Health News & Notes

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

A Publication of the Northwest Portland Area Indian Health Board
October 2013

THE AFFORDABLE CARE ACT (ACA) AND CHRONIC DISEASE PREVENTION

By Jim Roberts, Policy Analyst

The Affordable Care Act (ACA) is primarily touted as policy intended to control the rising cost of health insurance. Hence, it is often referred to as health marketplace reform. It is the rising cost of health insurance that is a barrier to most Americans not being able to afford insurance. However, the ACA will do much more than provide access to low cost insurance. Such benefits may not seem noticeable to the general public, including Indian health consumers. These benefits will help to address chronic disease issues. The ACA will provide increased access to prevention services. It also creates programs to address chronic diseases such as heart disease, cancer, stroke, diabetes, and arthritis. Taken together, the prevention activities and chronic disease programs will help Tribal communities.

Numerous studies illustrate that American Indian/Alaska Natives (AI/AN) are disproportionately affected by chronic conditions. The three most serious and pressing chronic diseases that affect AI/ANs include cardiovascular disease, cancer, and diabetes. Cardiovascular disease is responsible for over 40% of deaths in the U.S. general population. In 2001, heart disease was the leading cause of death among all AI/AN (accounting for 20% of all deaths) and stroke was the fifth leading cause of death (accounting for 5% of all deaths). More AI/AN men and women over the age of 45 now die of cardiovascular disease than any other single disease.

Cancer is currently the second leading cause of death for American Indians, and is the leading cause of death for Alaska Natives. Late diagnosis is a major contributor to cancer related mortality for AI/ANs. After being diagnosed with cancer, access to needed services through I/T/U programs and contract health providers in the private sector can be complicated and overwhelming. AI/ANs have among the highest rates of diabetes in the world. The prevalence of diabetes and the extent of diabetic complications have reached epidemic proportions. The age-adjusted prevalence for AI/AN adults is more than twice that of other U.S. adults.

Many of the chronic diseases and conditions

continued on page 3

IN THIS ISSUE:

Chairman's Note....................................2
B.C. First Nations Take Over Their Own Health Care Services....................................4
Native American Research Centers For Health (NARCH)....................................7
NPAIHB Takes Steps Towards Preventing Chronic Disease....................................8
2013 Dancing In The Square....................................10
New Face At The Board....................................12
Dr. Ursula Bauer Visits NPAIHBs Tribal Epidemiology Center....................................13
Upcoming Events....................................14

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CHAIRMAN'S NOTE

Andy Joseph, Jr., NPAIHB Chair, Confederated Tribes of Colville Tribe

The ongoing budget debate and sequestration has resulted in a slowdown in travel and meetings related to IHS business. While I am not complaining about not having to travel to meetings, it is a dangerous sign that funding for our health programs is in danger and we as Tribal leaders must be take note of this. IHS has postponed a number of meetings or started to conduct them by teleconference or Web Ex.

This past quarter the Board conducted a very important summit on Contract Support Cost (CSC) issues in Portland. The attendees for the summit represented over 300 Tribes and tribal organizations from across Indian Country. The meeting covered a range of CSC issues and attendees included Tribal leaders, health directors, tribal administrators, financial experts and law firms representing Tribes. The participants all felt that this was one of the best CSC meetings in the past decades and allowed tribes an opportunity to have a honest internal discussion about CSC issues. We should be proud that our organization continues to lead the charge on many national issues such as contract support costs.

I was also fortunate to be able to represent the Board and attend the Canoe Journey hosted by the Quinault Nation. Each Canoe Journey is a historic event, and it's important to our people to renew our traditions and culture through this event. The Quinault Nation were gracious hosts. I am grateful and thank them for their generosity and allowing me to be part of this event. Next year's Journey will be held in Bella Bella, British Columbia and I hope I will be able to attend it, too.

In August, several of the Board staff and I attended the National Indian Health Board's Annual Consumer Conference held in Michigan. NIHB continues to do a good job working on national issues for our Tribes. There were many informative sessions on CMS issues and implementation of the Affordable Care Act. Our Board is a strong partner with NIHB and participates in their Medicare, Medicaid Policy Committee (MMPC). The MMPC has been instrumental in developing a number of policy positions with CMS and on the ACA, and this work has had a positive impact for our Tribal health programs. Our Executive Director and Policy Analyst have worked with NIHB on CSC issues, the ACA hardship exemptions, and recent legislation to address appropriations and the Indian definition issues in the ACA.

Much of the Board's work continues to focus the Affordable Care Act, Medicaid Expansion activities, Contract Support Costs (CSC), and IHS budget and

continued on page 6

THE AFFORDABLE CARE ACT (ACA) AND CHRONIC DISEASE PREVENTION

continued from page 1

among AI/ANs can be prevented through behavioral, environmental, and social approaches. Switching the focus from treating chronic conditions to preventing the diseases will not only improve the health of our Indian people, but it will also lower health care costs. There are many side benefits to Indian communities that result from this, such as stronger economies, better educational systems, and other positive social outcomes. When people are healthy they are more productive and promote economic vitality and are self-sufficient. The savings from treating chronic conditions can be put to use to improve educational programs or other social programs that benefit Tribal communities. The ACA promotes these values by providing considerable resources to build the "health care architecture" and also promotes workplace "cultures of health."

The ACA will provide tax credits that many AI/AN people will be eligible for and can use to purchase insurance through state and the federal health insurance exchanges. This will save the Indian health system valuable resources that can be used to provide much needed services to other AI/AN people that are not eligible for the ACA benefits. Indian health providers can bill the insurance companies when they provide services and this generates a new income source to provide health care for AI/AN people. This savings will have its greatest impact in the Contract Health Service (CHS) program. This insurance will provide access to many types of prevention services that may not have been available through the Indian health system. Over the course of time it will help prevent the onset of chronic diseases in our Tribal communities.

The ACA also established a Prevention and Public Health Fund, which provides financial support for state and community-wide efforts to prevent disease and promote healthy lifestyles. These programs are intended to reduce the prevalence of chronic disease and promote healthy lifestyles. Over $100 million has been provided to state and community programs across the country. The ACA stipulates that $15 billion will be made available through the Fund between FY2010 and FY2019, and $2 billion each year thereafter. While the amount available to be spent every year is set in statute, the exact uses of the Fund will be decided annually through the Congressional appropriations process, and in coordination with the White House Office of Health Reform.

The Fund will offer opportunities to strengthen the public's health through workplace wellness initiatives. A declining workforce health results in increased health-related expenses. This is seen in both direct medical payments and professional shortages resulting from absenteeism or being over-

continued on page 9

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B.C. FIRST NATIONS TAKE OVER THEIR OWN HEALTH CARE SERVICES

Reprint with permission from Vancouver Sun:

vancouversun.com
Mon Sep 30 2013
Section: OnLine
Byline: Peter O'Neil

OTTAWA — The decades-long push to aboriginal self-government in Canada will cross a major threshold Tuesday with a historic, and potentially risky, change in the management of health services in B.C.

The federal government, which is responsible for health services on reserves, is handing over the budget, 134 staff, and the office keys in B.C. to a new entity called the First Nations Health Authority.

The authority will move into Health Canada's First Nations and Inuit Health Branch Pacific regional office in Vancouver on Oct. 1, and at the same time assume control of Health Canada's several dozen nursing stations and health centres in B.C. Eventually, the authority hopes to build its own head office in a Lower Mainland First Nations community.

The new authority, with just under 300 staff, takes over the federal government's $377.8-million annual budget that funds nurses, health care-focused social workers, dentists and, eventually, doctors serving roughly 150,000 aboriginals across the province.

The federal government expects to transfer control of a total of $4.7 billion in funding over the 10-year life of the agreement.

The authority will also get $83.5 million over nine years from the B.C. government, which began flowing in 2011.

If successful, the handover would provide a template — and a pool of experts — for First Nations leaders elsewhere in Canada who are closely watching the B.C. experiment.

A positive handover would also cement B.C.'s reputation as Canada's most progressive province in terms of aboriginal self-government innovation and leadership.

But there is some wariness among Health Canada staff who refused the authority's job offer, and some nervousness among First Nations communities about uncertainty over the future.

"It's a huge step," said Sto:lo Tribal Council Grand Chief Doug Kelly, who is also chairman of the First Nations Health Council. The council is a 15-person team of aboriginal political leaders that broadly oversees — but is not supposed to politically interfere with — the authority's work.

Kelly said it's appropriate that B.C. First Nations leaders were putting final touches on the takeover two weeks ago at the same time Ottawa's Truth and Reconciliation Commission held an event in Vancouver to discuss the decades of mental, emotional and physical damage caused by Canada's residential school policy.

Putting young children into residential schools to assimilate them "reflected a policy that basically said Indians could not take care of themselves, that they had to be wards of the government and weren't worthy of the rights given to other Canadians, including immigrants," Kelly said in an interview.

"So this is a huge departure from colonial thinking, and it's real progress."

The new authority is expected to have a far closer relationship with the B.C. government than Health Canada did, in coordinating resources to assist communities.

That point was not lost on federal Health Minister Rona Ambrose in statement on the handover.

"The transfer of responsibilities empowers First Nations while promoting a better, more responsive and integrated model of health service delivery," Ambrose told The Vancouver Sun.

continued on page 5

B.C. FIRST NATIONS TAKE OVER THEIR OWN HEALTH CARE SERVICES

There is some trepidation in communities like Hartley Bay, one of B.C.'s most remote aboriginal communities that has only float plane or boat access to doctors in nearby Prince Rupert.

The community has relied on a Health Canada-supplied nurse. A year ago a Prince Rupert-based doctor working under the B.C. government's Northern Heath Authority, who made twice-monthly visits to the community, stopped coming.

"We haven't been getting that good a service (from Health Canada) anyway, but I am concerned (about the transition)," said Arnold Clifton, the chief councillor of the Hartley Bay band council.

Dr. John O'Neil, dean of Simon Fraser University's health sciences faculty and an expert on aboriginal health issues, supports the move despite inevitable struggles filling gaps after 20 full-time Health Canada nurses refused the job offers from the First Nations authority.

Research, O'Neil said, has consistently shown that aboriginal communities are healthier when they run their own nursing stations and other health facilities.

He said the new authority's "extraordinary" staff are capable of setting a positive example for the rest of the country.

"This is a historic transformation, and the rest of the First Nations world is watching."

But. O'Neil said the authority faces considerable risks, including the challenge of dealing with the same cost issues facing provincial health ministries, and the difficulty in finding nurses to work in remote locations.

First Nations communities also have more significant health issues than most Canadians, especially a high rate of diabetes, obesity and substance abuse.

Kelly said aboriginal leaders and the First Nations Health Authority staff, led by chief executive Joe Gallagher, know there is enormous pressure to succeed.

"Yes, there are incredible expectations that B.C. First Nations will have improved services and health outcomes and greater decision-making, and that we'll do the job. We feel the expectations, but it's a very powerful motivator to get it done, to get it right, to learn from our mistakes, and to keep on growing."

Formal negotiations between Ottawa, the B.C. government and First Nations leaders began in 2005, with a final agreement in 2011.

Kelly said B.C. aboriginal leaders were already comfortable with the transition because roughly 150 of the 203 aboriginal communities already have Health Canada agreements for band to operate local health centres. Those centres will now receive their funding through the new authority.

But the launch missed its April 2013 deadline to begin operations, and one of the challenges has been to integrate anxious federal bureaucrats and the various unions representing the estimated 230 Health Canada workers who received job offers. Only 135 of them, plus 30 contract and part-time employees, accepted the move, with the rest finding other government jobs, taking early retirement, or opting to be laid off.

While nurses tend support the notion that a local authority is better-suited than a far-off and large Ottawa bureaucracy to handle public health matters, many are concerned about employer-employee relations in remote communities under the new system, said a spokesman for the Professional Institute of the Public Service of Canada, which represents the nurses and other professionals involved in the transition.

"We're behind this project, it's historic," Jamie Dunn said.

But he said nursing in remote aboriginal communities is one of the profession's most challenging jobs, and some are concerned about the increased influence of "band politics" on their jobs.

continued on page 6

B.C. FIRST NATIONS TAKE OVER THEIR OWN HEALTH CARE SERVICES

continued from page 5

"It's the fear of the unknown. Health Canada was always an intermediary between the band and employees, and now bands are in control through the FNHA. How will this influence the employment relationship?"

There have also been union-authority tensions that went to the B.C. Labour Relations Board, which ruled against the authority's bid to require workers to be represented by a single union.

But Dunn said his members see potential for innovative steps that could improve health outcomes.

"The feedback we got is, 'There's all kinds of potential to improve care for First Nations communities — if they'll listen to us."

The First Nations Health Authority's website is advertising for just under three dozen positions, the majority nurses, with many posted by band-run health centres rather than the authority. Most are in isolated communities on the north coast and B.C. interior, including like Bella Bella and Port Simpson.

Kelly, who noted that the Health Canada also had serious staffing issues, said the authority is committed to ensuring communities aren't left without nurses in the transition. He said it will fill gaps by either hiring nurses through agencies, as Health Canada regularly did, or by working co-operatively with the provincial government to share staff.

Kelly said he understands the concerns of Health Canada nurses about being on the wrong end of band politics, but said the health authority and the political council he chairs were set up in a way to specifically avoid political interference in health operations.

"There is an ironclad separation of business and politics. The government of Canada, the province of B.C., and more important the B.C. chiefs required this. So while I understand the fear I don't agree with the conclusion."

He had a similar message for the Hartley Bay chief. While there may be short-term transition issues, he said young aboriginal British Columbians will see a clearer path to becoming doctors, dentists, nurses and health administrators who can remain in, or serve, their communities.

"Yes, there's nervousness, but there's also a lot of hope and optimism.

poneil@postmedia.com

Twitter.com/poneilinottawa

The original article can be found online at: http://www.vancouversun.com/touch/health/First+Nations+take+over+their+health+care+services/8979530/story.html?rel=

CHAIRMAN'S NOTE

continued from page 2

appropriation issues. I know our upcoming Board meeting will provide an opportunity for us to learn more about this important work. I also hope you enjoy this edition of the newsletter, which focuses on chronic disease issues in our communities. Much more can be done to address chronic disease, and prevention is one of the solutions.

What's important to realize is that all of this work takes resources and advocacy, making our work at the Board very important. We could not do this work without the support of our Tribes, and I want to thank and acknowledge you all for this help!

Whi leem lem (Thank You)
Euuhootkn (Badger)
Andrew C. Joseph, Jr.

NATIVE AMERICAN RESEARCH CENTERS FOR HEALTH (NARCH 6)

Fostering chronic disease research skills among AI/AN researchers

Sub-Projects

- *Improving health research skills for AI/AN trainees (student development)*
- *Summer research training institute for AI/AN health professionals*

Project Leader: Thomas M. Becker, M.D.

E-mail: beckert@ohsu.edu; tbecker@npaihb.org

Marked differences in infectious and chronic disease incidence and mortality rates have been documented among American Indian and Alaska Native (AI/AN) tribes nationwide compared to U.S. whites, and most health indicators show that AI/AN people have comparatively poor health status. Although substantial research has been directed toward understanding reasons for high disease rates and health disparities among AI/AN people, involvement by AI/AN researchers in most of these studies has been particularly infrequent. Because cultural factors are central to the design and implementation in many clinical, behavioral, or population-based studies, increasing the involvement of AI/AN peoples to carry out effective research in AI/AN populations should be a priority concern.

The Board hosts two trainee development grants that are aimed at increasing research skills, particularly for chronic diseases, among AI/AN health professionals and graduate students in biomedical sciences. These grants are presented in more detail in the paragraphs that follow. We seem to be enjoying great success with our efforts, and have benefitted from having the Board as host organization, having competent faculty and staff, and enthusiastic students. The two grants are:

Student Development Grant

Our student program will increase the research capabilities of AI/AN investigators to carry out well-designed investigations within AI/AN populations and in other settings. Experienced epidemiologists, biostatisticians, ethicists, and other researchers at the Northwest Portland Area Indian Health Board (the Board), Oregon Health & Science University, and Portland State University will support individually-tailored training program for qualified AI/AN researchers at different levels—including graduate students, health professions students, and Board employees. The training program introduces participants to various research strategies, measurement issues, study design considerations, data management, data analysis, preparation of grant applications, ethics of research, and manuscript preparation. Mentoring from seasoned researchers forms a key part of the training experience for trainees who are based at various universities nationwide. This proposal builds upon existing grant-funded training programs for AI/AN trainees at our academic partner institutions, and will further the career development of AI/AN researchers through capacity building and research skill development. Through the development of qualified, independent AI/AN investigators, our effort may ultimately serve to reduce some of the many disparities in health that are observed among AI/AN groups, compared to U.S. whites nationwide, as well as reduce tribes' distrust of research.

Summer Research Institute

Carefully designed and implemented health research can provide solutions to help eliminate the vast disparities in health between Northwest AI/ANs and non-AI/ANs; however, AI/AN communities are generally distrustful of health research because of past experiences with non-AI/AN researchers. The overall goal of the Summer Research Training Institute for AI/AN Health Professionals is to develop a cadre of highly trained AI/AN biomedical and health researchers who are sensitive to the culture and specific concerns of Indian communities, and who can bring the benefits of academic research to these communities to reduce health disparities. The Summer Institute is operated by the Northwest Portland Area Indian Health Board (NPAIHB)—an Indian organization uniquely qualified to administer NARCH based on an active membership of all 43 Northwest Indian tribes. As it did in the earlier NARCH 4 funding cycle, the Summer Institute accomplishes

continued on page 12

NPAIHB TAKES STEPS TOWARDS PREVENTING CHRONIC DISEASE

By Supporting Physical Fitness of Board Employees
Rachel Ford, MPH

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

The NPAIHB Wellness Committee supports employee Wellness through monthly wellness newsletters and wellness tips, showing health-related documentaries such as "Kind Hearted Woman" and "Weight of the Nation," as well as scheduling 3-4 group workouts each week that are open to all Board employees. Workouts generally include running, walking, climbing stairs and Cross Fit. During the summer months there has been on average 5-7 people participating in each workout, and the walking workouts have included trips to the local Farmer's Market to stock up on fresh produce and healthy lunch bites.

The NPAIHB Wellness Committee also educates staff about community wellness events, including runs, walks, and concerts in the parks. NPAIHB also collaborates with the Native American Research Center for Health (NARCH) to bring lunchtime health seminars to the Board. The next speaker is David Gonzales, PhD. On November 6th he will be speaking about the risks of cigarette smoke exposure to cancer and other treatment outcomes.

Recently, there have been some new additions to the Board. We have acquired 5 treadmill desks, 3 of which are for all employees to use. There have been studies that support standing and/or walking instead of sitting while working at your desk.

Epidemiologist Steven Blair, a professor of public health at the University of South Carolina, has spent 40 years investigating physical activity and health. "We're finding that people who sit more have less desirable levels of cholesterol, blood sugar, triglycerides and even waist size, which increases the risk of diabetes, heart disease and a number of health problems."[1]

Dr. Hidde van der Ploeg, a senior research fellow at the University of Sydney's School of Public Health in Australia, found that sitting for 11 or more hours per day increased risk of death by 40 percent, regardless of other activity levels.[2] This startling finding emerged from a review of data from the American Cancer Society's Cancer Prevention Study II (CPS-II). Researchers concluded that:[3]

- Women who sat for six or more hours daily faced a 37% greater risk of death as compared to those who sat for three hours or less.

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1 Neighmond, P. (April 25, 2011). Sitting all day: Worse for you than you think. *NPR*. Retrieved from http://www.npr.org/2011/04/25/135575490/sitting-all-day-worse-for-you-than-you-might-think

2 Sitting at work: Why it's dangerous and when you can do. *Huffington Post*. Retrieved from http://www.huffingtonpost.com/2012/07/24/sitting-at-work-why-its-dangerous-alternatives_n_1695618.html?view=print&comm_ref=false

NPAIHB TAKES STEPS TOWARDS PREVENTING CHRONIC DISEASE

Mike Feroglia, Chris Sanford and Nicole Smith

- For men, the increased risk of death for those who sat at least six hours daily was 17%.
- Those who did not exercise regularly and also sat for long periods faced even greater mortality rates – a startling 94% higher for women and 48% higher for men.

The American Cancer Society has advice for what to do if you have a "desk job" – or drive for several hours at a stretch every day. Here are a few helpful suggestions for adding bursts of activity to your daily routine:[43]

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

3 Don't just sit there: Stay active all day to reduce cancer risks. *American Cancer Society*. Retrieved from http://www.cancer.org/myacs/illinois/do-not-just-sit-there

THE AFFORDABLE CARE ACT (ACA) AND CHRONIC DISEASE PREVENTION

continued from page 3

worked. Wellness programs have been shown to save money; however, such programs may be under-used or abused. One reason may be that the future benefits of healthy employees are significantly undervalued relative to the cost. Despite this, many businesses are taking a holistic approach to health by offering wellness programs to their employees. The Board, for example, is a shining star for offering such wellness programs. The Board allows its employees the opportunity to have a 30 minute wellness time each day. Employees are encouraged to use this time in some form of wellness or physical exercise activity. The Board, recently set up treadmill computer stations that employees may use during the day to do their work, stand and exercise at the same time. Such programs are becoming a common place in corporate America and it is exciting to see our own organization to be on the cutting edge of promoting such programs.

The ACA wellness and prevention programs aimed at preventing chronic disease and raising awareness about healthy living will help to address the onset of chronic disease in our Tribal communities. It won't happen overnight and will take time and commitment from us all. Staying the course by promoting and participating in the ACA programs will help to reverse the trend of chronic disease in our Tribal communities.

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Dancing in the Square 2013

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To Our Many Sponsors

On September 27, 2013 the Northwest Portland Area Indian Health Board was the proud sponsor of an Indian Day celebration event at Portland's Pioneer Courthouse Square. This was the 8th Annual Dancing in the Square celebration of National Indian Day, which is recognized on the fourth Friday in September. The event was a great success because of the people who attended and contributed. Our thanks to everyone involved and our special thanks goes to: ***MC: Bob Tom, Whipman: Ed Goodall, Colors: NIVA, Grand Ronde Canoe Family, Host Drum: Four Direction and our many Vendors!***

PLATINUM SPONSOR

Outstanding Community Partner

For their work in effectively advocating to address persistent health disparities in Indian country, the Northwest Portland Area Indian Health Board was selected as this year's recipient of the Oregon Health and Science University's **2013 Diversity and Inclusion Award** for **Outstanding Community Partnership.**

The Northwest Portland Area Indian Health Board (NPAIHB) is widely recognized in northwest Native American communities as an exemplary research and policy organization that is responsive to tribal health needs. Researchers at the NPAIHB, OHSU's Prevention Research Center and the Departments of Public Health & Preventive Medicine conduct research to improve Indian health, particularly among the 43 constituent member tribes in Oregon, Washington, and Idaho. The Indian Health Board's group's policy work has resulted in increased access to health care among tribal communities.

Nominations for the Diversity and Inclusion Awards are open to community organizations that work in partnership with OHSU students, clinicians, researchers, faculty and staff to solve health disparities and improve health outcomes in underserved communities.

Learn more about at ***www.ohsu.edu/diversity-awards***

Dancing in the Square 2013 Sponsors

New Face At The Board

Candice Jimenez, MPH Student, BA, Native CARS Research Assistant:

Candice Jimenez is a member of the Confederated Tribes of Warm Springs and is new to the NPAIHB beginning with the Native CARS Study project. Currently she is completing her MPH in Primary Care & Healthcare Disparities at OHSU and will be applying to medical school for Fall '15 admission. She has a BA in Biology from Concordia University. Her experiences include training physicians in electronic health records use (Epic), data entry, tribal community data collection, qualitative data coding and reporting, in addition to coordinating communications between tribes and project coordinators.

As a Research Assistant, Mrs. Jimenez will be responsible for day-to-day operational activities of the Native Children Always Ride Safe (CARS) study, under the direction of Tam Lutz.

Candice and her husband live in Portland, OR with their 3 year old toddler son who is learning Spanish while attending the International School. They enjoy hiking, mountain biking, camping, basketball and exploring the food culture throughout the city.

NATIVE AMERICAN RESEARCH CENTERS FOR HEALTH (NARCH 6)

continued from page 7

its goals through a series of research training and project development and implementation courses offered in modules each summer of the NARCH grant. We also developed an infrastructure for supporting AI/AN students in high quality health and biomedical research. Furthermore, we recruited summer interns who complete a core series of research courses and conduct a research project under the guidance of an experienced mentor. This project opens to AI/AN researchers the extensive health research training opportunities of the two premier academic health research institutions of the Northwest—Oregon Health & Science University (OHSU) and Portland State University (PSU). All of these projects will be accomplished through enhancements of the existing partnership among NPAIHB, OHSU, and PSU. The Summer Institute helps to fill the void of well-trained AI/AN health researchers, and will contribute to the national effort to reduce health disparities among AI/AN people, compared to other races, in the US. Next year will be our tenth year for the Institute.

DR. URSULA BAUER VISITS THE TRIBAL EPIDEMIOLOGY CENTER AT THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Back Row:Tim Gilbert, Cindy Gamble, Danielle Arellano, Beth Seltzer, Twila Teeman, Dr. Ursula Bauer, Shawna Gavin, Victoria Warren-Mears, Joe Finkbonner
Front Row: Ronda Metcalf, Mel Melmed

On June 27th and 28th, Dr. Ursula Bauer Director of the National Center for Chronic Disease and Public Health at the Center for Disease Control and Prevention, visited the Northwest Tribal Epidemiology Center with colleagues Charlan Kroelinger and Myra Tucker of the Maternal Child Health Program at CDC and Danielle Arellano who is an ORISE fellow with MCH. The primary purpose of the visit, was a close-out visit for our CDC Assignee Suzanne Zane, who was changing positions to work with the State of Oregon. Additionally, she was able to meet with staff of the EpiCenter; Executive Director, Joe Finkbonner; and most importantly Tribal Leaders to discuss both CDC funded projects and the needs of the Tribes in the Northwest. This also was an outstanding time for individuals representing Chehalis and Makah Tribes to present the results of the first year of their CDC funded Community Transformation Grants. Dr. Bauer was impressed by the work she observed and is planning to keep in touch with the Board to discuss potential ways to increase grants to tribes and tribal organizations.

OCTOBER

October 24
Washington Tribal Assister Certification Workshop
Webinar

October 28
NARA's Boo Bash
Red Lion, Portland, OR

October 29
AIHC Meeting
Webinar

October 29-31
NARA's 4th Annual Spirit of Giving Conference
Portland, OR

October 28 – 29
IHS Tribal Self-Governance Advisory Committee Meeting
Washington, DC

NOVEMBER

November 1
HHS American Indian & Alaska Native Heritage Month Event
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington. DC

November 4
Project Planning and Development (PPD) Training
Las Vegas, NV

November 5
Oregon Tribes TTWG Meeting
Grand Hotel Bridgeport
Portland, OR

November 5
Washington Get Covered Workgroup
Webinar

November 5
Washington DSHS Tribal Centric Behavioral Health Workgroup

November 7
Tribal Elders, Area Agencies on Aging, Home & Community Service Division
Northern Quest Resort
Spokane, WA

November 7 - 8
IHS Direct Service Tribes Advisory Committee Meeting
Mashpee, MA

November 14 – 15
HHS STAC Meeting
Washington, DC

November 19
Washington DSHS Tribal Centric Behavioral Health Workgroup

November 11
Federal Holiday - Veterans Day

November 19
MMPC Face to Face Meeting
Washington DC

November 20 - 21
TTAG Face to Face Meeting
National Museum of American Indian
Washington DC

November 28
November 28
Federal Holiday - Thanksgiving Day

DECEMBER

December 3
Washington Tribal Get Covered! Workgroup
Webinar

December 3
Washington DSHS Tribal Centric Behavioral Health Workgroup

December 4
MMPC Monthly Conference Call

December 12
3rd Annual Northwest Tribal Opiate Symposium
Muckleshoot Health & Wellness Center
Auburn, WA

December 13
AIHC Meeting
Muckleshoot Health & Wellness Center
Auburn, WA

December 17
Washington Tribal Get Covered! Workgroup Meeting
Webinar

December 17
Washington DSHS Tribal Centric Behavioral Health Workgroup

December 25
Federal Holiday - Christmas Day

JANUARY

January 1,
Federal Holiday – New Years'

January 21-23
NPAIHB Quarterly Board Meeting
Portland, OR

4TH ANNUAL THRIVE CONFERENCE

FOR AMERICAN INDIAN AND ALASKA NATIVE YOUTH

- Ages 13 - 19. Limit 4 youth per Tribe or Urban Area.
- 1-2 Chaperones per group registering.
- Registration is free!
- Activities, materials, and most meals will be provided.
- Travel, parking, and lodging are not included.

SAVE - THE - DATE!

JUNE 23 - 27, 2014

LLOYD CENTER DOUBLETREE HOTEL, PORTLAND, OR

Possible youth workshop tracks & activities:

- Art
- Leadership
- Digital Storytelling
- Film Production
- Song Writing & Production
- Dancing and cultural sharing

WHY THIS CONFERENCE?

- Building protective factors, i.e. the workshop tracks, for youth can help reduce the chances of engaging in risky behaviors and increase self-esteem and confidence.
- Protective factors focused on: connectedness to friends and culture, engaging in activities, support, encouragement, and more!

REGISTRATION OPENS IN APRIL 2014!

Hotel rates are $123/night for quadruple occupancy room, use group "Annual THRIVE Conference" or "THC". Call 1-800-996-0510 for reservations.

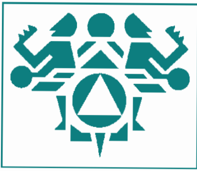
Contact Information

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Colbie Caughlan
THRIVE
2121 SW Broadway
Suite 300
Portland, OR 97201
Phone: 503.416.3284
Email: ccaughlan@npaihb.org
Web: www.npaihb.org

I STRENGTHEN MY NATION

THRIVE

COME SHOW HOW YOU STRENGTHEN YOUR NATION!



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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S

JUNE 2013 RESOLUTIONS

RESOLUTION #13-04-01
NATIVE AMERICAN RESEARCH CENTERS FOR HEALTH (NARCH) VIII

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S AND CALIFORNIA RURAL INDIAN HEALTH BOARD JUNE 2013 RESOLUTIONS

JOINT RESOLUTION #13-04-02
IN SUPPORT OF THE CONTRACT HEALTH SERVICE ALLOCATION FORMULA

JOINT RESOLUTION #13-04-03
CONTRACT SUPPORT COSTS

JOINT RESOLUTION #13-04-04
IN SUPPORT OF DATA-BASED RESOURCE ALLOCATION

JOINT RESOLUTION #13-04-05
IN SUPPORT OF THE U.S. CONGRESS & ADMINISTRATION ADOPTING THE DEFINITION OF INDIAN AT 42 C.F.R. § 447.50 UNIFORMLY IN IMPLEMENTING THE AFFORDABLE CARE ACT

JOINT RESOLUTION #13-04-06
INDIAN MANAGED CARE ENTITY

JOINT RESOLUTION #13-04-07
DHHS SUPPORT FOR THE TWELVE TRIBAL EPIDEMIOLOGY CENTERS TO PERFORM MANDATED PUBLIC HEALTH FUNCTIONS

JOINT RESOLUTION #13-04-08
DENTAL SUPPORT CENTERS