Amendment. For example, Idaho's abortion prohibitions that will soon be in effect impose requirements above and beyond those in the Hyde Amendment. Under Idaho's law, exceptions based on rape or incest must have been reported to law enforcement with a copy of the report provided to the physician. I.C. §18-622(3)(b)(ii)–(iii). Exceptions based on danger to the pregnant person are stated more narrowly in Idaho, requiring the abortion to be "necessary to prevent the death" of the pregnant person. Id. § 18-622(3)(a)(ii). Under both exceptions in Idaho law, the abortion has to be performed in a manner that best provides an opportunity for the unborn child to survive unless doing so poses a greater risk of death to the pregnant person. Id. § 18-622(3)(a)(iii), b(iv).

When state laws are more restrictive than the Hyde Amendment or other federal law, the question arises of which set of requirements apply—state or federal. The Biden Administration has engaged in a series of actions designed to assert that federal requirements preempt more restrictive state requirements.

Supreme Court Overturns Roe v. Wade and Other Policy Updates (Cont'd)

When state laws are more restrictive than the Hyde Amendment or other federal law, the question arises of which set of requirements apply—state or federal. The Biden Administration has engaged in a series of actions designed to assert that federal requirements preempt more restrictive state requirements.

- Executive Order on Access to Reproductive Healthcare Services: On July 8, 2022, President Biden signed his Executive Order on Protecting Access to Reproductive Healthcare Services, which included a directive to the HHS Secretary to identify steps to ensure that all patients receive the full protections for emergency medical care afforded under federal law.
- EMTALA Guidance: On July 11, 2022, HHS Secretary Becerra sent a Dear Health Care Provider Letter on the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Centers for Medicare and Medicaid Services (CMS) issued guidance entitled Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals). Both stated that EMTALA requires all hospital emergency departments to provide appropriate screening, stabilizing treatment, and transfer, if necessary, "irrespective of any state laws or mandates that apply to specific procedures." The State of Texas is already challenging this guidance in court, having filed suit in July 14, 2022.
- IHS Circular: On June 30, 2022, IHS issued a circular stating the Administration's position that "state law does not apply to IHS authority to perform abortions." It argues that based on Congress' vesting of authority in HHS and IHS, "states cannot take actions that are preempted by federal law, including but not limited to: 1.) compelling IHS federal staff to take any action inconsistent with the scope of their official duties; 2.) prohibiting the use of IHS funds for authorized Purchased/Referred Care (PRC) services; 3.) prohibiting IHS patients from accessing authorized services; and 4.) compelling access to IHS records." The IHS Circular does not address the extension of state jurisdiction in Dobbs, which was issued the day before.
- Pharmacy Guidance: On July 13, 2022, HHS's Office for Civil Rights (OCR) issued guidance to pharmacies warning that federal law prohibits recipients of federal financial assistance from denying benefits or otherwise discriminating against persons on the basis of sex or disability, both of which include pregnancy. OCR examples of potential discrimination include refusal to fill prescriptions of drugs that can cause abortion such as mifepristone, misoprostol, or methotrexate to a person who needs medication after a miscarriage, for ulcers, or to end an ectopic pregnancy. Another example includes failure to stock certain medications because they can be used to terminate a pregnancy.
- DOJ Position on FDA Preemption: In addition to OCR's pharmacy guidance, the Department of Justice (DOJ) has taken the position that state law restrictions on approved medications to terminate early pregnancies are preempted by U.S. Food and Drug Administration (FDA) approval. U.S. Attorney General Garland has stated in a Department of Justice press release that "the FDA has approved the use of the medication Mifepristone. States may not ban Mifepristone based on disagreement with the FDA's expert judgment about its safety and efficacy."

States with restrictive abortion laws, however, are likely to continue to challenge the Biden Administration's position that federal law preempts state law in a variety of areas related to abortion prohibitions. The law is not settled regarding questions such as whether state or federal law applies to abortion restrictions in various circumstances or whether states may outlaw the use of FDA-approved prescription drugs for purposes that are illegal under state law. Providers, therefore, may find themselves bearing the consequences of being stuck in the middle of state and federal laws until courts resolve such issues.

Additionally, courts have not yet addressed whether states have civil regulatory jurisdiction over non-Indian providers providing abortion services in Indian Country. This analysis could affect, for example, whether tribes may use their Purchased/Referred Care (PRC) dollars to fund out-of-state travel for abortion services. If a state tried to regulate such care, courts would apply the balancing test established in White Mountain Apache v. Bracker, which considers: (1) whether exercise of state jurisdiction would infringe on tribal self-government; (2) whether the exercise of state jurisdiction would harm federal or tribal interests as articulated in federal law; and (3) the state's interest in exercising regulatory jurisdiction. It seems likely the factors would weigh in favor of preemption of any state civil law prohibiting abortion services provided in Indian Country, but such a case has not yet been decided.

Tribal health programs will need to stay in contact with attorneys as matters continue to develop surrounding the impact of Dobbs. For example, to date states have not passed laws banning contraceptives such as birth control pills or emergency contraceptives such as Plan B. But, of course, this could change. The legal context surrounding Dobbs remains very much in flux as states enact new laws, the federal government asserts its position, and courts address open questions regarding federal preemption and state authority in the context of reproductive healthcare.

Major Developments in National Opioid Litigation

Two major tribal settlements announced earlier this year in the context of the sprawling national opioid litigation are expected to bring hundreds of millions of dollars in funding to help ameliorate the opioid crisis in Indian Country. Tribes will also see additional money set aside as part of the funds intended for public creditors in bankruptcy proceedings involving a separate manufacturer defendant. Meanwhile, some litigation continues against remaining defendants in courts around the country, although settlements are increasing in number. And, the company that started it all—Purdue Pharma—awaits the Second Circuit's approval or rejection of its bankruptcy and settlement plans.

Proposed Settlements with Johnson & Johnson and Major Distributors

Johnson & Johnson, a major manufacturer of prescription opioids, and distributors AmerisourceBergen, McKesson Corporation, and Cardinal Health, reached tentative settlement agreements with tribal plaintiffs in the opioid litigation earlier this year. Johnson & Johnson agreed to pay $150 million to settle all tribal claims against it, to be distributed over two payments, while the three distributors agreed to pay nearly $440 million to settle all tribal claims against them, to be distributed over six annual payments. Both settlements are expected to be finalized and implemented in the near future.

All federally recognized tribes and Alaska tribal health organizations are eligible to participate in both settlements. Many tribes and tribal organizations have already opted into the settlements, and those that have not will have three years from the effective date of the Johnson & Johnson settlement, and four years from the effective date of the Distributor settlement, to opt in. (However, the sooner a tribe opts in, the sooner it can begin receiving settlement distributions.) As these settlements are finalized, the defendants are expected to pay into the Opioid Trusts set up to administer the funds—known as the Tribal Abatement Fund Trusts (TAFTs). Be on the lookout for communications from the TAFT Trustees: Kevin Washburn, Kathy Hannan, and Mary Smith. A separate process to finalize the allocation formula for settlement funds will be carried out by court-appointed Special Master David Cohen and former federal judge Layn Phillips.

Ongoing State Opioid Litigation

Despite the settlements, litigation continues around the country. The Cherokee Nation bellwether case continues against three major pharmacy chains and was earlier this year remanded to state court. Several states also continue to pursue litigation outside of the federal multidistrict litigation. Further, generics manufacturers Teva Pharmaceuticals, Anda Inc., and Allergan will soon face a damages trial after a New York jury found the manufacturers liable for creating a public nuisance in Suffolk and Nassau Counties. The New York Attorney General also recently alleged in that matter that Teva made intentional misrepresentations to the Attorney General and the court. Companies like Johnson & Johnson, Rite Aid, Walgreens, the Distributors, and Teva also continue to reach settlements to avoid disposition at trial.

Bankruptcy Proceedings: Mallinckrodt & Purdue

Courts have finally approved a bankruptcy plan proposed by Mallinckrodt Pharmaceuticals, a major manufacturer of generic prescription opioids. The Mallinckrodt plan would create a $1.75 billion opioid abatement trust, from which tribal claimants would receive approximately three percent (3%) of dedicated government abatement funds. The plan reached its Effective Date on June 16, 2022. For ease of administration, Mallinckrodt is likely to begin payments into the TAFTs following the finalization of the Johnson & Johnson and Distributor Settlements, which will be managed through a similar process. The total payout to Tribes is expected to be in the $20-30 million range, over approximately eight years.

Although Mallinckrodt is the first tribal opioid settlement to become fully effective, Purdue Pharma—the manufacturer of OxyContin—was the first opioid Defendant to declare bankruptcy. Its proposed bankruptcy plan was initially approved by the federal bankruptcy court, but in December of 2021, U.S. Federal District Court Judge Colleen McMahon reversed the approval.

Supreme Court Overturns Roe v. Wade and Other Policy Updates (cont'd)

Among other things, that plan would have created multiple opioid abatement trusts for state, local, and tribal governments using a $4.3 billion cash contribution from members of the Sackler family (the shareholders of Purdue) and other company assets. Judge McMahon's reversal of the plan was based on her holding that the civil liability releases that were negotiated by the Sackler family in exchange for their cash contribution to the plan are not authorized by the bankruptcy code. That reversal decision has been appealed to the Second Circuit, where the parties are still awaiting a decision. Subsequently, Purdue and the objecting states reached a new agreement that would increase the Sackler family contribution up to $5.5 billion—but implementation of that agreement still hinges on the Second Circuit's ruling, which is expected to be released sometime this summer.

McKinsey MDL

On February 4, 2022, global consulting firm McKinsey & Co. announced a $573 million settlement with the Attorneys General of 47 states, the District of Columbia, and 5 territories. Thereafter, hundreds of local subdivisions and tribal governments brought suit against McKinsey as well, alleging that it played a key role in the development and implementation of the fraudulent and misleading marketing practices that led to the opioid epidemic through its work with clients like Purdue Pharma and Endo Pharmaceuticals. That case is still in the relatively early stages of discovery.

McKinsey has nevertheless been the subject of a number of recent news articles addressing McKinsey's role as a consultant for the Food & Drug Administration while the FDA was meant to be formulating regulations for opioids, and detailing reports that McKinsey used its experience leading the FDA's opioid regulation discussions to better solicit McKinsey's opioid clients for business, based on the firm's contacts at and experience with the industry regulator.

Settlement Updates Available on Public Website

As the opioid litigation continues, Tribes and members of the public can obtain updated information about tribal specific settlements on the public tribal settlement website, https://www.tribalopioidsettlements.com. You are encouraged to check the website frequently, and use the "Contact Us" links for any questions, including questions for the court-appointed Trustees of the tribal settlements.

Contract Support Cost Legislative Fix and Third-Party Revenue Claims

A major issue being litigated is whether the Indian Health Service (IHS) owes contract support costs (CSC) for health care services funded by third-party revenues that tribes generate under their Indian Self-Determination and Education Assistance Act (ISDEAA) agreements with IHS. The additional services made possible by the collection and expenditure of third-party revenues—or what the ISDEAA refers to as "program income"—require tribal providers to incur additional administrative and overhead costs that meet the definition of CSC. In the 2016 Sage Memorial decision, a federal court in New Mexico ruled that program income expended on additional services is part of the "federal program" entitled to CSC under the ISDEAA. Since then, however, all courts to address the issue have sided with IHS, holding that only funds appropriated to IHS and transferred in the ISDEAA agreement generate CSC requirements. Two of those cases are on appeal: the San Carlos Apache case in the Ninth Circuit, and the Northern Arapaho Tribe case in the Tenth Circuit. The Northwest Portland Area Indian Health Board signed onto amicus briefs supporting the Tribes in both of these appeals. Oral argument in Northern Arapaho took place on January 19, 2022, and the San Carlos argument took place on March 7. Decisions could come any day. If either appeal is successful, it would create a conflict with the D.C. Circuit, which ruled against the Swinomish Indian Tribal Community last year. Such a "circuit split" would increase the odds of the Supreme Court granting a petition to decide the issue. In the meantime, several similar cases have been filed in the lower courts, some of which are on hold pending the appeals.

A recent court decision has thrown into question the very definition of CSC. In Cook Inlet Tribal Council, Inc. v. Dotomain, the D.C. Circuit Court of Appeals held that any costs associated with activities IHS normally carries out in direct service must be funded (if at all) through the Secretarial amount and are not eligible to be paid as CSC. Since most costs currently reimbursed as CSC are also incurred by IHS when it operates programs directly, this ruling has the potential to drastically reduce CSC payments—as demonstrated in a recent IHS decision cutting the Fort Defiance Indian Hospital's CSC by almost 90%, from $18,515,007 to $1,887,739. The Hospital has challenged that decision in court, and last month won a preliminary injunction restoring full payment on a prorated monthly basis until the litigation is resolved.

In the meantime, tribal advocates have been working toward a legislative fix to overturn the Cook Inlet decision. On April 8, 2022, Rep. Tom Cole (R-OK) introduced H.R. 7455, the "IHS Contract Support Cost Amendment Act." The bill would make simple technical amendments to the ISDEAA to essentially overturn the Cook Inlet decision and clarify that administrative and overhead costs normally incurred by IHS (or BIA) but not fully paid in the Secretarial amount can be paid as CSC. This would restore the status quo, not expand the CSC entitlement. The bill has a long, bipartisan list of co-sponsors.

JUUL Litigation

In ongoing JUUL multi-district litigation (MDL), tribal governments are seeking to hold defendants Altria Group and JUUL Labs, Inc., along with several of JUUL's executives (Defendants), liable for their role in defrauding tribal communities and creating an e-cigarette epidemic among tribal citizens, particularly tribal youth. To this end, tribes and tribal organizations have filed Tribal Complaints which set forth violations of the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1961, et seq., in addition to state public nuisance, negligence, and consumer protection law claims.

Specifically, the Tribal Complaints allege that Defendants knowingly or negligently marketed and promoted JUUL products to the Tribes within geographic areas controlled and occupied by the Tribes and that Defendants specifically and deceptively targeted American Indian and Alaska Native (AI/AN) communities with their highly addictive and damaging products. The Complaints uniformly allege that Defendants' misconduct led to a vaping epidemic within AI/AN communities, resulting in very disproportionate negative impacts on Native American people. The Tribal Complaints seek equitable relief; injunctive relief; abatement; and statutory, exemplary, and compensatory damages.

Each party was allowed to select one Bellwether Tribal Plaintiff, in addition to a proposed Bellwether Tribal candidate for the Court's consideration as a third Bellwether Tribal Plaintiff. As their designated first choice for the Bellwether Tribal Plaintiff case, Plaintiffs selected Fond du Lac Band of Lake Superior Chippewa v. Juul Labs, Inc., No. 3:20-cv-03995. Defendants designated as their first choice for Bellwether Tribal Plaintiff Klamath Tribes v. Juul Labs, Inc., Case No. 3:20-cv-03987. On May 9, 2022, Judge Orrick determined that Defendants' proposed candidate, the Cheyenne and Arapaho Tribes of Oklahoma (MDL Member Case No. 3:21-cv-05134), would be the third Bellwether Tribal Plaintiff.

With the Court's May 9, 2022 approval of the three Bellwether Tribal Plaintiffs, the Tribal Bellwether Schedule has begun, and case-specific discovery for Bellwether Tribal Plaintiffs is therefore underway. Under a process not yet determined, only one of the three tribes now identified will be selected to have the contemplated Bellwether trial. That trial is expected to be held sometime in late 2023 or early 2024.

Program Profile: Native Cars TIPCAP

Olivia Whiting
Oglala Sioux

Native CARS TIPCAP
Project Coordinator

Are you passionate about motor vehicle injury and violence prevention? Join the Native CARS TIPCAP coalition today!

What is the Native CARS TIPCAP coalition?

The coalition is a group of individuals seeking a similar goal; preventing child passenger and pedestrian injuries throughout tribal communities in the Pacific Northwest.

The coalition is comprised of injury prevention professionals representing many different tribes, tribal organizations, and state organizations from Oregon, Idaho, and Washington. Many members are certified Child Passenger Safety Technicians (CPSTs). Some members join to connect with other CPSTs working for tribes and urban American Indian/ Alaskan Native organizations to build their CPST network.

Why should I join the coalition? Here are a few reasons you may benefit from joining:

- We can support you in obtaining CPST certification for you or your staff
- We can partner to coordinate car seat check events and activities at your tribe
- We can help collect community car seat use data and provide training on using best practices when collecting data
- We can help conduct community pedestrian safety evaluations and work with you to carry-out evidence-based approaches to improving community pedestrian safety

To join the coalition and to receive more information and updates from Native CARS TIPCAP follow this QR Code:

OR Use this link:
https://lp.constantcontactpages.com/su/6xgRwuZ

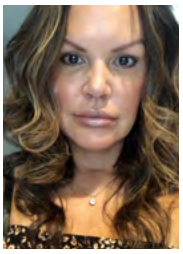
Native CARS TIPCAP Helps Coordinate Child Passenger Safety Technician (CPST) Certification Courses for those serving Northwest Tribes

We held our first CPST certification course at the NPAIHB in Portland, with great interest from tribal members and employees from Oregon, Idaho, and Washington. This nationally certifying course allows successful tribal trainees coming from various sectors within tribal nations to assure children in their community always ride safe

If staff in your community are interested in attending or hosting a CPST course you can contact: Olivia Whiting at owhiting@npaihb.org

Newly certified CPSTs with the instructors and MCH Programs Director Tam Lutz right after completing the first Native CARS TIPCAP sponsored CPST course car seat check event at NAYA Family Center in Portland, OR)

Breaking News! "Breaking Teeth News"



Ticey Mason, MA
Siletz, Sixes (Kwatami), Mikonotunne, Joshua (Chemetunne), Chasta Costa, Tututni

NTDSC Director

The Northwest Tribal Dental Support Center would like to remind you to please be safe and use appropriate safety gear in order to prevent dental injuries when playing sports, not to use your teeth as a tool, and watch out for items that you can trip and fall over. Watch out for those Legos!

Below are some prevention tips and stories about dental injuries from the Grand Ronde Dental Program and the Marimn Dental Program:

Dr. Taylor Wilkens, DDS, Dental Director for the Marimn Dental Program for the Coeur d'Alene tribe shares this recent experience:

I just saw a young child a month ago who knocked out his lower permanent front tooth completely after he fell. He had some tissue trauma that we had to clean and manage at that visit as well. We were able to re-implant the tooth and splint it in place. A month later now things look great, patient is doing well. We just took the splint off. He will likely need follow up care with the specialist to address the nerve of the tooth, but it looks like the tooth is saved.

If someone finds themselves in this situation, I think the best thing to do would be as follows:

1. Find the tooth and pick it up by the crown and not the root. Try to avoid disturbing the root and any tissue attached as much as possible.
2. Rinse the tooth with clean water to ensure no debris is present and fully re-insert the tooth as soon as possible. (ONLY APPLIES TO PERMANENT TEETH, NOT BABY TEETH)
3. See a dentist immediately for evaluation and likely splinting.
4. If someone is not comfortable re-implanting the tooth by themselves, then they should see a dentist immediately if they wish to save the tooth. In my experience and from what I've read, the ideal window to re-implant a tooth is under an hour. Place the tooth in saline or milk to keep it hydrated.
5. If it is a baby tooth that is knocked out, it should be left out and not re-inserted.

Dr. Taylor Wilkens, DDS, Dental Director for the Marimn Dental Program for the Coeur d'Alene tribe

Sheila Blacketer, RDH, Dental Manager for the Grand Ronde Dental Program does a circle time presentation with Head Start students 2-5 years of age about tooth safety. She then sends a letter out to the Head Start parents discussing what was presented and includes an instruction sheet on what to do if the child breaks or loses a tooth. Sheila shares these prevention tips:

1. Pick up your toys—they are a trip hazard
2. Don't use your teeth to pry open potato chip bags, cereal etc.
3. Don't use your teeth to pull apart Legos or any other toys
4. Don't chew on pencils, crayons etc.
5. We don't bite our friends
6. Don't chew ice

Sheila Blacketer, RDH, Dental Manager for the Grand Ronde Marimn Dental Program

NORTHWEST TRIBAL DENTAL SUPPORT CENTER
NPAIHB

"Weaving oral health into healthy lives"

SAVE THE DATE
AUG. 15-17

2022 Portland Area Dental Meeting

Inviting all dental staff! We strongly encourage Dental Directors and Prevention Coordinators to attend this meeting. You are welcome to invite other health or community staff to this meeting, but please make sure they register.

Date:	Content:	Dates:
Monday, Aug.15, 2022	Dental Director's Meeting	12:00 pm – 5:00 pm
Tuesday, Aug. 16, 2022	Portland Area Dental Meeting	8:00 am – 5:00 pm
Tuesday, Aug. 16, 2022	Reception	6:00 pm – 9:00 pm
Wednesday, Aug. 17, 2022	Portland Area Dental Meeting	8:00 am – 12:00 pm
Wednesday, Aug. 17, 2022	We Smile: MID Style meeting	12:30 pm – 5:00 pm

SUQUAMISH CLEARWATER CASINO RESORT

Suquamish Clearwater Resort 15347 Suquamish Way NE
Suquamish, WA 98392
Room rate is $96 + Tax
For calling in room reservation 866-609-8700
Northwest Portland Area Indian Health Board-Dental Conference
For online booking go to:
Link to direct group reservation Use Group ID: 20302
Reservations must be booked by July 14, 2022
Please contact Ticey Mason for details at tmason@npaihb.org.

A travel scholorship is available up to $1,000 per eligible program!

Below is the surveymonkey link and for the save the date:
https://www.surveymonkey.com/r/ntdsc2022

SCAN ME

1972 - 2022
NPAIHB

The Northwest Portland Area Indian Health Board (NPAIHB) and IHS Release Maternal-Infant Health and Substance Use Resources

Lt. Cmdr. Sherry Daker

PharmD, Advanced Practice Pharmacist, Red Lake Hospital

Capt. Cynthia Gunderson

PharmD, Chair, IHS National Committee on Heroin, Opioids, and Pain Efforts

Wendee Gardner, DPT, MPH

Consultant, Good Medicine Tribal Public Health Consulting Services

Jessica Leston, MPH

Clinical Programs Director

The Indian healthcare system understands the importance of building healthy communities by contributing to the overall health and well-being of American Indian and Alaska Native (AI/AN) pregnant and parenting people, infants, partners, and families – including those impacted by substance use disorders (SUDs).

Pregnancy is often described as a window of opportunity for substance use intervention because it can be a powerful motivation for change. A persons need to access maternal health services increases during pregnancy, providing an opportunity to strengthen patient-provider relationships which has been shown to lead to better patient health outcomes.

Healthy babies begin with healthy and supported pregnant and parenting people and their families. Pregnancy and parenthood are sacred times where we can engage and support evidence-based, holistic, and culturally responsive care. There are three potential points of intervention during pregnancy – prenatally, birth, and postnatally where healthcare providers can engage with patients and families to provide education, support, and resources.

The Northwest Portland Area Indian Health Board (NPAIHB) alongside Indian Health Service, Tribal, and Urban Indian (I/T/U) healthcare providers, and AI/AN individuals impacted by substance use disorders developed best practice considerations for providers and educational fact sheets for AI/AN pregnant and parenting people and families experiencing SUD.

The goal of these resources is to wrap pregnant people in blankets of care and weave strong networks of support for their partners and families.

A family wellness plan template was also created for pregnant and parenting people to reflect and identify their individual needs and supports. Although a family wellness plan is a personalized plan for the pregnant or parenting person, it can also be a tool for providers for care coordination to medical, social, cultural, and spiritual care.

Fear of stigmatization, being reported to social services, and losing custody of children are barriers to care, often leading to pregnant people delaying or avoiding prenatal care services altogether. Pregnant people who access prenatal care have greater opportunities to engage in their healthcare, shared decision-making, and more positive birth outcomes than those who do not receive care.

The Northwest Portland Area Indian Health Board (NPAIHB) and IHS Release Maternal-Infant Health and Substance Use Resources (cont'd)

Pregnant and parenting people may also face challenges in receiving support from their healthcare providers who may have their own biases. Traditionally, treatment of SUDs was separate from general healthcare services which provide challenges for providers who may have limited training in treating pregnant people with SUDs.

Today, we know that the most effective way to help a person who is misusing substances and who may be at risk for developing a substance use disorder is early identification and intervention. Because timely intervention leads to an increased chance of long-term recovery, it is important that healthcare providers routinely screen all persons, including those who are pregnant, about their use of substances. Screening also creates opportunities to engage with patients early on and to connect individuals to care.

In any setting, learning and practicing use of supportive, nonjudgmental language that treat pregnant and parenting people with compassion and respect can often be a first step to establishing trusting relationships that creates a space to better understand patients and how to support their recovery.

Increasing access to preventative comprehensive care, empowering and educating families, and facilitating greater integration of care across health systems is the best chance of promoting the health of pregnant and parenting people, infants, partners, and families impacted by SUDs.

Additional Resources:

Indian Health Service Maternal and Child Health and Wellness

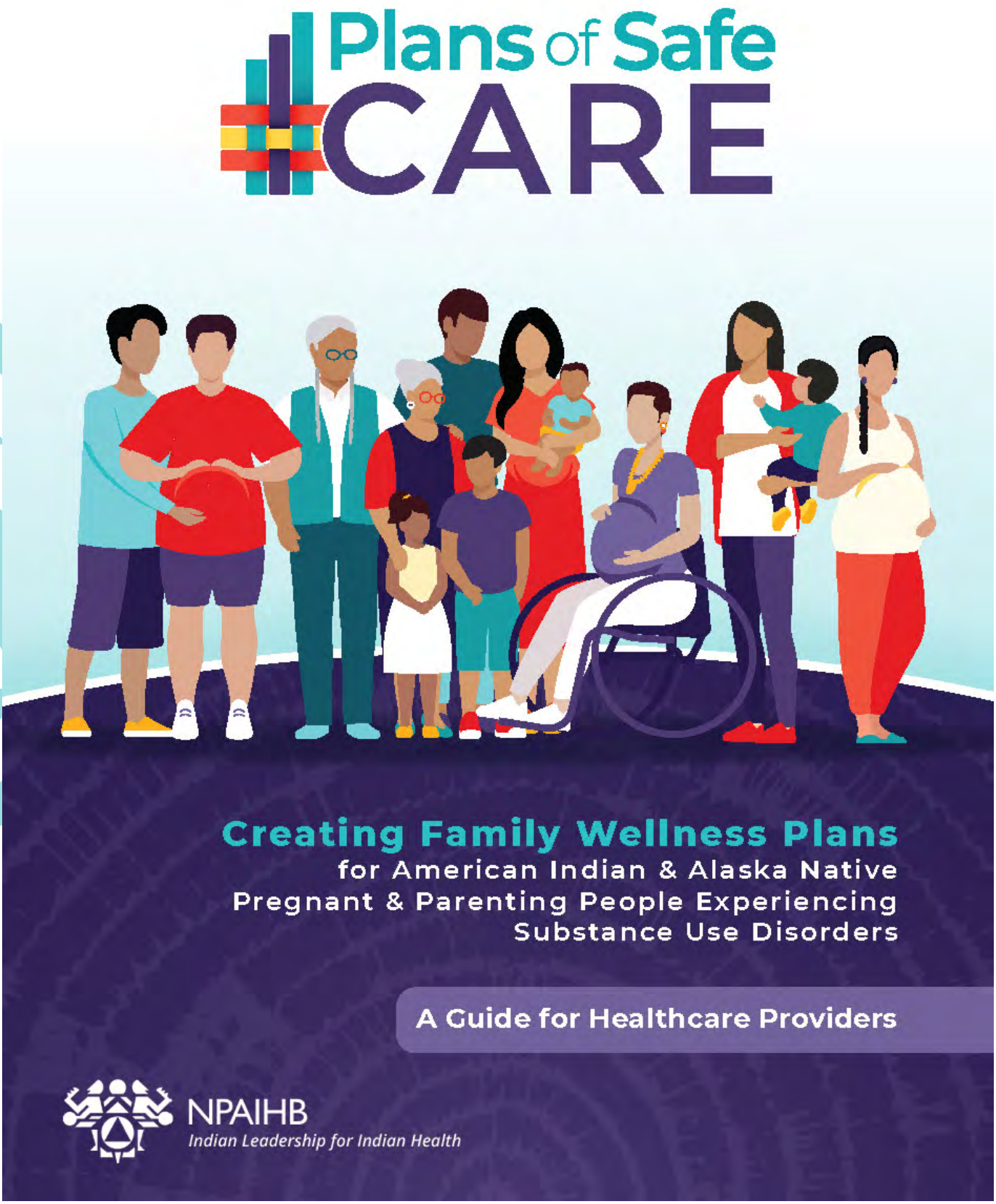
Indian Country Substance Use Disorder ECHO Program

National Clinician Consultation Center Substance Use Warmline

Related Content:

National Recovery Month: Recovery is for everyone

IHS announces requirements to increase access to Medication Assisted Treatment for Opioid Use Disorder



Full Guide Avalilable **HERE**

Pregnancy Experiences of American Indian and Alaska Native birthing people during the COVID-19 pandemic

Natalie Roese, MPH

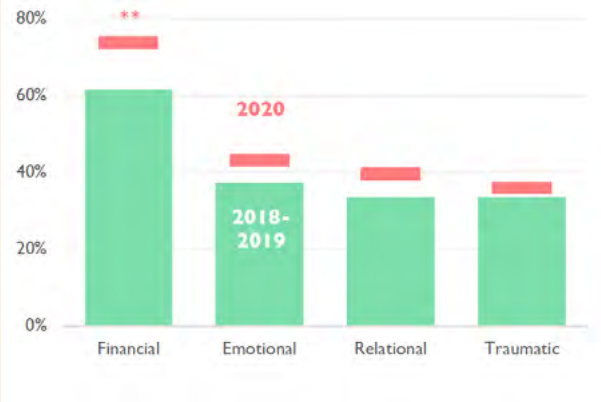
Improving Data & Enhancing Access (IDEA-NW)
Biostatistics Consultant

The COVID-19 pandemic placed unique burdens on pregnant people, who in 2020 faced pandemic-related healthcare shortages and a higher risk of COVID-19 complications. This risk is exacerbated for American Indian and Alaska Native (AI/AN) pregnant people who experience both higher rates of COVID-19 and face pre-existing financial and structural barriers to continuity of care across pregnancy. Together these factors placed a substantial burden upon AI/AN pregnant people to navigate a pandemic healthcare system and protect themselves from COVID-19

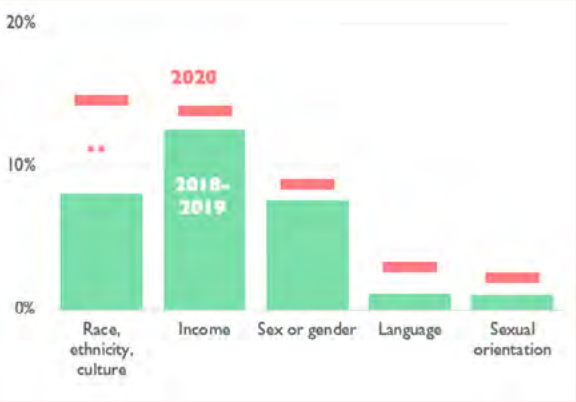
74% of AI/AN pregnant people who gave birth in 2020 reported financial stressors in the year before pregnancy

The COVID-19 pandemic brought financial and social upheaval, with many people losing their jobs and isolating from friends and family. AI/AN people who gave birth between June and December of 2020 reported higher financial stressors (73.7% in 2020 v. 61.3% in 2018-2019, p=0.019) with twice as many respondents losing their jobs (22.8% v. 11.7%, p<0.001) and more than half of all respondents changing their residence during the 12 months before the baby was born. In 2020, fewer AI/AN pregnant people reported having someone to take them to a clinic if they were sick (p=0.002), someone to talk to, or someone to show love them and affection other than a child (p<0.10). AI/AN pregnant people in 2020 were almost twice as likely as those 20 When comparing AI/AN and NHW respondents who gave birth between June-December 2020, AI/AN respondents reported a lower income distribution (p<0.0001) and were more likely to use Medicaid as the primary source of payment (p=0.0017). AI/AN respondents were more likely than NHW respondents to experience healthcare discrimination on the basis of income (p<0.0001), age (p=0.0002), or race/ethnicity (p<0.0001).

AI/AN respondents who gave birth during the COVID-19 pandemic reported greater stressors those who gave birth during 2018-2019.



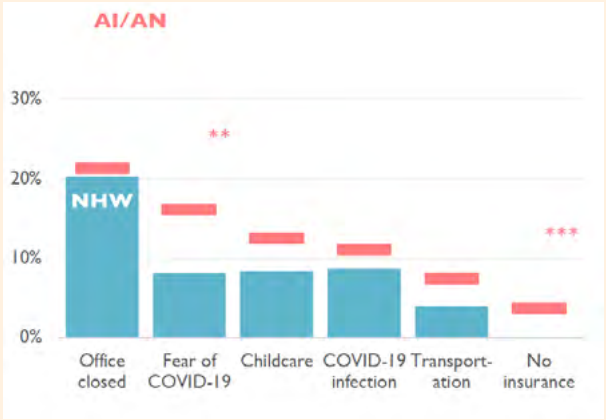
AI/AN respondents who gave birth during the COVID-19 pandemic reported greater healthcare discrimination than those who gave birth during 2018-2019.



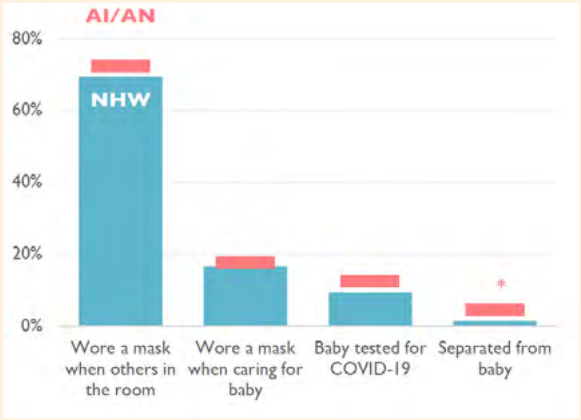
When comparing AI/AN and NHW respondents who gave birth between June-December 2020, AI/AN respondents reported a lower income distribution (p<0.0001) and were more likely to use Medicaid as the primary source of payment (p=0.0017). AI/AN respondents were more likely than NHW respondents to experience healthcare discrimination on the basis of income (p<0.0001), age (p=0.0002), or race/ethnicity (p<0.0001).

Data from the COVID-19 supplement indicate that AI/AN respondents had more difficulty than NHW respondents in finding personal protective equipment such as masks (p=0.028), sanitizer or soap (p=0.0144) and disinfectant (p=0.043) to protect themselves from COVID-19. These respondents faced greater food insecurity (p=0.0069), more problems paying bills (p<0.0001), and were also more likely to report losing childcare (p=0.0168), having to move (p<0.0001) and becoming homeless (p=0.0048). AI/AN respondents were more likely face barriers to prenatal care such as not having a phone (p=0.0438), cellular data (p=0.002), and a lack of space (p=0.012). AI/AN mothers were more likely to report delayed or cancelled PNC appointments due to lost insurance (p=0.002) or fear of COVID-19 (p=0.008).

AI/AN respondents who gave birth during the COVID-19 pandemic reported missing PNC appointments due to COVID-19 more than NHW respondents.



AI/AN respondents who gave birth during the COVID-19 reported greater COVID-19 hospital precautions than NHW respondents.



At the time of delivery, AI/AN respondents were more likely than NHW respondents to report not being allowed to have a support person in the room (p=0.026) and being separated from their infant (p=0.038). AI/AN pregnant people experienced higher preterm birth (p=0.0054) and longer hospitalizations (p=0.0548). After birth, AI/AN respondents were more 2.5 times more likely to receive no postpartum care (16.1% v. 6.1% p=0.007) were 2 times more likely to have postponed immunizations for their infant (12.4% v. 6.6%, p=0.045) for their infant, and were more likely to have canceled infant checkups (p=0.028).

AI/AN pregnant people were more likely than NHW pregnant people to be denied a support person during delivery due to COVID-19 precautions.

Across pregnancy, delivery, postpartum and infant care, AI/AN birthing people who delivered in the second half of 2020 faced steeper challenges to a healthy pregnancy than those experienced by NHW pregnant people and by AI/AN pregnant people in previous years. Underlying structural and financial barriers to timely and culturally competent care for AI/AN pregnant people are compounded during healthcare crises and these barriers increase the risk of complications for birthing people and infants, with generational consequences yet to be determined.

Data Source:

Analyses are based on the Oregon Pregnancy Risk Assessment Monitoring System (PRAMS), which collects data on maternal attitudes and experiences. In July 2020, Oregon added a COVID-19 supplement was to the PRAMS survey. AI/AN birthing people were identified by records with any mention of AI/AN race or Tribal affiliation. AI/AN respondents classified as other races were re-coded, and for this reason unweighted data were analyzed. The analytic sample is composed of AI/AN (n=137) and non-Hispanic White (NHW, n=368) PRAMS respondents who gave birth in June-December of 2020 and 841 AI/AN respondents who gave birth in 2018 and 2019. 2020 AI/AN responses were compared to 2020 NHW responses and 2018-2019 AI/AN responses using Chi-squared or Fisher's exact tests.

Caring For the Health of Our Brain:
The Benefits of Early Detection and Screenings for Memory Loss and Cognitive Decline

Chandra Wilson, MSW
Modoc/Klamath/Yahooskin

NTEP/BOLD Program Manager

How important is recognizing changes in your brain and cognitive function? The National Institute on Aging, Alzheimer's Disease and Education Referral Center published a series of educational booklets promoting awareness and education to understanding Alzheimer's Disease, dementias, and memory loss. Some of us get more forgetful as we age, - when do we take memory loss seriously?

June was Alzheimer's and Brain Health Awareness month. The Northwest Tribal Elder Program and the board collaborated with other local, state, National and tribal partners to promote the importance of keeping our elders safe and healthy. There is limited data available linking AI/ANs to Alzheimer's and dementia. Alzheimer's disease and dementias are one of the most critical public health issues. Understanding the differences between Alzheimer's disease and dementia from normal aging is important – recognizing the signs and symptoms early on can benefit the person living with memory loss.

Symptoms of dementia vary from person to person and may show up in behavioral and emotional symptoms, to physical and movement symptoms. According to the CDC, each year, one in every three elders age 65 and older falls. Falls are the leading cause of injury deaths for American Indian elders age 65 and over, according to the Centers for Disease Control's Web-based Injury Statistics Query and Reporting System. Unintentional injuries have traditionally been the 7th leading cause of death among adults age 65 and over and for elders falling or having unintentional injuries is a bigger issue than most people realize. Falls can cause moderate to severe injuries, such as hip fractures and head traumas, and can increase the risk of early death (cdc.gov).

How important is recognizing change in your brain and cognitive function? Important! The more knowledge our elder caregivers, families, health providers and community folks know of the common signs and symptoms of age-related cognitive changes allows for early detection, intervention, diagnosis and appropriate treatment, education, support and life planning.

Here is what we do know:

1. Those living with memory loss or dementia related diseases, have a higher risk of falls and unintentional injuries.
2. American Indian and Alaska Native elders report the greatest percentage of falls (34.2 percent) of all races/ethnicities.
3. Early detection and screening for Alzheimer's and related dementia provides a range of benefits to the individual experiencing Alzheimer's Disease and Related Dementia signs and symptoms.

What can we do to support our elders' safety and well-being?

1. Engage with our elders in any safe comfortable movement or physical exercise
2. Take elder to get hearing and vision screenings
3. Have a plan for medication distribution that may have side effects that make you sleepy or dizzy
4. Limit alcohol
5. Wear grip or non-skid shoes
6. Use a walking stick or assisted walking tools

Get educated and aware of Alzheimer's and related dementia and normal aging:

1. Watch for early signs and symptoms
2. Make an appointment with your provider and be specific of your symptoms
3. Advocate for memory screening

The Northwest Tribal Elder's project is funded on a 3-year cooperative agreement and will focus on supporting our member tribes, and providing training and technical assistance/resources for capacity building, program and policy development, mobilizing partnerships, providing health education and promotion, to our member tribes in areas that will enhance community development and health equity.

For more information and project updates, please contact:
Kerri Lopez, Project Director at **Klopez@npaihb.org**
Chandra Wilson, Project Manager at **cwilson@npaihb.org**
MartiRai Ramsey, Project Coordinator at **mramsey@npaihb.org**

Roadmap for Indian Country

CDC collaborated with tribal leaders across the nation to develop and implement the Healthy Brain Initiative and the Road Map for Indian Country (RMIC). This is a first-ever public health guide focused on dementia in AI/AN communities. NPAIHB is the first AI/AN CDC funded collaborative grant. The HBI/RMIC is a community engagement tool that can empower tribal communities to:

- **Understand effects of dementia in tribal communities**
- **Understand and provide training and resources to caregivers and providers**
- **Identify prevention, early detection and preventive strategies for public health approaches**

SAVE THE DATE

Savvy Caregiving in Indian Country
A Train-the-Training Trainer
By Dr. Neil Henderson
Portland, Oregon
August 15-17, 2022: 8 am – 5pm
REGISTER HERE
Spokane, Washington
September 18-21, 2022
REGISTER HERE

Sources Cited:
Common Injuries as We Age (cdc.gov)
Alzheimer's Disease and Related Dementias | National Institute on Aging (nih.gov)

Understanding Vaccine Safety

Tyanne Conner, MS

Native Boost
Project Coordinator

As COVID-19 vaccines roll out for children under 5 years of age, we want to answer common questions about vaccine safety so you can rest easy knowing how your family is protected should you choose to vaccinate.

Are vaccines safe?

Vaccines are some of the most safe, effective, tested, and monitored medicines we take. Many checks and balances go into vaccine creation and monitoring. To be approved, vaccines must have fewer side effects than harm caused by diseases themselves. Thankfully there are safety systems in place to make sure that vaccines are helping more than harming.

How is vaccine safety monitored?

Vaccine safety is monitored throughout the vaccine creation process and for the entire time vaccines are being used. The Vaccine Adverse Event Reporting System (VAERS) for all vaccines, and the v-safe system collect information on any side-effect possibly related to vaccines. Anyone including providers and patients who have received a vaccine can report events serious or non-serious. This process ensures that not only doctors, but also citizens are able to report their own experiences with vaccines.

An important note is that even health problems unrelated to vaccination can be reported. It is good to remember that when looking at data reported to the safety monitoring systems, we understand those reports will show whether or not the event is actually related to the vaccine or whether it is a coincidence.

For example, imagine that Joe went to the doctor and was given a vaccine in his left arm. On the way home, Joe was in a car accident and his left arm was injured when a car crashed into the driver's side door where Joe was sitting. It is possible that the arm injury could be reported to VAERS, but is actually unrelated to the vaccination. It happened close to the time of vaccination, but we know that the vaccination did not cause the arm injury. If we don't look at context, someone might think that a vaccine caused a terrible injury to Joe's arm. We must remember that some things may look related until you look closer and see the whole picture.

Even as safe as vaccines are, it's important to note that sometimes there are adverse events after vaccination.

What are adverse events or vaccine injuries?

Any health problem that happens after a vaccination is considered an adverse event. Soreness or redness at the injection site are common examples of local (injection area) reactions. Systemic (whole body) reactions might include a fever, headache or fatigue. These types of reactions typically resolve within a few days. More serious side effects such as hospitalization are very rare and if linked to a vaccine, can be considered a vaccine injury. If someone is injured by the vaccine itself, there are programs to help.

What are Injury Compensation Programs?

In very rare cases, a vaccine might cause a serious problem. Those who petition and are found to have been injured may receive compensation through the Vaccine Injury Compensation Program (VICP). In the United States in the 34 years, from 2006-2019, billions of covered vaccines were given and an average of only 265 claims were found to be related to vaccines and were compensated. This means that for every 1 million vaccines given, only 1 individual who filed a claim was compensated, meaning that a vaccine was found to be related to their injury. You can find more information about the National Vaccine Injury Compensation Program at the HRSA website. The program for COVID-19 vaccine injury information can be found at the Countermeasures Injury Compensation Program CICP site.

What does this all mean?

Vaccines are important medicines that save lives and prevent diseases. Serious vaccine injuries are very rare. Many layers of safety monitoring make sure those who have already taken a vaccine will be safe and that the process of vaccine creation continues to improve.

Should children 6 months and older receive COVID-19 vaccines now that they are available?

Children are at risk for serious disease, hospitalization, and also at risk for post-COVID conditions. In fact, COVID-19 has become a leading cause of death among children and teens. We don't know which child will become sick or die from COVID-19. Even healthy children are at risk so it's important to use all of our weapons against this illness.

COVID-19 vaccines are safe and effective at preventing serious illness and death. Vaccinating children can protect them from getting seriously ill, being hospitalized, and from dying. Protecting the little ones also helps to prevent the spread to those who are most vulnerable including babies, elders, and those who are immune-compromised.

You can find information about vaccine side-effects here and we always recommend talking with your trusted healthcare provider.

Scan our QR code below to go directly to the Native Boost webpage

Contact:

Please feel free to reach out with any questions to the NPAIHB vaccine team at Native Boost.

Tam Lutz, Project Director
tlutz@npaihb.org

Tyanne Conner, Project Coordinator
tconner@npaihb.org

Youth and Community Resources to Increase Awareness about Fentanyl

Adolescent Health Team, NPAIHB

Everyone is talking about fentanyl for good reason; it's more common than most think, and the rates of accidental overdoses are the leading cause of death for 18 to 45 year-olds.

What is fentanyl?

Fentanyl is a synthetic opioid that is 50 to 100 times more potent than heroin or morphine.
Drug traffickers often mix fentanyl into other drugs because it is cheaper, and a small amount goes a long way.

Why is fentanyl dangerous?

Those who cut drugs with fentanyl do not always know how much product they are using, so it is easy to overdose. It's often mixed with other substances like: powders (cocaine), capsules, fake Rx pills (like Xanax or Oxy/ M30s) and many more.

Fentanyl is so incredibly potent only 2mg can be lethal and many counterfeit pills contain 5mg, which is more than twice the lethal dose.

Nearly half of counterfeit pills tested by DEA contain a lethal dose of fentanyl.

We R Native has Tips for Staying Safe: **https://www.wernative.org/articles/why-is-fentanyl-dangerous**

Resources for Schools and Educators

A comprehensive Fentanyl & Opioid Response Toolkit for Schools has been added to Healthy Native Youth's website. The Oregon Health Authority (OHA) and the Oregon Department of Education (ODE) co-developed the Toolkit for Schools to support educators, administrators, school nurses, students and families in response to the public health crisis related to rising youth and adult opioid overdoses and deaths in Oregon. The toolkit provides information about how to create an emergency protocol to administer Naloxone, also known as Narcan. The toolkit includes information on how to access, administer and store this life-saving opioid overdose prevention medication. Additionally, the toolkit has resources to support staff training, prevention education, and resources to develop and implement emergency response procedures in school and community settings.

THRIVE 2022 Brings Youth Back Together

Maleah Nore

THRIVE Suicide Prevention
Project Coordinator

A For the first time in nearly two and a half years, youth from the Pacific Northwest and beyond gathered in Portland, Oregon for the annual THRIVE Conference hosted by the Northwest Portland Area Indian Health Board's THRIVE suicide prevention project. Approximately 40 Native youth representing 13 federally-recognized tribes joined the conference from June 27th-July 1st. The message of this year's conference was to "Take Healthy Risks", and our participants truly delivered. Many youths found their voice during the conference. From leading lunchtime prayers to singing traditional songs to teaching other youth their skills, participants in THRIVE 2022 did not hesitate to step up and speak out.

Each youth participated in one of four interactive workshops that taught about art, healthy lifestyles, and coping during hard times. Topics discussed include exploring healthy ways to deal with stress, building community connections, and how to channel challenging life events into positive outcomes, such as creating song lyrics, public art, being a leader in the community, or diving into movement and nature.

The five-day agenda was comprised of guest speakers and four workshop sessions. The workshop sessions featured beadwork, movement and exercise, mural painting, and music making. Each session incorporated American Indian/Alaska Native culture, traditional learning strategies, and skill-building activities that educated youth about healthy decision-making.

The Washington Youth Sexual Health project hosted a workshop called Sex is Sacred. Youth in this workshop practiced beadwork while learning about sexual health, decolonizing the mind, and how a healthy relationship with sex can promote mental health. These youths learned about a stigmatized topic from their facilitators as well as each other, all while in a supportive environment. Participants learned a variety of beadwork skills, including peyote stitch, beading on felt, and beading around cabs.

We R Native led a workshop inspired by the many ways to incorporate movement into one's life. Nine Native youth from the Northwest region learned fun and exciting ways to keep their bodies and minds active. Participants learned about traditional and modern forms of movement, including canoeing, frisbee golf, and urban hiking, and how these activities promote mental health and intersect with creative movement and art. Thanks to our indigenous community leaders helping with the We R Native workshop, facilitator's, the youth were engaged and inspired.

In another workshop, youth promoted social change and action by creating an activism mural at the Portland State University skate park, "The Courts". Muralist N. O. Bonzo and a team of facilitators assisted students with the creation of a mural titled, "Culture is Resistance". Each youth poured their own creativity and cultural knowledge into the mural. Participants learned how creating public art brings you closer to the community, while the art itself promotes change and unity. After the workshop, several teens said they intend to continue painting or creating public art.

Each day the conference hosted guest speakers and/or health educators to teach the youth about healthy lifestyles. The first guest speakers included Asia Brown, Celena Ghost Dog, Roger Peterson, and Maleah Nore of the Northwest Portland Area Indian Health Board. Through their unique stories and work, they gave powerful testimony on the power of community and how to be involved in public health. Another speaker session was led by Rosanna Jackson and Mel Butterfield with Lines for Life, who taught youth about self-care and how to cope with stress. Rosanna and Mel shared some of their experiences from creating the Pacific Northwest's first Native teen-led crisis support and help line, which will open in fall of 2022 on the Warm Springs reservation. Another day, Vashti Langford and Doug Barrett gave youth a lesson on active listening, the canoe family, and canoe journeys. Vashti and Doug inspired many youths to want to learn about traditional dug-out canoeing. Lastly, the Native Wellness Institute taught participants some unique skills that can be used during mental health struggles, such as ways to reach out, activities that can distract the mind, and mindfulness. The conference ended with a full day of performances, speeches, and games led entirely by the youth participants who were proudly smiling ear to ear.

Thank you to all the chaperones, facilitators, presenters, and staff that took the time to invest in these talented youth! Don't forget to SAVE-THE-DATE for next year's conference which will be held June 26-30, 2023 in Portland, OR.

Funding for this conference was made possible (in part) by funding from the Indian Health Service (IHS) and grant number SM082106 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the author and do not necessarily reflect those of SAMHSA, HHS, or IHS.

New Faces

Patrick Greener

Operations Director

Hello, My Name is Patrick Greener (He/Him) . I am excited to join NAIPHB as the Operations Director. I am a recent transplant from Iowa. I have a fairly broad background in management and operations having worked in operations for publicly traded companies as well as non-profits. I have a Law Degree and Masters of Law in Taxation from Mitchell Hamline Law School and a BA in Anthropology from the University of Minnesota.

Outside of work, I am married to Amy and we have three daughters (Anna, 24; Catherine, 22; Rita, 19) and a dog (Halbert, 6). We are currently enjoying being semi empty nesters as our youngest is a freshman in college. I enjoy running, reading, cooking and in my spare time I can be found creating craft cocktails as a bartender.

MartiRai Ramsey

Confederated Tribes of Warm Springs

BOLD/NTEP Project Coordinator

My name is MartiRai Ramsey. I am an enrolled member of the Warm Springs Nation and mother of three amazing children. I currently reside in Lynnwood, Washington with my children and our beagle, Kiave! I am very excited to join the NPAIHB team and partake in the healing movement! I am a passionate advocate for all of our relatives and truly a servant to my communities!

I love worshipping in washut services in our longhouse with my little sister! I believe in our Creator and the many ways His love for our people continues to persevere! I enjoy swimming, singing, cooking, watching powwow and paddle boarding! Music is my first language!

Catherine Stensgar

Aloha, my name is Catherine Stensgar, and my traditional name is Tsayamaut. I come from the Nooksack and Colville tribes in Washington state. I was born and raised in Nooksack territory, until 2018 when I moved to Hawai`i for college. I graduated this May from the University of Hawai`i at Manoa with a BA in Business Administration and Management.

Since I was 14, I have paddled traditional war canoes with the Rikkole Cree Canoe Club. Here my grandparents instilled the importance of mental and physical health for ourselves and our community. Canoe paddling has given us a positive outlet to promote the well-being of native communities and I am so excited to continue these values through the work of NPAIHB and getting to know everyone!

New Faces

Matthew Ellis

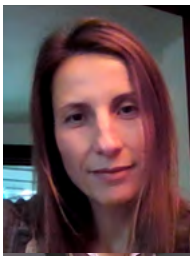
Institutional Environmental Public Health
Program Manager

Hello, my name is Matthew Ellis and I am so looking forward to joining the NPAIHB and the Environmental Public Health Program team as the Institutional Environmental Health Program Manager. For the past 3 years I have served as the Infection Prevention and Control Coordinator within the IHS Office of the Director-Office of Quality. Prior to that position, I worked as the Institutional Environmental Health Consultant/Pubic Health Emergency Manager at the Portland Area IHS for 8 years. I know many of you from our previous work together in the Tribal healthcare facilities across the region and look forward to supporting your teams again in any way I can!

I have a Master's Degree in Public Health and am Certified in Infection Prevention and Control (CIC) by the Certification Board of Infection Control and Epidemiology. I hold Certified in Dental Infection Prevention and Control (CDIPC) and Registered Environmental Health Specialist (REHS) designations and am an authorized OSHA General Industry Trainer. My previous healthcare infection control and safety position tenures include a private healthcare consulting firm, University of Kentucky Medical Center, and the Veteran's Healthcare Administration. I'm a United States Army infantry veteran and currently serve on the Organization for Safety Asepsis and Prevention (OSAP) Board of Directors.

My wife Jeanne, and I were born and raised in Lexington, Kentucky. We have an 11-year-old daughter named Catherine and a golden retriever named Ruby. We spend much time exploring with our RV and supporting my daughter's English horse riding/ jumping team.

NARCH: 2022 Summer Research Training Institute



Grazia Cunningham, MPH

NARCH Project Manager

The 2022 Summer Research Training Institute (SRTI) opened its virtual doors on June 13 and welcomed 72 students for an intensive learning experience. From debuting a new learning management system to launching a new intensive track, this year's SRTI delivered on a promise to engage students in new ways while keeping planners & instructors on their toes!

Institute Highlights

Sue Steward, NPAIHB Deputy Director, and Barbara Gladue, Oregon Tribal Public Health Improvement Manager, set us off in a good way at our Opening Ceremony with a prayer and a song. The Opening Ceremony was a wonderful opportunity for participants to connect with one another and with instructors prior to class, which can be challenging in a virtual environment. From these introductions, it was clear that participants were ready to learn and excited to make new connections.

Week One continued with the first of three Lunch Seminars and the launch of Canvas courses. A staple of the Summer Research Training Institute, the SRTI Lunch Seminars offer students a chance to learn about various topics in an informal setting. While we couldn't cater lunch this year, students engaged in wonderful presentations by Dr. Jorge Mera and Dr. Kathy Tomlin ("End-of-Summer Research Training Institute Tracks"), Dr. Ramona Beltran ("Using Storywork and Arts-based Methods as Decolonizing Approaches to Health Research With and for Indigenous Communities"), and Dr. Mica Estrada ("Pathways of Growing Kindness & Inclusion in Academia").

Participants

Like previous years, the 2022 SRTI brought together dedicated American Indian & Alaska Native health professionals and students eager to develop health research skills and knowledge. Our participants included clinicians, public health researchers, academics, policymakers, and our first sophomore in high school!

Courses

For the first time this year, participants had a choice of week-long, intensive courses or shorter one & two-day data science skill-building courses in week two & three. Course topics are summarized in the following table:

Faculty included veteran and first-time SRTI instructors who made the most of the virtual experience utilizing tools like Zoom chat, breakout rooms, Canvas, and Google Jamboards to explain concepts, foster collaboration, and create community. Instructors adapted to the needs of their students, modifying the week's curriculum after the first session to best meet those needs. New this year, fifteen trainees began their two-year journey in the new **Applied Biostatistics and Data Science (ABDS) track**. Trainees were selected for their demonstrated interest in deepening quantitative research skills and commitment to enhancing tribal health.

Course	Class Size
Epidemiology	13
Grant Writing	12
Program Evaluation	8
Designing Survey Instruments	25
Data Wrangling & Summarizing	22
Intro to ArcGIS Pro	24
Indian Health Policy	23
Data Visualization	24
Statistical Methods	27

Representing Navajo, Apache, Dine, Choctaw, and Chickasaw Nations as well as the Central Council of Tlingit and Haida and Native Village of Unalakleet, this cohort of trainees joined the full suite of biostatistics skill-building courses as well as two additional cohort-only courses -- all taught by a hand-selected team of instructors (some from NPAIHB) who coordinated closely in developing course curricula. Over the next two years, this cohort will build on the foundation of skills learned in these courses through regular seminars on topics tailored to their needs and goals, as well as follow-up intensive courses and a mentored capstone project. We look forward to fostering their development and following each of them on their journeys.

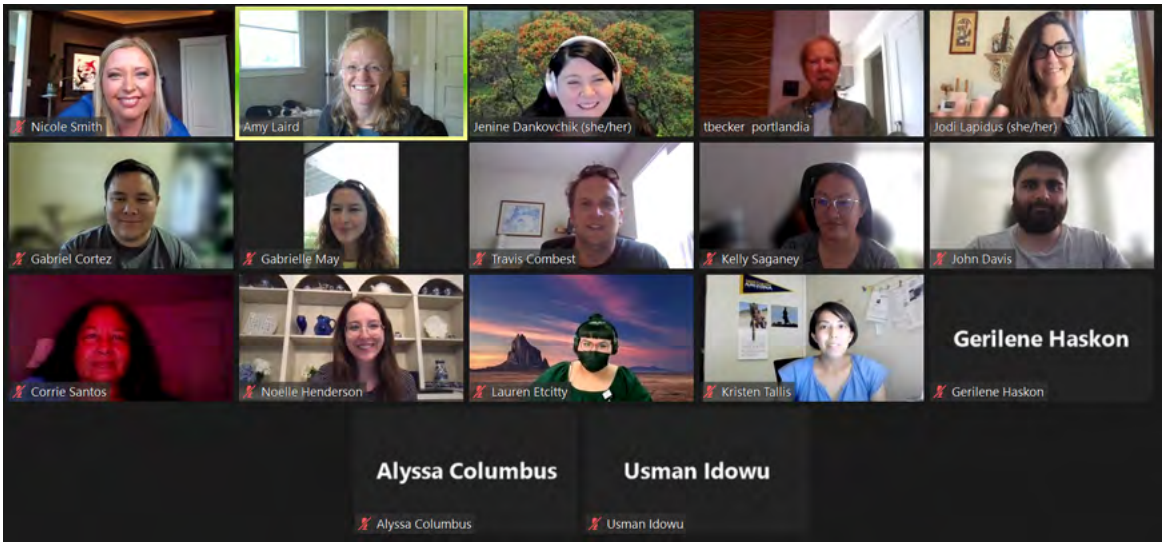
Our biostatistics & data science skill-building courses were extremely popular, ranging in size from 20-27 students. These data science courses brought together the ABDS track participants and general SRTI participants.

Our Dream Team of Indian health policy experts – Liz Coronado, Jim Roberts, Brett Shelton, & Dr. Don Warne - summarized hot topics in Indian Health Policy and addressed hot-of-the-presses court decisions. There were days when topics were difficult to discuss or technology wasn't cooperating, but we supported one another and created a safe place to share personal experiences and offer encouragement.

Summary

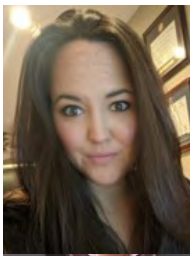
Despite the challenges of being remote, instructors and students consistently stepped up to the plate to deliver engaging courses and make the most of their experiences together. We were impressed by the students' effort and expertise, and we're excited to see the great work they will do. We will check in after six months to see how the SRTI has helped them in their professional or educational endeavors!

We would like to thank NIH/NIGMS for funding the SRTI, and to NPAIHB for continued support of this program. Special gratitude to the entire SRTI team – Tom Becker, Clif Poodry, Grazia Cunningham, Naomi Jacobson, Jojo Lutz, and Ashley Thomas.



ABDS Cohort

Tribal Researchers' Cancer Control Fellowship Program



Ashley Thomas, MPH

Senior Program Manager
NW NARCH

The NW Native American Research Center for Health welcomed it's fifth cohort of AI/AN researchers into the Tribal Researchers' Cancer Control Fellowship Program this summer! Seven qualified and motivated applicants were selected to participate this year. The overall goal of this fellowship program is to reduce cancer incidence and mortality and improve cancer survival in tribal communities through the efforts of AI/AN researchers. Specifically, we aim to increase research capacities and build research skills among AI/AN researchers, so that they will be better prepared to design and implement cancer-related research projects within their communities. Building on our earlier success in this area, our aims are:

1. to recruit and retain 40 qualified AI/AN researchers (over four years) who seek additional training in cancer control research and in the implementation of cancer control projects;
2. to design and offer a tailored cancer control research curriculum using experienced and qualified faculty and consultants, leading to a capstone cancer prevention research project for each trainee;
3. to provide follow-up support, including field support, trips to professional meetings, distance learning opportunities, and mentoring to the trainees after they complete the formal curriculum in cancer control research; and
4. to evaluate the progress and success of trainees in meeting benchmarks for the fellowship.

Due to the persistence and uncertainty of the COVID-19 pandemic, we designed the 2022-2023 training curriculum to be delivered virtually over the course of one year. We held our formal training in Cancer Prevention and Control during June 6th-10th followed by a course on NIH Grant Writing from June 13th-17th. The remainder of our curriculum will be offered as two-hours learning sessions throughout the year.

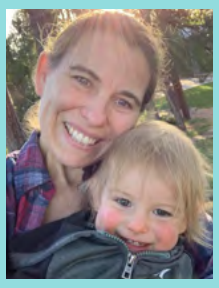
On February 2, 2022, President Biden announced a reignition of the Cancer Moonshot, highlighting new goals: to reduce the death rate from cancer by at least 50 percent over the next 25 years and improve the experience of people and their families living with and surviving cancer. We are excited to bring experts from around the country who have been working toward these goals in Indian country to share their knowledge and experiences with our trainees.
Modules offered in our follow-up training include:

- SEER*Stat
- Conducting Focus Groups
- Effective Biomedical Research Engagement with American Indian/Alaska Native Populations
- The Role and Promise of Physical Activity in Cancer Prevention and Survival
- Dietary Interventions for Cancer Prevention
- A Partnership to Explore Helicobacter Pylori Infections Among Navajo Adults
- Gynecologic Cancers
- Patient Navigation
- Environmental Health Studies on the Navajo Nation
- Follow-up on Abnormal FIT: Using Targeted Patient Navigation to Support Patients Along the Colorectal Cancer Continuum

Meet the 2022-2023 TRCCFP Fellows!

Jacob Smith
Confederated Tribes of the Umatilla Indian Reservation

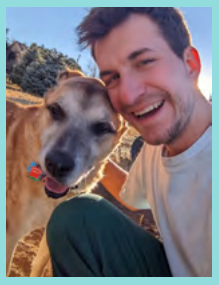
Medical Student at Oregon Health & Science University.



Regina Idoate, PhD

Cherokee

Assistant Professor at University of Nebraska Medical Center.



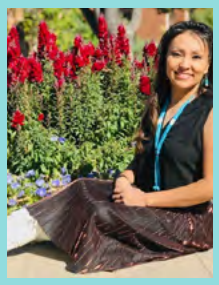
Christopher Kalas

Chickasaw Nation

Mental Health Technician and is completing a PhD at Northern Arizona University

Abbie Willetto, MS
Navajo

Health Research and Specimen Coordinator at Alaska Native Tribal Health Consortium



Jackie Slowtalker, MPH
Navajo

Community Health Research Educator at The Partnership for Native American Cancer Prevention, University of Arizona Cancer Center

Marquis Yazzie
Navajo

Graduate Research Assistance completing a Master of Science in Chemistry at Northern Arizona University.

Jessica Buck-DiSilvestro, MD
Caddo Nation of Oklahoma

Gynecologic Oncology Fellow Physician at Brown University/ Women and Infants Hospital

NW NATIVE AMERICAN
RESEARCH CENTER FOR HEALTH

NPAIHB On the Hill - Washington, D.C.

Candice Jimenez, MPH
Confederated Tribes of Warm Springs

Health Policy Specialist

June 2022

Northwest Tribal leaders (Nickolaus Lewis and Anthony Hillaire, Lummi; Nate Tyler, Makah) were joined by NPAIHB staff (Laura Platero, Executive Director and Candice Jimenez, Health Policy Specialist) from June 21-23 to meet with ID, OR and WA Representatives, Senators and their congressional staff on priority areas, which included the following topics:

- Full Funding, Advanced Appropriations and budget requests for IHS
- H.R. 7455 – IHS Contract Support Cost Amendment Act (link)
- House Interior Appropriations and CHAP Funding for FY 2023
- Update on Portland Area Regional Specialty Referral Center
- Substance abuse and mental health services incl. recent H.R. 7666 MH legislation
- On CMS: Making permanent telehealth reimbursement and at OMB Encounter Rate
- On CDC: HIV & Hepatitis C funding opportunities and GWHIC funding increase
- On HRSA: Addressing provider shortages and needs incl. Increased tribal set-aside for loan forgiveness program, support CHAP program expansion and provider relief funds

As follow-up to the recent set of hill visits, we are actively communicating with congressional staff on priority area advocacy related to appropriations, contract support costs, CHAP funding and mental health legislation. We heard specifically on a coordinated strategy to funding as it relates to the Indian Health Service and how to weigh in directly with NW congressional leaders and appropriations staff. We also learned more about H.R. 7666 (as noted above) and prioritized direct funding to tribal nations for mental health resources, as it relates to SAMHSA. We also learned the more about our NW congressional staff, which includes the following:

- Senator Jim Risch (ID): member of International Illicit Narcotics Caucus
- Representative Jamie Herrera-Beutler (WA): Co-chair of Mental Health/Addictions Task Force
- Representative Derek Kilmer (WA): Main sponsor of H.R. 6307 Tiny Homes for Veterans Act
- Representative Pramila Jayapal (WA): Sponsoring Mental Health-Suicide Prevention Bipartisan bill

We look forward to our next set of hill visits and representing NW tribal health priorities! Thank you to Nickolaus Lewis, Anthony Hillaire and Nate Tyler for representing the Tribes on the Hill.

Indian Health Service Fiscal Year 2023 Federal Budget Updates

Elizabeth J. Coronado, JD Chukchansi

Senior Policy Advisor

June 2022

President Biden's Fiscal Year (FY) 2023 budget request was released in May of 2022 that includes a historical request for mandatory funding for the Indian Health Service (IHS). This proposal includes a total budget for FY 2023 in the amount of $9.3 billion, $2.5 billion above FY 2022 enacted that would grow to $36.7 billion by FY 2032. Mandatory funding has been a longstanding request of Tribal Leaders as a path forward towards full funding of the IHS. Mandatory funding will require legislative action and would ensure predictable funding over a 10-year period that discretionary funding is unable to provide for. Individual program increases for FY 2023 in the President's Budget Request include the following:

- Hospitals and Health Clinics –$3.4 billion (+$967 million)
- Purchased/Referred Care--$1.2 billion (+200 million)
- Mental Health--$200 million (+78 million)
- Alcohol/Substance Abuse--$345 million (+87 million)
- Hep C/HIV--$52 million (+47 million)
- Tribal Epi Centers--$ 25 million
- IHCIF--$317 million (+ 243 million)
- M&I--$346 million (+176 million)
- Facilities and Environmental Health Support--$371 million (+ 88 million)

[Read the FY 2023 Congressional Justification of Estimates for Appropriations Committees Here.]

House Appropriations Committee Bill for Interior FY 2023 Appropriations

On June 29, 2022, the House Committee on Appropriations approved FY 2023 Interior, Environment, and Related Agencies funding bill which includes appropriations for the Indian Health Service (IHS). The full House is expected to vote on this funding bill the week of July 18. The Committee recommends $8.1 billion for IHS, a $1.4 billion increase to IHS over FY 2022 enacted level. However, this recommended amount for IHS is $1.2 billion less than what was recommended in the President's Budget Request. The Committee noted in their markup of the Interior Appropriations bill that IHS did not put forward a mandatory funding legislative bill so they did not make any recommendations for mandatory funding for FY 2023. Additionally, the House Committee did not include advance appropriations for IHS. Northwest Tribes and the Northwest Portland Area Indian Health Board are continuing to advocate for the inclusion of advance appropriations in the FY 2023 funding bill.

The Committee Report includes the following notable program increases to IHS:

- Hospitals and Health Clinics--$2.8 billion (+367 million)
- Purchased/Referred Care--$1.1 billion (+112 million)
- Mental Health--$130 million (+8 million)
- Alcohol and Substance Abuse—$ 264 million (+6 million)
- Hep C/HIV--$52 million (+47 million)
- Tribal Epi Centers--$34 million (+10 million)
- IHCIF--$232 million (+158 million)
- M&I--$311 million (+141 million)
- Facilities and Environmental Health Support--$303 million (+20 million)

[Read the House Committee on Appropriations, Interior Report Here.]

Senate Appropriations Committee and Subcommittees

The Senate Appropriations Subcommittee on Interior, Environment, and Related Agencies has not released their recommendations for FY 2023 funding. The Senate is still concluding their appropriations hearings this week. Although the House Committee has recommended a proposed $1.2 billion increase to the IHS budget, we expect that the Senate will not agree to a similar significant increase. Last Fiscal Year, the IHS only received a $395 million increase despite the President's Budget Request proposing a $2.2 billion increase and the House approving a similar increase.

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[1] The funding amounts with a (+) indicate the increased amount over FY 2022 enacted.
[2] President's Budget Request proposes to move IHCIF under Services Account.

Major Drivers of Hospital Charges for Motor Vehicle Injuries among American Indian and Alaska Native people (AI/AN) in Oregon and Washington from 2012-2016

Margaret Munroe, MPH

Student in the OHSU/PSU MPH in Biostatistics program and completed this work as part of an internship with the Native CARS team

Motor vehicle crashes are a major cause of death and unintentional injury in the AI/AN community, and, accordingly, a major contributor to medical costs. In recent months, the Native CARS team analyzed hospital discharge data from Oregon and Washington to better understand motor vehicle-related hospital charges among AI/AN. A major objective of this analysis was to inform Tribal policy-making and resource usage, to help focus interventions that might reduce both the economic burden and the human toll of traffic incidents.

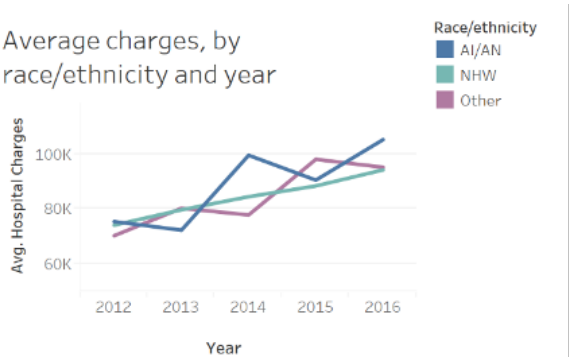
The data analyzed were from 2012-2016, which was the most recent data available from both states. Over this time period, 944 AI/AN with traffic-related injuries were admitted to hospitals in Oregon and Washington for stays of at least a day, with their hospital charges averaging $93,954.34 per person/visit (median $52,524.07) and ranging from $2,983.23 to $4.47 million. Mean charges among Non-Hispanic White people for same period were $84,682.38. Because AI/AN men were more likely to be in motor vehicle crashes (making up 57% of motor vehicle injury stays), they had higher total charges than women; however, their mean hospital charges were not significantly different from those of women.

To determine the most important factors contributing to hospital charges for motor vehicle injuries among AI/AN, a statistical model was built. We found that the age of the individual, type of road user, state of hospitalization, category of primary injury, and payer were most predictive of hospital charges. Across all age groups, adults age 40-59 years old had the most expensive visits, with mean charges of $104,273.92. Overall, mean charges were lowest in the 0-5 and 60+ age groups and higher for the age range in between, with the major burden of total charges coming from individuals in the 18-60 age range.

The type of road user was another significant determinant of hospital charges. Although the majority of the individuals hospitalized (68%) were motor vehicle occupants, the mean charges for pedestrians were 22% higher than those of motor vehicle occupants, even after statistical adjustment for other contributing factors. Pedestrians were more likely to be men, and more likely to be in the 40-59 year old age group.

Key findings:

- **Pedestrian injuries are the most severe and expensive of all motor vehicle injuries**
- **American Indians are more likely to be injured as pedestrians than other races**
- **Medicaid has the highest average charges of all payers**



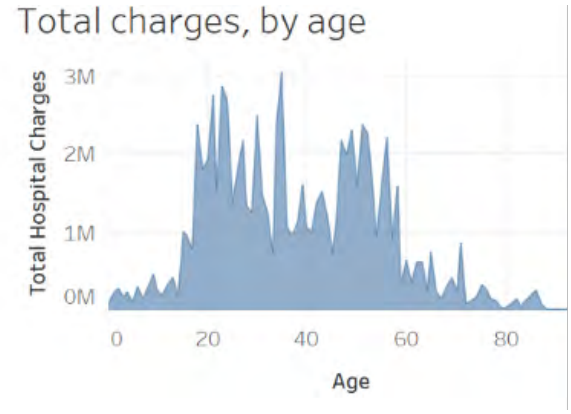
AI/AN had higher charges for motor vehicle related hospitalizations than other race/ethnicity groups on average

Total charges, by year and sex

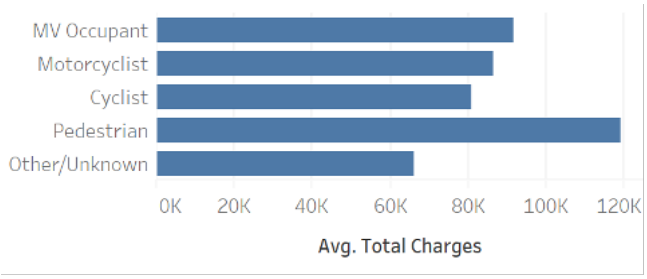
Year	Men	Women	Grand Total
2012	$7,652,355	$6,370,335	$14,022,690
2013	$6,902,383	$5,457,579	$12,359,962
2014	$8,672,809	$6,252,360	$14,925,169
2015	$11,823,420	$10,742,934	$22,566,353
2016	$14,366,486	$10,452,234	$24,818,721
Grand Total	$49,417,452	$39,275,442	$88,692,895

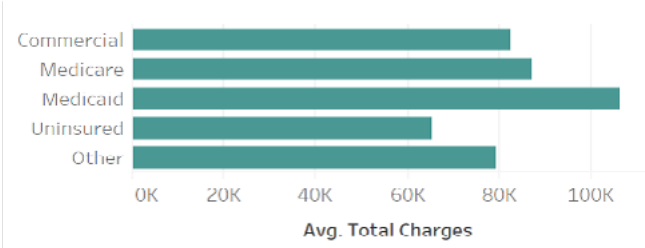
A higher rate of traffic injuries among men meant their care made up a larger proportion of all hospital charges

They also had a higher proportion of some of the most expensive types types of injuries, including limb fractures and head or neck injuries, and were treated in Trauma I hospitals (offering the most intensive care for more severe injuries) more often. The elevated cost and severity of injuries among pedestrians is particularly relevant in light of the fact that AI/AN were more likely to be in this type of accident than other groups: 16% of AI/AN injured were pedestrians compared to 11% of Non-Hispanic Whites over the same time period.



Most hospital charges from 2012-2016 were contributed by individuals aged 18-60, with highest mean charges in the 40-59 year old age group





Mean charges were highest among pedestrians and individuals paid for by Medicaid

A final factor that was significantly related to hospital charges was payer. Average charges among AI/AN paid for by Medicaid were the highest out of all payer groups, at $104,145.84. Notably, individuals on Medicaid were more likely to be injured pedestrians.

The findings from this analysis indicate the need for continued work to prevent traffic-related injuries among AI/AN in the Pacific Northwest. Reducing the economic burden of these injuries will require a combination of outreach to groups most likely to be in crashes and interventions that create safe environments for pedestrians, including protected walking paths and street lights. Successful action in these areas will mean not just money saved but better health and well-being for individuals and the community at large.

For more information, please contact: Nicole Smith at nsmith@npaihb.org


PLEASE SAVE THE DATE!
NW Tribal Food Sovereignty Coalition
NW Tribal Food Sovereignty Coalition Gathering
Host:
Grand Ronde Tribes
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Please email your questions to swalker@npaihb.org
See you on October 11-13, 2022!

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 JULY 2022 RESOLUTIONS

22-07-11 National Indian Health Board (NIHB) Tribal Oral Health Initiative

22-07-01 Washington Tribal Safety Commission (WTSC) Traffic Records Improvement and Traffic-Related Data Research

22-06-06 Centers for Disease Control and Prevention - Tribal Public Health Capacity-Building and Quality Improvement Umbrella Cooperative Agreement

22-06-01 U.S. Department of Health and Human Services: Health Resources & Services Administration - Bureau of Health Workforce Division of Nursing and Public Health: Community Health Worker Training Program (CHWTP)

2022-04-06 Support of Reproductive Rights of American Indian and Alaska Native People

2022-04-03 Support for Incorporating Portland Area CHAP Certification Board Programs, Functions, Services, and Activities in ISDEAA Contract

2022-04-02 Approval of the Portland Area Community Health Aide Program Certification Board By-Laws and Standards and Procedures

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