Health News & Notes

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

A Publication of the Northwest Portland Area Indian Health Board July, 2010

Summertime Safety Concerns

Fireworks and Sparklers

In 2007, an estimated 9,800 people were treated in emergency rooms for injuries caused by fireworks, according to the National Fire Protection Association (NFPA). Children aged 5-14 were more than twice as likely to get hurt as people of other ages.

In 2008, fireworks caused an estimated 22,500 reported fires, including 1,400 structure fires, 500 vehicle fires, and 20,600 outside and other fires. These fires resulted in an estimated 1 death, 40 injuries and $42 million in direct property damage.

How to avoid firework injuries: Fireworks and sparklers are designed to explode or throw off showers of hot sparks. Did you know, the tip of a firework or sparkler can get as hot as 1,200 degrees Fahrenheit? This is hot enough to cause third-degree burns, according to the NFPA. Don't let kids pick up leftover fireworks – they can still be active, according to NFPA.

How to treat injury: Get to the emergency room right away, especially for sparkler burns. Don't mess with the burn area, don't put anything on it. Same goes for injuries sustained from explosions, especially to the eye.

In the Northwest the death rates from fire at 1.42 per 100,000 people for American Indian/Alaska Native men and women of all ages. The specific numbers from Idaho and Oregon are not shown due to the small number of deaths.

Bicycle Injuries

There are more than 275,000 annual bike injuries among kids. Each year, approximately 140 children up to age 14 are killed riding their bicycles, according to Safe Kids USA.

How to avoid them: An estimated 75 percent of bicycle injuries could be prevented by wearing a helmet, according to Safe Kids USA. Skateboarders should put on wrist guards.

How to treat them: Watch for loss of consciousness, headache, vomiting, tiredness, confusion or disorientation–those are signs of concussion that require an immediate trip to the doctor. Your child may have broken a leg if he can't bear

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MEANINGFUL USE

By Joe Finkbonner, Executive Director

Meaningful Use (MU) – what is it besides another Federal acronym?

Before I begin discussing Meaningful Use (MU) I want to start with how it came about. MU started with the American Recovery and Reinvestment Act of 2009, better known as ARRA. Many understand the ARRA's purpose was to jumpstart our economy, but critical to the act was that it is also intended to "preserve and improve affordable health care." The specific section within ARRA to address this task is the Health Information Technology for Economic and Clinical Health (HITECH) Act. This vehicle is allowing an unprecedented investment in health information technology.

Provisions within ARRA authorize CMS to make incentive payments to eligible hospitals and providers to promote the adoption and "meaningful use" of inter-operable, certified electronic health record (EHR) technology. The goals of MU are to 1) Improve quality, safety, efficiency and reduce disparities by using computerized-provider order entry. 2) Engage patients and families in the health care (electronic copy of their health information). 3) Improve care coordination through the exchange of key clinical information with other providers. 4) Improve population and public health (coordination of immunization registries). 5) Ensure adequate privacy and security protections for personal health information.

Meaningful use implementation will occur in three stages, with full implementation of MU by 2015. Stage 1 implementation will begin in 2011. The primary focus of stage 1 will be data capture and developing processes for data sharing. Stage 2 will be focused on advanced clinical processes and Stage 3 will work toward improved outcomes. The requirements and more specificity will be further defined by CMS rulemaking likely in 2013 and 2015.

Certification criteria for EHR will be defined by the Office of the Coordinator for Health Information Technology (ONC) which outlines how the EHR must work. I want to distinguish that from how the EHR must be used, which is defined by CMS. Certification is different from MU and should not be used interchangeably to define EHR. To restate the difference certification is what the EHR can do and MU is HOW the EHR is used. This is a key distinction, because you will not obtain the incentives simply by implementing a certified EHR. In order to receive the incentives you must show that you are using the certified EHR technology in a meaningful way.

Tribes may not be eligible for these incentive payments. As stated earlier, CMS is authorized to make incentive payments to eligible hospitals and providers. Eligible professionals include physicians, dentists, certified nurse midwives, nurse practitioner,

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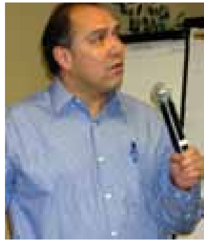
THE ROLE OF TRIBAL EPIDEMIOLOGY CENTERS



By Jim Roberts, NPAIHB Policy Analyst

First authorized in 1997, Tribal Epidemiology Centers (EpiCenters) augment public health infrastructure by developing expertise in epidemiology and building on the capacity of regional tribal organizations like Area Health Boards (AHBs). Tribal EpiCenters were first authorized by the Indian Health Care Improvement Act (P.L. 94-437, Section 214[1]) to assist Indian Tribes and the Indian Health Service (IHS) to develop data sets to define the health status of Indians toward meeting the Healthy People 2000 objectives. The very first Tribal EpiCenter was located in the Portland Area and activities included enhancement of disease surveillance, epidemiologic analysis, interpretation, and dissemination of surveillance data, and the development and health promotion and disease prevention programs.

Today, a network of twelve Tribal EpiCenters provides the foundation for most public health activities in Indian Country. Tribal and IHS facilities deliver the majority of public health services such as immunization and cancer prevention and control programs to Indian communities. More efficient service delivery and effective interventions to improve health requires in-depth knowledge of the causes of illness and mortality among the population and epidemiology provides that knowledge. Operating from within Tribal organizations (usually Area Health Boards), EpiCenters are in a unique position to provide support to local tribal disease surveillance and control programs. Data generated locally and analyzed by Tribal EpiCenters enable Tribes to evaluate community-specific health status data so that planning and decision-making can best meet the needs of their communities. Because these data are used at the local level, immediate feedback is provided to the local data systems which also can lead to improvements in Indian health data overall.

The impact that Tribal Epi-Centers have had on Area Indian Health Boards has been extremely beneficial. Most AHBs carry out EpiCenter functions that have expanded their capacity and infrastructure to provide services and conduct health programs on behalf of the Tribes they work. Once an EpiCenter has been established, the resources provided by IHS have been leveraged to develop other programs and acquire additional funding opportunities. These activities enhance the ability of Area Health Boards to conduct—not only epidemiologic activities—but to also carry out health promotion and disease prevention activities as well as conduct various aspects of health policy work and budget advocacy. This has been very beneficial for Area Health Boards, Tribes, and to

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The Role of Tribal Epidemiology Centers

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the Indian health system.

The recent reauthorized IHCIA amended the EpiCenter provision by retaining current law authorities, but also changing the statute to give EpiCenters "public health agency" status under the Health Insurance Portability and Accountability Act (HIPAA) in order to facilitate acquisition of data. Some of Tribal EpiCenters were having difficulty obtaining protected health information under HIPAA from the IHS or from States. The IHCIA now requires that the U.S. Department of Health and Human Services (HHS) Secretary to grant Tribal EpiCenters access to data and protected health information in the possession of the HHS Secretary. Hopefully this new provision will alleviate the objections by IHS or States in granting access to data by Tribal EpiCenter, however there already seems to be some objection to what this provision covers. Tribal EpiCenters believe that it pertains to any data "in possession of the Secretary" which can be construed as the collection of any data financed in whole or part by HHS. Others interpret the provision more narrowly and may not be as willing to provide Tribal EpiCenters with the access they believe they have now under the new law.

Despite many of the challenges of the Tribal EpiCenters, their future looks bright and it's important that partners of the Indian health system continue to build on their capacity. There are new opportunities under health reform in which EpiCenters can play an important role. The recent Community Health Data Initiative announced by HHS will put health data to work to help communities and consumers improve health outcomes. This initiative will use data to help raise awareness of health status and trigger efforts to improve it. The data can help Indian communities determine where action is most needed and what approaches might be most helpful. There are other opportunities around data requirements to track maternal, infant, and early childhood programs to determine evidence based home visiting strategies. EpiCenters can also play an important role in implementing electronic medical records and meaningful use requirements.

These emerging opportunities look bright and it's important that IHS and other federal agencies support their work of Tribal EpiCenters, which can address national public health goals through work to improve data needed for GPRA reporting and monitoring of the Healthy People 2010 objectives. This can only be accomplished through collaborative federal partnerships and its important the agencies continue to build on the capacity of the Tribal EpiCenters so that Indian people can benefit from the same type of epidemiologic activities that the rests of the United States enjoys.

1. 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

Meaningful Use

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and physician assistants practicing in rural health clinics or Federally-Qualified Health Centers (FQHCs). In addition, in order to be eligible non-hospital based health professionals must have at least 30% patient volume enrolled in the Medicaid program or physicians who practice in FQHCs. The incentive payment program begins January 1, 2011 and spreads payments over a 6-year period with the first year payment of up to $21,250 and five subsequent annual payments of up to $8,500.

There is a developing need for increased workforce development activities to educate eligible providers on MU to achieve maximum amount of incentive payments, especially as the rulemaking is developing for Stage 2 and Stage 3 implementation. As resources and training opportunities develop the NPAIHB will be sure to notify Northwest Tribes to provide you the greatest chance of participating.

Summertime Safety Concerns

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Heat Exhaustion and Heatstroke

About 400 deaths in the U.S. each year are caused by extreme heat--nearly half from weather, the CDC reports. Heat exhaustion, which induces dizziness, nausea and heavy sweating, can progress to heatstroke, when the body's temperature rises to 104 degrees Fahrenheit or higher.

How to avoid it: Limit most activities to early morning and evening and take hourly breaks in the shade. Drink water regularly, or beverages with sugar and electrolytes if activity is prolonged. Never leave a child alone in the car, even with the windows slightly open--temperatures can rise by 20 degrees Fahrenheit within the first 10 minutes, according to the Centers for Disease Control and Prevention (CDC).

How to treat it: Air conditioning and a cool drink for mild dizziness, fatigue, headache or stomachache. Call 9-1-1 or go straight to the ER if a child faints, is breathing unusually fast, has a rapid pulse or heart rate or is confused or disoriented.

Boating Safety: Boaters enjoy the feel of sun and spray. So it's tempting to boat without wearing a life jacket – especially on nice days. But modern life jackets are available in a wide variety of shapes, colors, and sizes. Many are thin and flexible. Some are built right into fishing vests or hunter coats. Others are inflatable — as compact as a scarf or fanny pack until they hit water, when they automatically fill with air (US Coast Guard).

Accessibility

- Wearable life jackets must be readily accessible.
- You must be able to put them on in a reasonable amount of time in an emergency (vessel sinking, on fire, etc.).
- They should not be stowed in plastic bags, in locked or closed compartments or have other gear stowed on top of them.
- The best life jacket is the one you will wear.
- Though not required, a life-jacket should be worn at all times when the vessel is underway. A wearable life-jacket can save your life, but only if you wear it.
- Throwable devices must be immediately available for use.

Stay Sober While Boating: It's dangerous to operate a boat when drinking. Operating a boat under the influence of alcohol or drugs is illegal in all states and is a violation of Federal law. An operator with a blood alcohol content about .08 (equivalent to consuming five beers in one hour for the average 180-lb. male) – is ten times more likely to die in a boating accident than an operator with zero blood alcohol level

Have a wonderful and safe summer and fall.

AI/AN Graduate Scholarships Available

What: Year round stipends to support training in biomedical research careers (including MPH, PhD, MD, DO and other research-related degrees)

Who: American Indian and Alaska Native graduate students

When: September 2010 – August 2011

Our NARCH grant has provided graduate student funding to a large number of American Indian and Alaska Native students in support of their health sciences research-related careers. If you are accepted into or already enrolled in an advanced degree program and are looking for financial support for school, please contact us at the address below. We will provide application forms and further information upon request.

Tom Becker
Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300
Portland, OR 97201
Email: tbecker@npaihb.org
Phone: 503-494-1175

Funded by
Native American Research Centers for Health (NARCH)
Northwest Portland Area Indian Health Board (NPAIHB)

2010 NICOA Biennial Conference
Aging in Indian Country: Embracing the Past and Facing the Future

September 25-28, 2010
Grand Traverse Resort & Spa
Acme, Michigan

CHR PROGRAM HAS BUILT A SOLID FOUNDATION

By Eric Metcalf, NPAIHB Vice-Chair & Delegate of the Coos, Lower Umpqua & Siuslaw Tribes

The Community Health Representative (CHR) program has built a firm foundation for its program base and the Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians (CTCLUSI) Tribal Members are accessing the entire program and all it has to offer. The CHR program was recreated within the CTCLUSI Health department in 2008. The Tribes have one full-time CHR in each of the Tribe's three offices—Coos Bay, Florence, and Springfield. The CHR's duties vary greatly from day-to-day dependant upon the needs of the clientele they are serving. While they serve all Tribal members who live within the five county service delivery area, their top priorities are Elders and families with infants and small children. The CHRs also integrate prevention within their programs whenever the opportunity presents itself.

One new and exciting program that the CHRs just rolled out is the 100-mile club. The 100-mile club is funded through our IHS Diabetes Grant and is for Tribal Families that live within the five county service delivery area. Each CHR in every office is available for Tribal Members to report their miles walked on a weekly, biweekly or monthly basis. The Tribes have purchased pedometers and water bottles (available for all Tribal Members over the age of six), with carryover funds from the Diabetes grant. Each CHR has them available to hand out along with instructions on how the 100-mile club program works as well as log books for logging miles. The Tribes are currently holding an art contest for Tribal Members to come up with the logo that will go on a "very nice" T-shirt for those Tribal Members who reach 100 miles. The Health Director will also come up with two nice prizes for whoever reaches 100 miles first and whoever walks the most total miles. To help motivate Tribal Members to get out walking, the CHRs have started walking in our three main geographical areas—Coos Bay, Florence, and Springfield.

Another CHR prevention program that has proved very successful is the monthly Family Gatherings. The Family Gatherings rotate monthly between our three main areas as mentioned above. Each Gathering consist of 1-2 presentations, of which at least one is by the CHRs on a Health Promotion/Disease Prevention topic and the second topic either by a different department within Health or from outside of the Health Department, such as the Cultural Department or the Housing Program. A nutritious and healthy dinner is always provided usually by Mr. Eddie Helms—a fabulous Tribal Chef.

The Elders Program is a long-standing program within the Health Department. The Elders meet the first Thursday of the month at 3RC&H, with transportation provided by the CHRs. The Elders also have three overnight functions at 3RC&H each year and approximately five other overnight events throughout the year that the CHRs staff and ensure that the Tribal Elders needs are taken care of. For a single Elder, the Title VI grant provides congregate meals for the Elders once a month and provides six frozen meals (12 for a married Elder), plus each Tribal Elder receives bread, milk, and cheese each month. The grant also provides $250.00 for Chore Services (an Elder can hire someone to work around their house, i.e. mow their lawn, prune trees, clean gutters, etc) and $250.00 for respite care when caring for a spouse.

As with most CHR programs in Indian Country, office visits, transportation, and home visits make up the majority of the CHR's workload. In 2009 the CHRs had 2,804 office visits (Coos Bay-680, Florence-1026 and Springfield-1098), they also had 324 transports (Coos Bay-180, Florence-64 and Springfield-80). The transports range from several miles to obtain a prescription, to overnight trips to OHSU in Portland. Also in 2009, the CHRs provide 385 home/hospital visits (Coos Bay-62, Florence-83 and Springfield-240). Another integral part of the job is the Over-the-Counter program that is run through the Health Department—last year we had a total of 685 Tribal Members access this program.

Within the CTCLUSI Health Department we require that all alternate resources be exhausted before utilizing the funds we receive from IHS for two reasons; 1) it is required in our Self-Governance Compact with IHS and, 2) it make the few dollars (IHS funds about 60 % of Tribal needs) IHS allocates for us to operate our programs, stretch further. The CHRs help the Contract Health Program by assisting Tribal Members and their families in finding all alternate resources that may be available to them. Our CHRs spend a sizable amount of time assisting individuals with the Oregon Health Plan and the new Healthy Kids applications. Part of their salaries are paid for by the State to do this outreach work.

Ms. Heidi Helm is a CTCLUSI Tribal Member and has been a full-time employee with the Tribes for a little more than two years as the Springfield CHR. Ms. Helms took over our Tobacco grant in the beginning of 2009 and has done a wonderful job in creating awareness for our Tribal Members and proposing new policy changes that will provide greater protection from second hand smoke inhalation. Ms. Helms also took over the Nike shoe program in September of 2009 and delivered 115 shoes to Tribal families within four months of taking the program over.

The Coos Bay CHR—Ms. Delilah Baldwin, is a CTCLUSI Tribal Member and has been with the Tribes for about two years and with the Health Department as a CHR for the last nine months. Ms. Baldwin hit the ground running. She has training as a caseworker in the family services department, which certainly assisted her in transitioning to a CHR position. Ms. Baldwin is fast becoming the Tribes' baby seat specialist and within several months will have completed all the training necessary to assist families to ensure that children are buckled in car seats in the correct and safe way.

The Florence CHR Coordinator, Ms. Elaine Williams, has been an employee of the Tribes for approximately fifteen years. Ms. Williams was recently (June 1, 2010) promoted back to her previous position of supervisor of the CHR program and A/D Prevention program. She also serves as our backup Elders Coordinator and often fills that void whenever we need her to. Ms. Williams also manages our Title VI Grant and in the absence of a Diabetes Coordinator, manages our Diabetes Grant as well. Ms. Williams has proven she is very dedicated to her work here at the Tribes and has been a CHR for most of her years at CTCLUSI.

As the Department Administrator, I am thankful to have these three ladies working for the good of the Tribes. Besides the programs I outlined previously, other duties I have noticed them performing of late were: Providing a very nice Breast Cancer awareness party every fall (pink party), LIHEAP (energy assistance) Referrals, baby baskets (for newborns) monthly reports, managing department budgets, attending departmental and grantee meetings, emergency management (H1N1 outreach, education & vaccination campaign), smoke alarms, bike helmets, collaborating with other departments and being active listeners. Keep up the good work!

Andy Joseph, Jr. Testifying in front of the Department Operations, Oversight, Nutrition and Forestry

COQUILLE INDIAN TRIBE COMMUNITY HEALTH

By Drew Adams, Coquille Assistant Health and Human Services Administrator/Quality Improvement Program Coordinator

The Coquille Indian Tribe Community Health Center (CITCHC) is located on the Coquille Indian Tribal Reservation and resides within the city limits of Coos Bay, a rural community on the southern Oregon coast. The Community Health Center is comprised of a primary care medical clinic, Contract Health, a Head-Start Program, an After school Program, Community Center, and Social Service programming focused on Indian Child Welfare, Elders Care, Youth Services, Infant Care, Foster Care, and Mental Health and Chemical Dependency Referral.

The CITCHC underwent survey from the Accreditation Association for Ambulatory Health Care (AAAHC) in March, 2010. In April of 2010 we received word that we had passed and received a three-year Accreditation for 2010-2013. This marks the fourth consecutive successful submission relating a ten-year span of continuous excellence. It should be noted that not all CITCHC programming falls under AAAHC jurisdiction (such as, Head-Start and After school programming) but the personnel, facilities, and related policy and procedures do. In essence, the entire scope of our service delivery system was under the microscope and received exemplary marks.

An insightful question should be raised, however, in that why would an American Indian/Alaskan Native Healthcare Organization undergo Accreditation? There is no financial gain or licensing requirement for Accreditation. It's an invasive process. Surveyors dig and cause major havoc across the full spectrum of operations. Credentialing organizations, such as the AAAHC, are generally located on the east coast, 3000 miles away. Significant healthcare resources are spent, stressed, and utilized in a manner that may take away from short-term patient care. In the end the *surface* result is, quite simply, a paper certificate that hangs in the Clinic lobby.

Except - it just isn't a piece of paper. It's confidence. Confidence that your organization is doing the very best it can to provide the best possible care to your patient population. Confidence that you have the right staff, confidence that they are performing the right mission, and confidence that it is being performing it the right way. An Accreditation certificate means that your healthcare service delivery system is on par, or exceeds, the very best available.

The AAAHC is the leading oversight agency for Ambulatory Healthcare with membership of over 5,000 healthcare operations nationwide. Organizations that undergo survey are required to demonstrate their ability to provide quality medical care to established best practice standards. Core standards include, but are not limited to, Rights of Patients, Governance, Administration, Quality of Care Provided, Quality Management and Improvement, Clinical Records, Safety and Health Information, and Facilities and Environment. The CITCHC was able to demonstrate excellence in each standard during this (and each previous) Accreditation surveys. Here's some of what we did.

Rights of Patients, Governance, and Administration: Maintaining accurate and best practices in this arena is both the easiest and most difficult aspect of continuous Accreditation. The AAAHC publishes annual updates to the core standards (in relation to improvements in best practice standards) and it is the responsibility of the organizations to mirror those upgrades. The CITCHC, sensitive in the assurance that our patients receive the best possible care, actively pursue updates to the core standards and upgrade accordingly. There were no findings related to any of these core categories during the survey review.

Quality of Care: In the 2010 survey, as with each prior survey, the provision of quality care to our patient population was commended by the AAAHC. Both of our medical providers participated in the process, received commendation for their exceptional patient care, and relate that the survey process (and related peer review) is critical in the maintenance of a quality organization.

Quality Management and Improvement: The QI program permeates all aspects of the healthcare delivery system ranging from provider credentialing, patient satisfaction, conflict resolution, quality initiatives and benchmarking, and is the backbone of any healthcare organization. In this survey special notation was made of our efforts in Gardasil and Youth Immunization projects, Diabetes Case Management, and Contract Health Cost reduction programming.

Tangential to the QI Program is the patient complaint/grievance program. It is vital to the process in that it enables a patient's voice to be utilized in the direction of program design and the efficacy of patient care. Organizations that utilize this process travel three paths. The first receives few, if any complaints. The second has a plethora of complaints. Neither is healthy. The former relates a closed and the latter relates severe dysfunction. The CITCHC falls in the middle road and this was evidenced though the Survey process. We demonstrated our ability to utilize the patient perspective to resolve each patient's issue and improve programming in diverse areas such as our referrals, ancillary relations, program admission, and patient responsibilities. The AAAHC commended our practice in this arena.

Clinical Records: The only issue of note was an inconsistency in recording patient medication reconciliation during each patient visit. This standard was recently adopted from JCAHO and has been difficult for may accredited organizations to adopt. Utilizing guidance from the AAAHC Surveyor, however, we were able to design a process (concurrent with our upcoming implementation of the Electronic Health Record) that will sufficiently address this patient care and core standard need by the end of 2010.

Safety, Health Information, Facilities and Environment. CITCHC received positive marks, with a couple of minor consultations, across the board for each of these standards. Special commendation was noted for our efforts in diabetes health education and our formulated response to the H1N1 outbreak.

In closing, successful attainment of Accreditation is critical to the identity of the CITCHC. AAAHC core standards provide a framework for the design, implementation, and maintenance of a high quality health care delivery system. We have embraced this process for both the short and long term. We are, to coin a phrase, *confident.*

In Celebration of National Indian Day
The Northwest Portland Area Indian Health Board Presents the
5th Annual
Dancing in the Square
POWWOW
September 24th, 2010
Pioneer Square - Portland, OR
Grand Entry - 330pm
MC - Gilbert Brown
Whipman - Ed Goodell
Color Guard - NIVA
Host Drum - TBA
First 4 drums registered will be paid
For more information please contact:
Lisa Griggs at 503.416.3269 or lgriggs@npaihb.org
For more information about the Northwest Portland Area Indian Health Board or the 43 Federally Recognized Tribes of Oregon, Washington and Idaho please visit www.npaihb.org
This event is Drug, Alcohol , Commercial Tobacco and Violence Free.
Sales of sacred items are forbidden.
The Committee is not responsible for lost or stolen items or any travel or parking costs.
PORTLAND
Design by
thesebraids...since 1980
thesebraids@gmail.com

The Northwest Portland Area Indian Health Board (NPAIHB) and other local area American Indian organizations will be hosting an American Indian Day Celebration at the Pioneer Courthouse Square in downtown Portland on **Friday, September 24, 2010.** We hope you will be able to join us in this celebration and learn more about the issues and culture of American Indian people and Northwest Tribes.

For information on exhibit or arts and crafts booths contact Lisa Griggs, lgriggs@npaihb.org (503) 416-3269. For additional information on the event or about NPAIHB, please visit www.npaihb.org.

EPICENTER EXAMINES TRIBAL PRIORITIES AND EVALUATES EPICENTER PROGRESS

By the Evaluation Workgroup, Tam Lutz, Kristyn Bigback, Matthew Town, Tosha Zback and Michelle Edwards

In 2007, the EpiCenter constructed an assessment tool to identify priority health objectives among member tribes in Idaho, Oregon and Washington. This assessment tool, the Health Priorities survey was administered annually in 2007-2010. The Health Priorities survey was administered to both Tribal Health Directors and NPAIHB delegates. In years 2007-2009 the Health Priority Survey was administered by both paper questionnaire and by "survey monkey," an online survey. In 2010, the health priority survey was administered by paper questionnaire at the April quarterly board meeting and by "turning point," an audience response system administered through a power point presentation at the April 2010 Health Director meeting.

The questionnaire asked respondents to prioritize health conditions and strategies to address health conditions and asked two demographic questions. In 2009 a section was added for one year to inquire about tribal grant writing capacity. In 2010 a new section was added to the Health Priorities Survey to evaluate EpiCenter progress and assess whether the EpiCenter meets the needs of member tribes.

In 2010, forty respondents, including health directors, delegates, elected officials and a medical director, completed the questionnaire. Eighteen percent (18%) came from tribes of small user populations of less than 750, 48% came from tribes of user population of 750 - 2,500 and 28% came from tribes of larger user populations of greater than 2,500.

Respondents were provided a list of eight health conditions and were asked, which they would consider high priorities for the *EpiCenter,* rating each priority on a scale of 1-6, 1 being the lowest priority and 6 being the highest priority, or responding don't know/ not sure, not applicable or refuse to respond. In addition respondents were given the opportunity to add any other condition they thought should be a high priority for the EpiCenter. The highest average rating for health conditions were cancer (5.45), diabetes (5.42), mental health (5.29), and heart disease (5.26) with the remaining condition rated between 4.37 and 4.89. In addition there were eight write in responses for substance use/abuse and three write in responses for suicide.

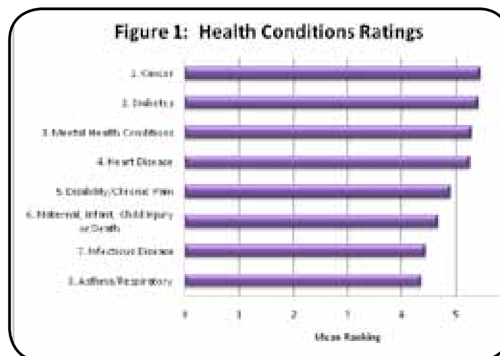
Figure 1: Health Conditions Ratings

Respondents were provided a list of nine strategies to address health conditions or event and asked which they would consider high priorities for the EpiCenter, rating each priority on a scale of 1-6, 1 being the lowest priority and 6 being the highest priority, or responding don't know/ not sure, not applicable or refuse to respond. Respondents were given the opportunity to add any other strategy they thought should be a high priority for the EpiCenter. The highest rated for strategies were preventing substance use (5.63), preventing obesity (5.58) and promoting physical activity (5.38) with the remaining strategies rated between 4.55 to 5.08. Only one write in response, long term care, had more than one response.

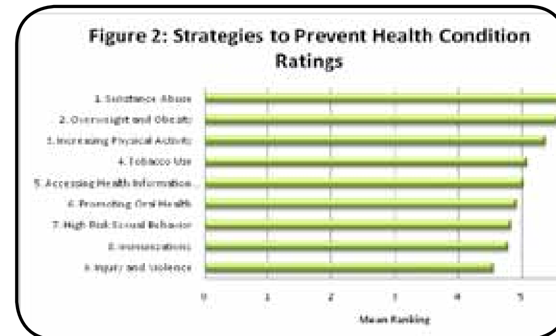
Figure 2: Strategies to Prevent Health Condition Ratings

A new section in 2010 asked tribes to describe their knowledge of and their community's experience with the EpiCenter's projects and requests for technical assistance. Respondents were asked to indicate how strongly they agreed or disagreed with five statements regarding the EpiCenter on a scale of 1-6, 1 being the lowest and 6 being the highest level of agreement or don't know/not sure, not applicable or refuse to respond. Respondents were asked if they had ever requested and received data from the EpiCenter. When asked if they had a working relationship with the EpiCenter 56% indicated that they agreed (a score of 4-6) with a mean score of 4.25. However, 25% of respondents indicated they didn't know or were not sure. When asked if the EpiCenters keep their community apprised of opportunities to work

together, 54% indicated that they agreed (a score of 4-6) with a mean score of 4.1. However 19% of respondents indicated they didn't know or were not sure. When asked if there was a health condition or infectious disease concern would they initiate contact with the EpiCenter to discuss how to address it, 43% indicated that they agreed (a score of 4-6) with a mean score of 4.04. However 22% of respondents indicated they didn't know or were not sure. When asked whether the EpiCenter projects kept them abreast of progress or results, 57% indicated that they agreed (a score of 4-6) with a mean score of 4.18. However 16% of respondents indicated they didn't know or were not sure. When asked if the EpiCenter had increased their community's capacity to address the health concerns of their community 55% indicated that they agreed (a score of 4-6) with a mean score of 4.035. However 16% of respondents indicated they didn't know or were not sure. Over half of respondents (56%) indicated that they had requested and received data from the EpiCenter; however, 19% did not know or were not sure.

In addition two open ended questions were asked. The first question asked, "What do you think are the strengths of the EpiCenter?" The most common responses to this question were access to data and information, skill, knowledge and leadership of EpiCenter staff, training opportunities and communication with tribes. The second question asked, "How could the EpiCenter better assist your tribe?" The most common response to this question was better public relations, followed by going to the local level, health status reporting and outreach to smaller tribes.

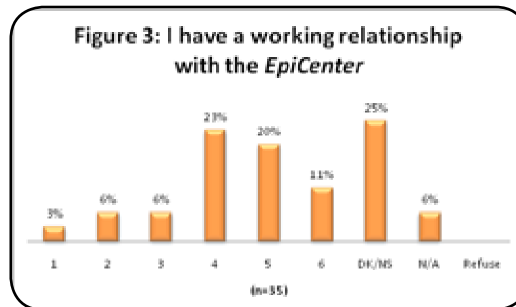

Figure 3: I have a working relationship with the *EpiCenter*

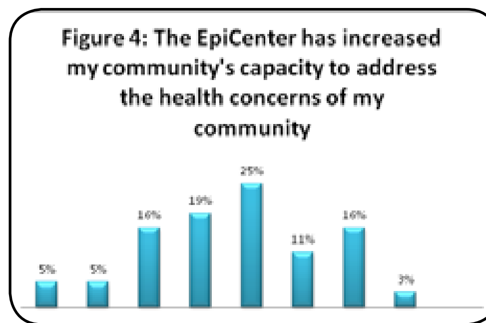

Figure 4: The EpiCenter has increased my community's capacity to address the health concerns of my community

Following the collection and analysis of the Health Priorities Survey, the result were presented to the EpiCenter Director and the EpiCenter steering committee, a five member steering committee which reviews planning documents, abstracts, proposals and NPAIHB resolutions. The EpiCenter and EpiCenter Steering Committee, along with the EpiCenter Evaluation workgroup will make recommendations on how to respond to the results of the 2010 Health Priorities Survey. An immediate response already has resulted in conducting more aggressive public relations efforts for a recent publication of an EpiCenter study. Other responses may include further inquiry into whether current studies, projects and efforts tribal priorities, and what opportunities there may be to obtain further resources to address these. Further inquiry may also be needed to determine ways to improve tribes recognition, experience or utilization of the EpiCenter.

Womens Voices

PARENTS ALWAYS IMPRESSED on their children the motto: "Obedidence in listening to the words of wise elders makes a successful medicine person." While the power and the guidance for a career came from a spirit, it was the elders, learned in these tribal traditions, who provide the fine points of usage and established the social context for approved practices.

Grandparents were always kind and indulgent, teaching morality, through stories and example. They instilled the need for willpower, and concern for others.

Another warning often repeated with the advice of a tutor emphasized the importance of the family for an individual. Elders said: "The orphan has no education, schooling, or advice to become a great person."

Mourning Dove, Salish
from: The Spirit of Indian Women

THE EPICENTER CAN ASSIST YOUR TRIBE

The Northwest Portland Area Indian Health Board is one of twelve regional Epidemiology Centers across the United States, charged with gathering health data on behalf of tribes. We, in turn, offer training, advocacy and technical assistance to help tribes improve members' health status.

The mission of the EpiCenter is to collaborate with Northwest American Indian Tribes to provide health-related research, surveillance, and training to improve the quality of life of American Indians and Alaskan Natives (AI/ANs).

Tribal health research and surveillance priorities are identified by NPAIHB delegates on an annual basis. The EpiCenter's current goals include:

1. Assisting communities in implementing disease surveillance systems and identifying health status priorities.
2. Providing health specific data and community health profiles for Tribal communities.
3. Conducting tribal health research and program evaluation.
4. Partnering with tribal, state, and federal agencies to improve the quality and accuracy of AI/AN health data

Each of the tribes of the Northwest has access to over 25 staff members available to help you work on your members' health. Our programs include the following:

Program	Health Topic Area
Access to American Indian Recovery (AAIR)	Substance Misuse Treatment
Nak-Nu-Wit Circles of Care	Comprehensive mental health and substance misuse care
Native American Research Centers for Health (NARCH)	Broad based initiative, including annual Summer Institute Training to Build Tribal Capacity
Native Children Always Ride Safe (NATIVE CARS)	Examining Car Seat and Seat Belt Use and enhancing motor vehicle travel safety
NPAIHB Immunization Project	Immunizations
Northwest Tribal Cancer Navigator Program (NTCNP)	Providing support for patients receiving appropriate cancer care
Northwest Tribal Dental Support Center (NTDSC)	Providing support and training to tribal dental clinics and staff
Northwest Tribal Fetal Alcohol Spectrum Disorders (FASD)	Fetal Alcohol Spectrum Disorders
Northwest Tribal Registry Program	Providing a variety of health surveillance data
Indian Country Methamphetamine Initiative (ICMI)	Data on Methamphetamine and Substance Use
Portland Area Indian Health Service Institutional Review Board (IRB)	Reviewing of programs and research projects to ensure community and individual protection from harm.
Prevention of Toddler Overweight Study (PTOTS)	Obesity Prevention and Tooth Decay Prevention
Project Red Talon (PRT)	HIV and STD Prevention
Training and Outreach	Providing identification of public health training
Tribal Epidemiology Center Consortium (TECC)	Coordinating Projects of various epidemiology centers, includes Injury Prevention initiatives
Western Tribal Diabetes Project	Diabetes Data and Training

If you need to reach us with questions, all of our programs and e-mail addresses can be found on the Board Web Site www.npaihb.org or through our telephone number 503-416-3255. We look forward to serving you.

FALLS AMONG NATIVE ELDERS IN THE NORTHWEST

By Bridget Canniff, Tribal Epidemiology Center Consortium Project Director, and Megan Hoopes, Northwest Tribal Registry Project Director

In the Northwest, falls are responsible for up to 25% of unintentional injury deaths for American Indians/Alaska Natives (AI/AN) aged 55 and over, and are the leading cause of injury-related death for AI/AN aged 65 and over.[1] Falls are also the leading type of injury resulting in hospitalization among American Indians and Alaska Natives in Washington state.[2] Accidental falls can result in head trauma, serious fractures, and a limited ability to live independently. Many people who fall, even those who are not injured, develop a fear of falling. This fear may cause them to limit their activities, leading to reduced mobility and physical fitness, and increasing their actual risk of falling.[3]

In order to better understand how falls are affecting Native elders in the Northwest, NPAIHB's Northwest Tribal Epidemiology Center (The EpiCenter) is working to access and analyze data on falls and other injuries. The EpiCenter recently examined data from the Washington Department of Health's Comprehensive Hospital Abstract Reporting System (CHARS) and carried out a linkage to improve the quality of AI/AN hospitalization data. All of the hospital discharge records for the period 5/1/2007 – 12/31/2008 were matched with a tribal/urban AI/AN patient file to correct for missing and misclassified AI/AN race data.

Courtesy of Suquamish Tribe

Age distribution among patients hospitalized for falls in Washington differs by race. For non-Native people, the average age at admission for falls is 68.5 years, with a median age of 76. The number of fall injury admissions increases with age, up to a peak age of about 87, after which the numbers decline. However, for AI/AN, the average age at admission for falls is 54.3 years and the median is 57. The number of falls by year of age does not follow the distribution seen for all other races, and appears to be more spread out over the lifespan. The two most common reasons for fall injury hospitalization among Washington AI/AN are slipping, tripping, or stumbling; and falling from stairs or steps.

Most mainstream falls prevention programs target adults ages 65 and older. While differences in population distribution for AI/AN likely contribute to the younger average age for falls hospitalizations seen in the Washington state data, Indian-specific falls prevention programs may want to consider widening their target population to include those in their 50s, or use local data to ensure programs are reaching those who need them most.

The more we understand about elder falls from looking at the data, the better we can prevent falls and reduce injury, hospitalization and death. For information on some proven interventions that can help keep elders safe, see the box accompanying this article.

See Elder's Safety Sidebar next page

Elders are central to community wellness, and they possess unique knowledge about tribal history, culture and language. Falls are a serious public health issue affecting elders, but we can reduce falls by applying interventions that work. By working to prevent falls, we can preserve elders' independence and help ensure that their wisdom can be passed on to future generations.

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1. Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS). 10 Leading Causes of Unintentional Injury Deaths, United States 1999 - 2006, Am Indian/AK Native, Both Sexes, ID/OR/WA. URL: http://www.cdc.gov/ncipc/wisqars. Accessed 6/3/10.
2. Comprehensive Hospital Abstract Reporting System (CHARS), Washington Dept. of Health. Linkage & analysis: Megan Hoopes, Northwest Tribal Registry Project, NPAIHB, May 2010.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Falls Among Older Adults: An Overview. URL: http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html. Accessed 6/14/10.

Elder's Safety Side Bar

Prevent Elder Falls...

Make the home a safe place
- Remove rugs, wires, and other trip hazards
- Use non-slip mats and install grab bars in the bathroom
- Improve lighting
- Wear shoes at all times, inside or outside the home. Avoid going barefoot or wearing slippers

Manage medications
- Have a doctor or pharmacist review prescriptions
- Some medications or certain combinations can cause dizziness or drowsiness

Check vision
- Poor vision can increase the chances of a fall
- The wrong glasses, cataracts or glaucoma can limit vision
- Vision may change with age, so regular checkups are a must

Exercise regularly
- Exercise and stretching increase strength and reduce the chances of a fall
- Other health benefits of exercise include living longer and feeling better!

COMMUNITY-BASED PARTICIPATORY RESEARCH

By Stephanie Craig Rushing, Suicide Prevention & PRT Project Director

Community-Based Participatory Research (CBPR) is a collaborative research approach that equitably involves all partners in the research process (Israel et al. 1998; Minkler & Wallerstein 2003). While research activities can vary from project to project, the approach embraces four core concepts:

1. local participation in the research process
2. immediate use of the information generated by the research to address local needs
3. steps to minimize power discrepancies between researchers and participants
4. community empowerment and action

CBPR is deeply committed to ensuring meaningful participation by those impacted by the research during all phases of the study (Minkler & Wallerstein, 2003). Involving community members in research design, data collection, and interpretation helps foster trust and legitimize findings, increasing the likelihood that resultant data will be used by the community to promote healthy change (Israel, Schulz, Parker, & Becker, 1998). This process improves the effectiveness and efficiency of interventions, empowers participants, generates knowledge that can be used to influence policy and resource allocation, and builds local capacity to conduct future research (Minkler & Wallerstein, 2003).

There are several distinct benefits to using CBPR in Indian Country, including that it: (a) reflects and acknowledges tribal sovereignty, self determination, and self governance;(b) allows research to occur in circumstances where it otherwise wouldn't; and (c) better aligns with traditional research approaches. CBPR mirrors the values and strengths of many AI/AN Nations,including respect for community processes and consensus, sincere equal partnership, and the ecological view of the individual as intricately linked with family and tribe. In CBPR, equal weight is given to both scientific and indigenous expressions of knowledge, employing both western and cultural lenses in the interpretation of data. Consequently, CBPR has become an informal "code of conduct" for research in Indian Country, including at the Northwest Portland Area Indian Health Board's Tribal Epidemiology Center (EpiCenter).

Research that Benefits Native People: A Guide for Tribal Leaders

In response to requests for more basic information about research, the National Congress of American Indians (NCAI) Policy Research Center developed a 5-module curriculum in 2009 to equip tribal leaders and community members to better understand and manage research and evaluation projects. American Indians and Alaska Natives are underrepresented in many major data collection efforts and statistical analyses, making it difficult for tribes, states, and the federal government to provide policy solutions and social programs that effectively target and benefit Native communities. Access to data allows tribal leaders to make informed decisions, be proactive about shaping the future of their communities, secure funding, and refine programs offered to tribal citizens. By recognizing the value of both Indigenous ways of knowing and Western research approaches, tribal leaders can reap the benefits of Western research while still respecting their own community standards.

Tribal leaders and Native communities can use the curriculum to increase their ability to identify, access, and understand data, and engage in research that may benefit their communities.

To download the curriculum in its entirety, please visit: http://www.ncaiprc.org/research-curriculum-guide

A Brief Excerpt From:

MODULE ONE: Foundations of Research: An Indigenous Perspective

Indigenous knowledge is:

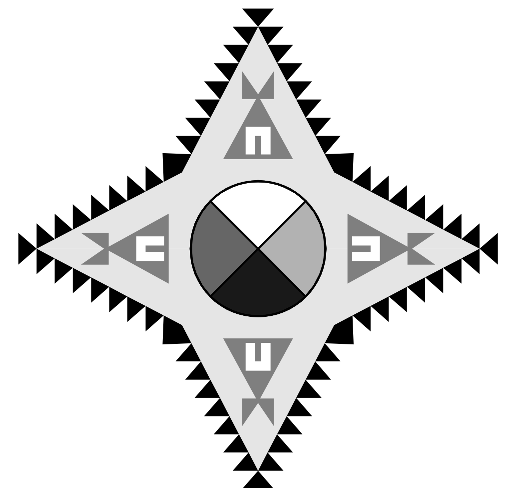
- as old as Indian cultures
- based on the collective wisdom of ancestors
- built through careful observation and experiences of natural patterns of life
- learned, transmitted, and retained in the telling of stories
- complex, interrelated, and based on diverse conditions
- closely linked with cultural views of the world

Indigenous knowledge is of equal weight and value as Western knowledge. It cannot be compromised, but it can be expanded. Indigenous and Western knowledge have a long history of borrowing from and sharing with each other.

- Tribal peoples have adapted the results of Western knowledge when it is useful. Examples: firearms or modern trucks and boats.
- Western society has also eagerly used Indigenous knowledge. Examples: Most modern food sources and medicines have Indigenous origins.

Native and non-Native people should show respect and understanding for both tribal and other systems of knowledge.

- It is not important to try to determine whether one system is better than another.
- Respect and understanding may not necessarily mean agreement, and that is all right.
- There is Western and other knowledge that Native peoples may choose to disagree with or ignore.
- There may be Indigenous knowledge that Western or other people may likewise choose to disagree with or ignore.
- The point is that there is mutual respect between systems, and an openness to listen to and understand one another.



NATIVE CHILDREN ALWAYS RIDE SAFE: Six Northwest tribes are committed to improving child passenger safety in their communities

By Tam Lutz, Nicole Smith,and Kristyn Bigback

In 2003, with funding from the Native American Research Centers for Health (NARCH initiative), six tribes conducted an observational survey to see if children were using car seats that were appropriate for their age and weight. After seeing the results of the survey, the tribes strengthened their efforts to increase child safety seat use in their communities.

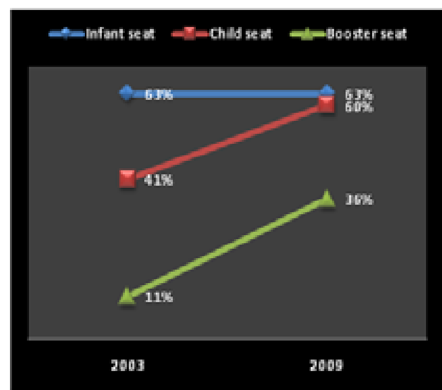
After several grant writing efforts, NPAIHB and the six tribes were successfully funded by the National Center on Minority Health and Health Disparities (NCMHD) to formally develop interventions to improve child passenger safety in these communities. At the project kickoff meeting, the tribes decided to call this collaboration Native Children Always Ride Safe, or Native CARS for short.

Since several years had passed since the 2003 observational survey, our first task was to repeat the survey to see how child safety use had changed in six years. We surveyed vehicles with child passengers age 8 and younger. Trained observers looked into the vehicle to assess how the driver and passengers were restrained. They then asked drivers for information about the child's age, height, and weight, as well their opinions about child safety seats. The interviews took about four minutes and drivers received a $5 gift card as a token of appreciation.

From the observational survey, we found the following:

- The percent of properly restrained infants remained constant at 63% from 2003 to 2009.
- Forward-facing harness seat (child seat) use increased from 41% in 2003 to 60% in 2009.
- Booster seat use had the greatest increase from 11% of booster-eligible children being properly restrained in 2003 to 36% in 2009.

Child Safety Seat Use in Six Northwest Tribes in 2003 & 2009 (Trend lines)



The project team then conducted focus groups in the different communities and interviewed key people to learn more about community members' attitudes and beliefs about child safety. The tribes have used all this information to design community-specific interventions to increase child passenger safety. Three tribes are implementing interventions from Fall 2009 until Spring 2011 (Round 1), while the other three will implement interventions from Fall 2011 – Spring 2013 (Round 2). The tribes and the project team will conduct more vehicle observations in Spring 2011 and Spring 2013 to evaluate the impact of the interventions.

Applying Data to Develop Community Interventions

Three Tribes Share their Experience

The Shoshone-Bannock, Nez Perce, and the Colville Tribes are all participating in the Native CARS study and are currently implementing their community interventions.

Shoshone-Bannock

The Native CARS study found that only 23% of children were properly restrained in tribal communities not subject to a tribal or state child safety seat law. Shoshone-Bannock does not currently have a seat belt or child safety seat law. Site Coordinator Lee Ann Dixey-Avila is undertaking the daunting task of getting a tribal law on the books. "I hear a lot of people say that car seat and seat belt laws are

Lee Ann Dixey-Avila, Shoshone-Bannock Native CARS Coordinator

'white man laws,' but this law will be our Tribe's testament to how strongly we feel about keeping all our children safe here. It's not mine or yours here -it's ours when it comes to keeping our children safe." Mrs.. Dixey-Avila added, "I anticipate that the law change will be a struggle for some, but in recent interviews, several community members said that for some people to take it seriously it will take something like a ticket that will really hit the pocket book hard to make people change their behaviors."

Mrs. Dixey-Avila, along with Tribal Health Director Angela Mendez, and Health Education Coordinator Rebecca Washankie, will begin the law change process by proposing a declaration to the Fort Hall Business Council. The declaration proposes the development of a tribal law that goes beyond the Idaho State Law to include the current National Traffic and Highway Safety Administration child passenger safety recommendations.

After a declaration is signed, Mrs. Dixey-Avila will begin working with Tribal attorneys to draft the law and order code and work with her partner in The Fort Hall Police Department to campaign to make the community aware of the upcoming law change. The Fort Hall Police and Fire Departments will work with Mrs. Dixey-Avila to organize checkpoints in the community where community members not observing the law will be provided with information on the new law change and a referral to obtain a child safety seat appropriate for their child. Mrs. Dixey-Avila has also planning an extensive community campaign including poster, billboards, press releases and brochures to increase awareness. Mrs. Dixey-Avila concluded, "While this seemed daunting at first, for a tribe without a law, it can be done. You just have to get out there and stick with it. There are a lot of lives that could be lost without it. Those are stakes I'm just not willing to ignore, nor will our law enforcement or tribal leaders."

Nez Perce

The Nez Perce Tribe has decided to use social media as a modern approach to improve child safety seat use. "We need to get the word out to our communities about child safety seats and how important they are to use properly and consistently," explained Susie Ellenwood, a Licensed Practical Nurse (LPN) from Nez Perce. "Pinpointing where communities get most of their information for family health and safety is important so we can use those resources to our advantage."

The Internet has become the "go-to" place to find information on many issues, including child passenger safety. "As a parent, I find most of my information on general safety for my child from the Internet," says Andy Albert, mother and Nez Perce Native CARS site coordinator. Just like Ms. Albert, many participants from the 2009 Native CARS observations also stated that they get information on child safety seats from the Internet - in fact, the Internet was the second most commonly cited source of child passenger safety information. Tribally operated programs, such as Maternal Child Health (MCH) and Supplemental Nutrition for Women Infant and Children (WIC) were the most commonly cited source of information. Internet communication through websites such as Facebook and Twitter has become rooted in society in recent years. Social media sites have become so popular that it's not just the young crowd using them any more – adults also use these sites to connect with old friends, keep in the loop about what's going on in their social circles, and even to join groups that support a certain cause. In addition, many cell phones now have applications to allow users to check their social media websites from anywhere they can find cell phone reception.

Andrianna Albert, Nez Perce Native CARS Coordinator

Recognizing the substantial networking power of these sites and the overall power of the Internet as a safety information resource, the Nez Perce Tribe will be creating a Native CARS Facebook "Fan Page." The Facebook Fan Page will be used to start conversation on topics such as the importance of using child safety seats. It will also be used to share national recommendations on the proper seats for a child's age and size,

continued on page 18

Native Children Always Ride Safe

continued from page 17

advertise project events such as car seat clinics, and post media created by the Native CARS study. It will be easy for Tribal members to join the Fan Page– it just takes one click once you have Internet access, and you don't have to be a member of Facebook to do it. By utilizing the cyberspace portion of their communities' interactions, the Nez Perce tribe will be able to capture audiences who might otherwise have missed child passenger safety messages.

Colville

The Native CARS study found that only 41% of booster seat eligible children (children 4-8) were properly restrained. Furthermore, 39% of drivers thought children younger than eight years old could appropriately use an adult seat belt. Armed with a scale and tape measure, Colville Confederated Tribe Tribal Health Manager Zekkethal Vargas-Thomas recently manned a booth at a well attended annual community event working with children and parents to not just talk about currently child safety seat guidelines but to physically measure children so children and their parents could determine what child safety seat would be most appropriate to use or whether they were tall enough to graduate out of the booster seat. "Children were surprised that they were not tall enough to be out of the booster seat yet and parents were thankful to know," stated Mrs. Vargas-Thomas, "Many parents just aren't aware that there child is simply not tall enough for a seat belt alone to safely restrain them." Mrs. Vargas-Thomas and Native CARS Site Coordinator Bernadine Phillips have continued to provide training and information in hopes that it will spread throughout the community. They recently collaborated with two Safe Native American Passenger (SNAP) Trainers from the Safety Restraint Coalition from Seattle to instruct the two day course is designed after the National Highway Traffic Safety Administration (NHTSA) National Standardized Child Passenger Safety Training. This training was American Indian specific and introduced the basic concepts of child passenger safety to staff from 15 different tribal programs. In addition, Ms. Phillips and Julia Corbiere successfully passed their Child Passenger Safety (CPS) Technician training to join two other tribal health CPS Techs Diane Mills and Sally Hutton, to provide car seat clinics in the four districts on the reservation. Ms. Phillips is planning to hold car seat clinics to provide further education to parents on the appropriate child safety seat for their children as well as referrals to parents on where they can obtain or replace a child safety seat.

To view or download the Native CARS 2009 Aggregate Report, please see the NPIHB website at: http://www.npaihb.org/epicenter/native_cars_aggregate_report_2009/

COMMUNITY INTERVENTIO CHILDREN

Interventions increase breastfeeding & decrease consumption of sugar-sweetened beverages, study finds

(PORTLAND, Ore.) June 2010—Community intervention can help American Indian families change behavior related to early childhood weight gain and obesity, according to a new Kaiser Permanente and Northwest Portland Area Indian Health Board (NPAIHB) study.

The study, published online in the *Journal of Community Health,* also finds that adding in-home visits to the community intervention has an even more profound effect on behavior change, and can reduce a child's body mass index.

Funded by the National Institutes of Health, this is the first study to target obesity prevention among American Indian children starting at birth.

"Nearly half of American Indian children are overweight and their rapid weight gain starts at birth. By starting interventions early we can have a long-term impact on their behaviors and may be able to slow down excess weight gain," said study lead author Njeri Karanja, an investigator with the Kaiser Permanente Center for Health Research in Portland, Ore.

"Tribal community health workers designed the interventions to fit the specific needs of their community and families," said Tam Lutz, study co-author and junior investigator with the Portland Area Indian Health Board. For example, one tribe created and maintained a breast-feeding room at

NS AND IN-HOME VISITS MAY SLOW EXCESS WEIGHT GAIN IN AMERICAN INDIAN

its tribal health clinic; another passed a resolution to stop buying sugar-sweetened beverages for tribally sponsored events. "Community health workers also customized home visits to the needs of the family," Lutz added. "For example, mothers who needed more breastfeeding support received additional home visits to address that need."

The study included 205 families from three American Indian tribes in Oregon and Washington. One tribe received only community interventions and two tribes received the community intervention along with in-home visits and telephone calls from community health workers. The visits started in the third trimester of pregnancy and lasted until the babies were 2 years old. The intervention boosted breastfeeding rates, reduced consumption of sugar-sweetened beverages and helped to slow excess weight gain.

According to a national pediatric nutrition survey done by the U.S. Centers for Disease Control and Prevention in 2003-2005, 60 percent of American Indian mothers in the United States start out breastfeeding their babies, but six months after birth that figure falls to only 23 percent. In comparison, 74 percent of mothers who received community intervention and in-home visits started out breastfeeding, and at six months 38 percent still were breastfeeding.

At the end of the intervention, families also filled out a survey indicating their confidence level about drinking more water and fewer sugar-sweetened beverages. Ninety percent said they were confident they could help their family drink more water, and 82 percent said they would limit sugar-sweetened beverages.

Body Mass Index —which is a measure of weight in relation to height - did increase for all of the children in the study, but the increase was significantly less in the tribes that received the community intervention and in-home visits. BMI scores increased by 30 percent in the tribe that received community intervention alone and by 8 percent in the tribes that received both interventions.

The study did not have a control—a tribe that received no intervention—so it is not possible to assess the effect of the community intervention alone or determine whether or not other factors influenced the results. However, authors say the results show that community-based interventions are feasible and acceptable to several different American Indian tribes and they suggest that simple interventions may slow down trends in escalating overweight and obesity in children. The study was conducted from 2001-2006. A larger study involving different Northwest tribes is underway.

In a report released earlier this month, the White House Task Force on Childhood Obesity acknowledged the promise of these types of interventions and the importance of focusing on early childhood.

This study is part of both partner's ongoing work to identify, prevent and treat childhood obesity through research, education and community programs. NPAIHB's efforts grew out over a decade of surveillance, measuring an alarming increase in type 2 diabetes in their population and a concern that diabetes was increasing even more rapidly among adolescents. The NPAIHB leaders indicated that investigating "upstream" interventions preventing obesity beginning at birth was a high priority. Kaiser Permanente's recent study of 710,949 children published in the *Journal of Pediatrics* found that extreme obesity is affecting more children at younger ages.

For more information othe TOTS Study please contact Tam Lutz, Project Director or Carol Grimes, Research Coordinator at 503.228.4185 or via e-mail at tlutz@npaihb.org.

Authors of this study include: Njeri Karanja from the Kaiser Permanente Center for Health Research in Portland, Ore.; Tam Lutz from the Northwest Portland Area Indian Health Board in Portland, Ore.; Cheryl Ritenbaugh and Mikel Aickin from the University of Arizona in Tuscon; Gerardo Maupome from the Indiana University School of Dentistry in Indianapolis; Joshua Jones from the Chicago Department of Public Health in Illinois, and Thomas Becker from Oregon Health and Science University in Portland, Ore.

Celebrating 10 years at the Board!!!
Thank you! For all that you have done, and continue to do!

Chandra Wilson and Dr. Tom Becker

Tam Lutz is a Lummi Tribal member with ancestral ties with the Quinault, Chinook, Cowlitz, Duwamish and Nooksack tribes. Tam has over sixteen years of expertise working in public health and health research for Indian communities. She is currently a Research Project Director and Junior Investigator at the Northwest Portland Area Indian Health Board (NPAIHB). The two studies Tam directs are the Primordial Prevention of Childhood Overweight in American Indians (PTOTS) and Native Children Always Ride Safe (Native CARS) study, both longitudinal studies with the northwest tribes.

For those who don't know me, my name is Chandra K. Wilson. I am Klamath-Modoc and a member of The Klamath Tribes. I grew up from the age of 8 years old on the Warm Springs Indian Reservation, and have lived in Portland for over 13 years. I started my career working at the Museum at Warm Springs, and have also worked for the Portland Area Indian Health Service. I started at the health board back in June of 1999 as the Project Assistant to the Northwest Tribal EpiCenter, and have worked in the Human Resources Department for over 5 years.

My heart and passion is to work with and contribute my knowledge and experiences to not only my own tribal people, but Indian people nationwide.

It's been my honor to work and service the tribes of the Northwest and I look forward to continuing my work with and for Indian people.

Tom Becker, MD, PhD, is the Medical Epidemiologist for The EpiCenter. He provides technical assistance for the Northwest Tribal Registry Project and is the Principal Investigator for the NARCH grant. Dr. Becker also servers as the Chairman of the Department of Public Health and Preventive Medicine at Oregon Health & Science University.

WELLNESS CORNER

Cow Creek's Diabetes coordinator getting this group moving pre-dinner activities

NPAIHB Staff and Family Softball Team

Frybread Mafia!: *Back row:* Eric Joseph, Elaine Dado, Steve Caughlan, Nicholas Belgrard, Damon Hilliard, Erik Kakuska, *Front row*: Lisa Griggs, Colbie Van Eynde, Casandra Frutos, Birdie Wermy

NPAIHB staff members at Breast Cancer Bingo at Spirit Mountain

SAMHSA & NCAI Meeting in Rapid City SD

Delegates Cheryle Kennedy, Grand Ronde, Brenda Nielson, Quileute Tribe and Elaine Dado, Executive Admin. Assistant

Brenda Nielson, Quileute Tribe and Elaine Dado, Executive Admin. Assistant

SUMMER RESEARCH INSTITUTE FOR AMERICAN INDIAN AND ALASKA NATIVE HEALTH PROFESSIONALS

By Tom Becker, MD, PhD
NARCH Program

The seventh annual Summer Institute has just wrapped up at the NPAIHB offices. This effort is sponsored by the Board, with input from Oregon Health & Science University (OHSU) faculty and staff, as well as a host of other professionals from around the country. The class content of the summer institute follows a purposeful design that builds on surveys of prospective students, past students and current public health hot topics. This year, two new courses were added to the program; one course focused on grant and project management; and the other on quality assurance and measurement of program outcomes. Each class is a week in duration.

Over 100 trainees enrolled in the program this summer. We trained professionals from around Indian Country. This year Dr. Teshia Solomon from Arizona brought 21 trainees to Portland for a special track focused on cancer in tribal people. Some of our trainees attended all three weeks, while some attended just a week of the institute.

Next year the Summer Institute will be held June 13 - 30, 2011 in Portland, Oregon. We hope that each of you will consider coming or sending some staff members. For more information visit: www.npaihb.org/summer_institute or e-mail summerinstitute@npaihb.org

PICTURES FROM 2010 SUMMER INSTITUTE

Tom Becker, MD, PhD NARCH Program (L) & Jacqueline Left Hand Bull, NPAIHB Administrative Officer (R) giving a warm welcome to this years attendees.

NATIONAL HEALTH OBSERVANCES & UPCOMING EVENTS

JULY

No Health Observance

July 25 – 28
2010 Tribal Best Practices Conference
Prior Lake, MN

July 27 – 29
IHS Behavioral Health Conference
Sacramento, CA

July 28 – 29
CMS Tribal Technical Advisory Group Face to Face Meeting
Washington, DC

AUGUST

National Infant Immunization Month
(Tribal EpiCenter Immunization)

August 4 -5
CMS – IHS Outreach & Education Training
San Diego, CA

August 5 – 9
AAIP 39th Annual Meeting & National Health Conference
Santa Ana Pueblo, NM

August 24 – 26
Direct Service Tribes National Meeting
Billings, MT

SEPTEMBER

Childhood Cancer Month
Leukemia & Lymphoma Awareness Month

Prostate Cancer Awareness Month
(NW Tribal Cancer Control Project (NTCCP)

National Child Passeger Safety Awareness Week
(TECC/Injury Prevention in conjunction with Native CARS)

National Suicide Prevention Week September 5-11th
(Meth & Suicide Prevention (MSPI)

September 3 – 10
Healing Our Spirit Worldwide Gathering
Honolulu, HI

September 11 – 14
2010 National Native American Cancer Conference
Seattle, WA

September 20 – 23
National Indian Health Board Consumer Conference
Sioux Falls, SD

September 20 – 23
Affiliated Tribes of Northwest Indians
Airway Heights, WA

September 21 – 23
Rural Behavioral Health Symposium
Glendale, AZ

OCTOBER

National Breast Cancer Awareness Month
(NW Tribal Cancer Control Project (NTCCP)

Family Sex Education Month
(Project Red Talon (PRT)

Brain Injury/Trauma Awareness Month/Week
(TECC/Injury Prevention)

Fire Prevention Week October 4-10th
(TECC/Injury Prevention)

National Mammography Day October 22nd
(NW Tribal Cancer Control Project (NTCCP)

October 18 – 21
NPAIHB Quarterly Board Meeting
Shelton, WA

Health News and Notes is published by the Northwest Portland Area Indian Health Board (NPAIHB). NPAIHB is a nonprofit advisory board established in 1972 to advocate for tribes of Washington, Oregon, and Idaho to address health issues. Previous issues of Health News and Notes can be found on the NPAIHB web page www.npaihb.org.

Contact Sonciray Bonnell (503) 228-4185 or sbonnell@npaihb.org., Health News and Notes Editor, to submit articles, comments, letters, and request to receive our newsletter by mail

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S APRIL 2010 RESOLUTIONS

RESOLUTION #10-03-01
Support for the NPAIHB 2010 Legislative Plan

RESOLUTION #10-03-02
Support to Pursue Funding for Governance Planning Activities for Regional Specialty Referral Center in the Portland Area

RESOLUTION #10-03-03
Supporting and Approving NPAIHB's FY 2011 Annual IHS Budget Analysis and Recommendations

RESOLUTION #10-03-04
Supporting the Recommendations of the Portland Area CHS Position Paper

RESOLUTION # 10-03-05
Support for NPAIHB *EpiCenter* Data Linkages with Communicable Disease Registries of Idaho, Oregon, and Washington

RESOLUTION #10-03-06
Support for NPAIHB *EpiCenter* Data Linkages with Lead Poisoning Registries of Idaho, Oregon, and Washington

RESOLUTION #10-03-07
National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations

RESOLUTION #10-03-08
Request for Consultation Between Northwest Tribes and Veterans Integrated Service Network (VISN)20