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.

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April 2013

CONGRESS WRAPS UP FY 2013 APPROPRIATIONS PROCESS AND ADMINISTRATION BEGINS IMPLEMENTATION OF SEQUESTRATION: IHS BUDGET TO LOSE $228 MILLION

Finally, after a long and arduous process, Congress has completed its work to finalize the FY 2013 appropriations process by passing the Consolidated and Further Continuing Appropriations Act of 2013 (H.R. 933). The bill is a full-year Continuing Resolution (CR) that will allow the federal government to continue to operate until the end of the 2013 fiscal year. The legislation funds five Appropriations bills that include Defense, Military Construction and Veterans Affairs; Homeland Security; Commerce; Justice and Science, and Agriculture. It also extends funding levels for other federal agencies, including the Indian Health Service (IHS), at the FY 2012 levels.

The year-long CR maintains funding for the Indian Health Service (IHS) at the enacted FY 2012 level for most programs. The bill does include a small increase of $53 million to phase in staffing for six new health facilities at Chickasaw (2), Cherokee, Southcentral, Tanana Chief, and Norton Sound. This staffing package comes from additional funds provided by Congress and likely includes an additional $3.3 million that will have to be reprogrammed from other budget line items. The additional funding provided by Congress totals $49.7 million. At this writing, it is not possible to determine where this additional $3.3 million will come from since there are not enough details from the appropriation managers.

Most alarming for Indian programs is that the funding provided is subject to the President's sequestration order contained in the Budget Control Act of 2011 (BCA, P.L. 112-25). This means that certain funding provided in the 2013 Consolidated Appropriations will have to be reduced by 5 percent. "Sequestration" is a process of automatic, largely across-the-board spending reductions under which budgetary resources are permanently canceled to enforce budget policy goals. This process will require that approximately $984 billion in discretionary spending will have to be reduced from the overall FY 2013 Consolidated and Continuing Appropriations Act.

On a call with the IHS Director, Yvette Roubideaux, held earlier this week, it was reported that approximately $228 million will have to be cut from the IHS budget. This represents a 5.3 percent overall reduction in the IHS budget. While the net effect on the overall budget will be the same, there are three critical budget line items that will absorb over 73 percent of the cuts. These include the Hospital & Clinics budget which will lose $95.8 million, the Contract Health Service (CHS) program will lose $44.6 million, and the Contract Support Cost (CSC) line item will

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This Issue Focus On Injury and Violence Prevention:

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CHAIRMAN'S REPORT

Chairman Andy Joseph, Jr. and CRIHB Chairwoman Michelle Hayward

I want to provide an update on the Board's legislative priorities and a report about our advocacy work during the NCAI Winter Session. Each year, the Board works with Portland Area Tribes and ATNI to develop a "Legislative and Regulatory Plan" on important issues affecting Northwest Tribal health programs. The Plan is used to advocate on important issues with Congress and the Administration. The Plan is always approved by resolution of our full Board and by Tribal leaders at ATNI.

My contributions to the Plan always include important health issues to the Colville Tribe. I always strive to make sure the Plan includes direct service and self-governance issues. At the end of the day, all the legislative and health policy issues included in the Plan directly impact all Portland Area Tribes. They also have national implications and affect Tribes throughout Indian Country.

A key element of the Plan is that it advocates on the importance of the Indian Health Service (IHS) appropriation and emphasizes the United State's responsibility to fund health care for our Indian people. Our Tribes all signed treaties with the federal government which establishes the government's legal and moral responsibility to provide health care for our people. The Legislative Plan focuses on administrative issues associated with implementation of the Affordable Care Act (ACA). The ACA presents opportunities for additional funding for our health programs to serve Indian people. This year's plan also includes several legislative priorities such as an Indian definition fix, reauthorization of the Special Diabetes Program for Indians, legislation for optional Medicaid benefits, and special funding for regional health centers and a regional youth treatment facility.

During our recent trip to Washington D.C. for the NCAI Winter Session, we presented our Legislative Plan to a number of congressional offices. Each year we try to visit each one of our Northwest Congressional delegates. Some folks we call on a number of times, and I know they may get tired of seeing us. But it's important they know that Northwest Tribes will always be coming back to make sure they know about our priorities and the importance to fund our health programs. Our visits included seeing staff members of Jaime Herrera Beutler, Patty Murray, Max Baucus, Maria Cantwell, and

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EXECUTIVE DIRECTOR'S NOTE

SEQUESTRATION EQUAL THE NEW NORM

Joe Finkbonner, NPAIHB Executive Director

The good news for FY 2013 is that we are no longer operating on our continuing resolution (CR) budget, the bad news is that now we have to implement the sequester that was supposed to be "so bad" that neither political party would allow it to happen. The net result for fiscal year budget is a 5.3% reduction applied to the FY 2012 budget resulting in our final FY 2013 budget and that followed a 0.189% rescission for an overall reduction of approximately 5.5% (5.479% to be precise).

Whew! It's all over now, right? We can go on and start budgeting with the reduced amount and try to make a case for a large increase in the next few years to try to "catch up" on the amount reduced in this budget cycle. Not really…sequestration is more than a one-time reduction, but will also impose spending caps on the federal budget for the next 10 years. The worst part of it, is that it is across-the-board reductions, not even allowing the Directors of Agencies to exercise priorities in who they chose to reduce, cut completely, or keep whole.

What does that mean? It translates into every sub-sub budget item being reduced by the 5.3% sequestration amount (for 2013), when in some cases it doesn't make any logical sense. An example I would use is facilities construction. It is likely okay to cut a construction project if you are still in the planning and site location stages of the project, but less logical to the budget for a project that is further along the construction cycle that could result in complete stoppage of the project. We all know that stoppage of a construction project typically means additional costs to the project in the long run. We will also have less funding for clinic operations, contract support costs, and contract health, which are the access issues that we all try to improve.

The disappointing fact is that in typical years where Indian Health has had reductions, we have been able to increase our efforts in obtaining funding from the likes of SAMHSA, CDC, ATSDR, or other HHS departments, but they are in the same position that our IHS budget is.

There are few options for mitigating the impact of the sequestration. The first is to increase your third party reimbursements and apply them to your health system to maintain current services. You can improve your success in obtaining outside grants for health programs to help with prevention or preparedness, but the resources there will be reduced as well, if they are federally funded. Go after private foundation funding for specific projects is another

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lose $24.9 million. Collectively these three budget line items stand to be reduced by over $165.2 million, undoing years of advocacy work by Tribes to have these programs funded at adequate levels.

In addition to the sequestration, H.R. 933 requires an .189% across-the-board rescission to the IHS appropriation. The amount for the rescission is approximately $8.1 million, while the estimated amount for the sequestration is $219.6 million, for an estimated total of $228 million. Because these reductions will be concentrated in the second half of FY 2013—rather than spreading over the course of a full fiscal year—they will be difficult to absorb with steep programmatic reductions required to absorb the loss in the remaining fiscal year.

The amounts reported in the attached table are not precise since the IHS and appropriation managers are not clear whether the sequestration should get applied to the additional funding provided for facilities staffing. However, the amounts are close estimates but could change based on the outcome of this decision. The following highlight reductions on the impact of the rescission and sequestration:

- Overall, the IHS budget must be reduced by $228 million
- The Hospitals & Clinics budget line item will lose $95.7 million
- The CHS program will be reduced by over $44.6 million
- The overall reduction for Clinical Services will be at least $163.1 million
- The Behavioral health services will lose over $14 million
- The IHS Prevention accounts will be reduced by $7.7 million
- Overall, the health services accounts (include H&C, CHS, Behavioral health, Prevention, Urban Programs, CSC, and others) will lose over $204 million

Current Services: Impact of Sequestration and maintaining the IHS program

Current services estimates calculate mandatory costs increases necessary to maintain the current level of services. These mandatories are unavoidable and include medical and general inflation, pay costs, staff for recently constructed facilities, and population growth. Last February, the Northwest Portland Area Indian Health Board estimated the FY 2013 current services need to be approximately $403 million. The President's 2013 request was only a $115.9 million increase for the IHS, and was 71% short of funding current services need. The impact of sequestration will make the current services deficit even worse. Sequestration will also reverse many improvements that the Indian health system has been able to achieve with the significant investments that have been made over the past few years. Now that the sequestration is upon us, it is very likely that IHS, Tribal and urban Indian health programs will have to cut costs by furloughing staff, reducing the levels of health care services, restricting pharmaceuticals as well as taking other cost saving measures that will result in less care and lower health quality outcomes.

FY 2013 Current Service Requirements
Dollars in Thousands

Mandatory Cost to Maintain Current Services	*Increase Needed*
CHS Inflation estimated at 5.5%; and Population Growth	$64,112
Health Services Account (not including CHS) inflation	$167,058
Contract Support Costs (unfunded)	$99,300
Population Growth (estimated at 1.6% of Health Services accounts)	$72,722
Total Mandatory Costs	$403,192

When the sequestration and across the board rescission are factored with the current services' need, the net effect on the IHS budget is dramatic. These draconian cuts will result in over $631 million in lost

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VIOLENCE AGAINST WOMEN REAUTHORIZATION ACT (VAWA) 2013 AND TRIBAL JURISDICTION OVER NON-INDIAN PERPETRATORS OF DOMESTIC VIOLENCE

Congress recently passed the Violence Against Women Reauthorization Act of 2013, or "VAWA 2013." This new law includes significant provisions addressing tribal jurisdiction over non-Indian perpetrators of domestic violence. These tribal provisions were proposed by the Justice Department in 2011.

WHAT WILL TRIBES BE ABLE TO DO UNDER THE NEW LAW? Tribes will be able to exercise their sovereign power to investigate, prosecute, convict, and sentence both Indians and non-Indians who assault Indian spouses or dating partners or violate a protection order in Indian country. VAWA 2013 also clarifies tribes' sovereign power to issue and enforce civil protection orders against Indians and non-Indians.

WHEN DOES THIS NEW LAW TAKE EFFECT? Although tribes can issue and enforce civil protection orders now, generally tribes cannot criminally prosecute non-Indian abusers until at least **March 7, 2015.**

WILL THIS BE VOLUNTARY? Yes, tribes will be free to participate, or not. The authority of U.S. Attorneys (and state/local prosecutors, where they have jurisdiction) to prosecute crimes in Indian country remains unchanged.

WHAT CRIMES ARE COVERED? Covered offenses will be determined by tribal law. But tribes' criminal jurisdiction over non-Indians will be limited to the following, as defined in VAWA 2013:

- Domestic violence;
- Dating violence; and
- Criminal violations of protection orders.

WHAT CRIMES ARE NOT COVERED? The following crimes will generally not be covered:

- Crimes committed outside of Indian country;
- Crimes between two non-Indians;
- Crimes between two strangers, including sexual assaults;
- Crimes committed by a person who lacks sufficient ties to the tribe, such as living or working on its reservation; and
- Child abuse or elder abuse that does not involve the violation of a protection order.

WHAT IS THE PILOT PROJECT? A tribe can start prosecuting non-Indian abusers sooner than March 7, 2015, if—

- The tribe's criminal justice system fully protects defendants' rights under Federal law;
- The tribe asks to participate in the new Pilot Project; and
- The Justice Department grants the tribe's request and sets a starting date.

WHAT RIGHTS DO NON-INDIAN DEFENDANTS HAVE? A tribe must—

- Protect the rights of defendants under the Indian Civil Rights Act of 1968, which largely tracks the Federal Constitution's Bill of Rights, including the right to due process.
- Protect the rights of defendants described in the Tribal Law and Order Act of 2010, by providing—
    - Effective assistance of counsel for defendants;
    - Free, appointed, licensed attorneys for indigent defendants;
    - Law-trained tribal judges who are also licensed to practice law;
    - Publicly available criminal laws and rules; and
    - Recorded criminal proceedings.

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Sexual Assault Awareness Month

By: Carrie Sampson (Umatilla-Walla-Walla), Project Manager

The National Sexual Violence Resource Center (NSVRC) has dedicated this year's Sexual Assault Awareness Month (SAAM), April 2013, to focusing on healthy sexuality and its connection to child sexual abuse prevention. This campaign addresses the following: characteristics of healthy sexuality, identifying risks, support healthy boundaries and challenge negative messages. By discussing these topics, parents, community members, and organizations can works towards ending child sexual abuse. (NSVRC, 2013)

The NSVRC states that, "Sexuality is much more than sex – it's our values, attitudes, feelings, interactions and behaviors. Sexuality is emotional, social, cultural and physical. Sexual development is one part of sexuality, and it begins much earlier in life than puberty. Infants and children may not think about sexuality in the same way as adults, but they learn and interpret messages related to sexuality that will shape their future actions and attitudes." (NSRV, 2013)

Play a Role in Prevention of Child Sexual Abuse:

- Engage adults in addressing the issue
- Educate yourself, act as a resource
- Develop positive, open communication to build confidence and trust
- Model healthy behaviors and reinforce positive messages
- Challenge media and harmful messages
- Get involved and be aware of red flags
- Always report suspected child abuse – *ChildHelp National Child Abuse Hotline at 1-800-4-A-CHILD (1-800-422-4453)* (NSRV, 2013)

To learn more about this campaign, visit www.nsvrc.org/saam

Resources for Support

- Our Whole Lives: *Sexuality curricula for parents and adults.* http://www.uua.org/re/owl/faq/parents/index.shtml
- National Coalition to Prevent Child Sexual Abuse and Exploitation: *National Plan to Prevent the Sexual Abuse and Exploitation of Children.* http://www.preventtogether.org/Resources/Documents/NationalPlan2012FINAL.pdf
- Planned Parenthood Federation of America: *Talking With Kids of Sex and Sexuality.* http://www.plannedparenthood.org/parents/talking-kids-about-sex-sexuality-37962.htm
- Stop it Now!: *Let's talk: Speaking up to prevent child sexual abuse.* http://www.stopitnow.org/files/Lets_Talk.pdf (NSRV, 2013)

References
National Sexual Violence Resource Center. (2013). Sexual Assault Awareness Month 2013: An overview of health childhood sexual development, Resource for advocates, educators & preventionists, Resource for community members. Available at http://www.nsvrc.org

BOOST THEM IN THE BACK SEAT

By: Nicole Smith
NATIVE Cars

Boosters are for Big Kids

Automobile seats were designed for adults. Most kids need a booster seat from age 4 untill around age 10-12, when they are big enough to sit comfortably and safely in the auto seat, usually when the child is about 4 feet 9 inches tall. This simple 5-step test will help determine if a child is ready to use a safety belt without a booster.

The 5-Step Test

1. Does the child sit all the way back against the auto seat?
2. Does the child's knees bend comfortably at the edge of the auto seat?
3. Does the belt cross the shoulder between the neck and arm?
4. Is the lap belt as low as possible, touching the thighs?
5. Can the child stay seated like this for the whole trip?

Many big kids prefer to use a booster seat as it is more comfortable and gives them a better view out the window. Booster seats are often equipped with cup holders and sometimes have hidden compartments to stash small toys or other treasures, which is pretty cool for a kid. Children who are placed in seat belts without booster seats are twice as likely to suffer devastating injuries, including damage to the brain, liver, spleen, stomach, and spinal cord in the event of a crash. Booster seats are a good choice for kids age 4-10 or so for maximum protection and better comfort too.

The Back Seat is Safest

The back seat is the safest place to ride in a vehicle, regardless of whether the vehicle has an airbag. Back seat occupants are 59 percent to 86 percent safer than passengers in the front seat. A child who is too small for a seat belt to fit correctly who is placed in the front seat can be ejected in a crash. Air bags could seriously injure or even kill an unbuckled child or adult and can strike a rear-facing child seat with enough force to cause serious or even fatal injuries to a baby. If a child is too small for a seat belt, he or she is too small for the front seat. Washington State law requires children age 12 and under to be seated in the back seat if practical, and some tribes, such as The Colville Confederated Tribes, have enacted similar laws.

The Native Children Always Ride Safe study done in six Northwest tribes found that 15 percent of children age 12 and under were seated in the front seat of a vehicle. Only 9 percent of children age 4 and under were in the front seat, while 34 percent of children age 8-12 were in the front seat. Children riding in trucks were the most likely to be in the front (41 percent), partly because trucks often only have a front seat, but even among trucks that did have a back seat, 24 percent of kids were seated in the front.

There is no rush to graduate kids from a booster or to the front seat. Even big, tough kids are safer in a booster in the back seat. For more information, contact Native CARS at nativecars@npaihb.org

ELDER FALL PREVENTION

By: Luella Azule, Injury Prevention Coordinator

From the time I was a youngster, my parents, Lewis and Lillian Spino, taught me, my brothers and sisters to **"respect your elders."** An elder was defined as **"as anyone older than you."** Most Northwest Tribes define tribal elders as members aged 55 or older. Most Tribal Elders are highly respected for their knowledge of tribal language, tribal history, and tribal ceremonies.

In 2010, the Northwest Portland Area Indian Health board was awarded a Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) grant to focus on prevention of elder falls and motor vehicle crashes. Although mainstream falls prevention programs tend to focus on adults ages 65 and older, the data on American Indian/ Alaska Native (AI/AN) falls-related hospitalization data suggest that Native-specific falls prevention programs in the Northwest should include those in their 50s, as well.

Falls represent the leading type of injury resulting in hospitalization in Washington among AI/AN and all other races, though the proportion of falls is lower among AI/AN (27.8%) as compared to all other races combined (42.5%.) For AI/AN, the mean age at admission is 54.3 years and the median is 57, compared with a mean of 68.5 years and a median of 76 years for all races combined.

Why Prevent Falls?

- Each year, many American Indian elders are injured due to falls. In the United States, falls are the second leading cause of unintentional injury for Natives aged 55 and over. Falls are the leading cause of injury-related hospitalization and injury-related deaths.
- According to 2008 Indian Health Service contract health care records for AI/AN, the average charge per hospital day was $4,911, the average stay was 6.7 days, and the average hospital charge for a single fall-related hospitalization was $32,906.
- According to Centers for Disease Control and Prevention:
  - One-third of all older adults aged 65 or older report at least one fall in the past year
  - Every 15 seconds an older adult gets treated in an Emergency Department for a fall
  - Every 29 minutes an older adult dies from a fall
  - Many more falls occur that don't require medical treatment, but which still lead to serious consequences

Fall Consequences

- Fear of falling: tends to reduce activity, leading to an increased risk of falling and decreased quality of life
- Fractures: hip, spine, arm, legs, hand, ankle, pelvis, head trauma and traumatic brain injury,
- Loss of: independence, physical and mental health

What do we know?

The good news is: falls are **not** a normal part of aging, they **can be prevented**, they have **known risk factors** and causes, and **we know what works** to reduce falls. Fall prevention strategies and programs need to be more widely implemented.

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ELDER FALL PREVENTION

Risk Factors are a complex problem

Personal Risk Factors that **cannot** be changed include:

- **Age:** Fall risk and injury rates increase with age
- **Gender:** Women are more likely to fall and be injured, though men are more likely to die from a fall
- **Race:** Fall rates are highest among white older adults
- **Past history of falls:** Those who have fallen in the past are 3 times more likely to fall again

Personal Risk Factors that **can** be changed include:

- **Problems with gait and balance:** Lower body strength can be improved by exercise
- **Sleep disturbance:** Due to a number of changeable factors including poor sleep habits, illness, medications, or psychological distress
- **Fear of falling:** Can be reduced through education and outreach
- **Taking 4+ medications may cause dizziness or drowsiness:** Reviewing prescribed and/or over the counter medications regularly with a doctor, NP or pharmacist can help prevent or address interactions or side effects
- **Improper use of walkers or canes:** Learning to use mobility aids properly can give elders more confidence and assistance
- **Vision impairment:** vision problems caused by wearing the wrong glasses, cataracts, glaucoma, macular degeneration, or diabetic retinopathy can be treated with proper prescription glasses or surgery
- **Chronic disease:** Conditions such as diabetes, stroke, arthritis, Parkinson's disease, osteoporosis, Alzheimer's disease, or incontinence can be treated with exercise, prescriptions, surgery, and proper diet, reducing associated risk of falls

Environmental Risk Factors

Home and environmental hazards include:

- Poor lighting, especially in the bedroom, halls, bathroom or on stairs
- Unsafe bathrooms, without grab bars, walk in showers, or raised toilet seats
- Clutter, electrical cords, throw rugs, loose carpets, or
- Slippery surfaces from spills, snow, ice
- Lack of stair railings on steps or stairs, or lack of ramps
- Changes in floor surface, for example from carpet to linoleum or tile, or uneven/cracked pavement or floor
- Unstable or wobbly furniture
- Inappropriate chair or cabinet heights, pets, uneven/cracked pavement or surfaces, and obstacles in walkway.

What works to prevent falls? A Multifactorial approach works best.

Doctor Visits

Elders are encouraged to see their primary care provider at least once a year for a full physical examination. During the visit, patients should report any falls in the past year, because once a person falls, their risk of falling increases. Health care providers can also screen for issues that can increase the risk of falling: problems with vision, balance, gait; certain medications; and chronic diseases such as diabetes

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ELDER FALL PREVENTION

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– which can cause numbness in feet or legs – or low blood pressure – which can lead to dizziness when standing up from a sitting or lying position. There are many ways for patients and medical professionals to work together to reduce fall risks.

Medication Review

Elders are strongly encouraged to take all their medications, both prescribed or over the counter, to their doctor, nurse practitioner or pharmacist. Some medications or combinations of medicines can cause dizziness or drowsiness. In the event of a fall, elders may be unable to talk to the emergency response team, so they should post a list of medications they are currently taking on their refrigerator.

Vision

Poor vision can increase the chances of all fall. Vision should be checked yearly or at least every two years. Poor vision can be the result of wrong or new glasses, cataracts, glaucoma, or diabetic retinopathy.

Home Safety Assessment

Family members, community health representatives or public health nurses can assist elders to conduct home safety assessments. Key ways to reduce the risk of falls include:

- Keeping floors, pathways and halls free of clutter and furniture
- Removing rugs, wires and other trip hazards
- Installing grab bars and non-slip mats in the tubs and shower area
- Putting a night light by the bed, in the halls, and the bathroom
- Having elders wear sturdy shoes with low, non-slip soles both indoors and out

Exercise

When an elder make their muscles work, the muscles respond by growing stronger. It is important to make all the muscles work regularly! Exercise, such as walking in sturdy, well-fitting low heels for 30 minutes two to three times a week, can increase lower leg strength and balance, strengthen the heart, and improve bone density. Elders can also lift weights, swim, or attend chairobics (sit-down aerobic exercise) or Tai-Chi classes.

Conclusion

Elders have identified attributes that are important to aging successfully. They want to stay healthy in their later years, be involved with the world and others, make choices regarding things that affect them, live independently, meet their needs and wants, care for themselves, feel good about themselves, and stay free of chronic health problems. Some elders report that they do NOT want to know about falls because it makes them feel old and scared. What they do want is positive messages about feeling good, and staying healthy and independent. Most do NOT want to involve their adult children, and do NOT want health care provider messages.

Falls are a serious public health issue affecting our elders. Falls can be reduced by applying interventions that work.

When an elder leaves us to join those that have gone before into the spirit world, they take with them songs and dances, and knowledge of root digging, huckleberry picking, and fishing and hunting sites. Let's work together to keep our elders healthy and strong, and ensure that their wisdom can be passed down to future generations.

For more information about Elder Falls Prevention, contact:

Luella Azule (Yakama/Umatilla/Warm Springs/Nez Perce/Klamath), Injury Prevention Coordinator, Northwest Portland Area Indian Health Board at 503-416-3263 or lazule@npaihb.org

SAFE NATIVE AMERICAN PASSENGERS (SNAP) TRAINING

The Portland Area Indian Health Service (IHS) and Northwest Portland Area Indian Health Board are planning to co-host a 12-hour SNAP class later this year. Space will be **limited to 15 participants**. If you or your tribal community is interested in sending trainees or would like more information, please contact**: Luella Azule, Injury Prevention Coordinator, at lazule@npaihb.org or 503-416-3263.**

Since it was first released in 2003, the SNAP course has had an important impact in developing tribal capacity in child passenger safety. SNAP is currently taught in over 60 tribal communities a year and reaches 500 safety advocates annually. Many attendees have gone on to become NHTSA Child Passenger Safety Technicians (CPS Techs) who now serve as important resources to their local communities. **SNAP provides a basic overview of the proper use and installation of child restraints, including car seats and booster seats, while addressing several issues that are unique to Native American communities.**

The IHS 2009 version of the **Safe Native American Passengers (SNAP) training** for child passenger safety is modeled after the National Highway Traffic Safety Administration (NHTSA) National Standardized Child Passenger Safety Training, which normally lasts 4 ½ days. The SNAP course is **Native American specific** and introduces attendees to the basic concepts of child passenger safety (CPS). The updated version includes format changes and technical updates to reflect the changes made in the National Standardized Child Passenger Safety Training Program Curriculum in 2007.

Who should attend? Anyone who works in American Indian/Alaskan Native communities and is interested in Child Passenger Safety, including:

- Head Start staff
- child care providers
- childseat check event volunteers
- health educators
- Community Health Representatives (CHRs)
- clinicians and clinic staff
- law enforcement
- EMS personnel
- firefighters
- others who work in tribal or community health, safety, or social services

The SNAP course does not offer certification, and does not replace, supplant or serve as a substitute for the national standardized Child Passenger Safety Technician (CPS Tech) training course. Rather, it serves as an introduction to Child Passenger Safety or as preparatory training for the NHTSA Child Passenger Safety Technician course.

Continued from....

VIOLENCE AGAINST WOMEN REAUTHORIZATION ACT (VAWA) 2013 AND TRIBAL JURSIDICTION OVER NON-INDIAN PERPETRATORS OF DOMESTIC VIOLENCE

Continued from page 5

- Include Indians and non-Indians in jury pools.
- Inform defendants ordered detained by a tribal court of their right to file Federal habeas corpus petitions.

IS THERE FUNDING FOR THE TRIBES? In VAWA 2013, Congress authorized up to $25 million total for tribal grants in fiscal years 2014-2018, but Congress has not yet appropriated any of those funds. However, tribes may continue to apply for funding through DOJ's Coordinated Tribal Assistance Solicitation (CTAS), which can support VAWA implementation. Additional funding sources may be available through other Federal Agencies.

HOW CAN WE LEARN MORE? Please contact the Justice Department's Office of Tribal Justice (OTJ) at 202-514-8812 or Office on Violence Against Women (OVW) at 202-307-6026, or visit www.justice.gov/tribal.

NEW FACES AT THE BOARD

Congratulations to Jenine & Josh and big sister Juniper Dankovchik on the arrival of Calvin Leo!
January 22, 2013
10 lbs, 7 oz, 22 inches

CHAIRMAN'S REPORT

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Jeff Merkley. I also participated in a Tribal leader listening session hosted by the Senate Committee on Indian Affairs.

I will be back to Washington D.C. again this month to testify before the House Interior Appropriations Subcommittee on the IHS FY 2014 budget. Our lobbying work is more important than ever because of the severe budget cuts planned under sequestration. No one ever thought sequestration was going to happen, but it has, and it will cut over $228 million in IHS funding this year. We can't let this happen again next year.

I encourage you to read and use the Board's Legislative Plan for your own work at your Tribe. You are always welcome to add contributions to improve and strengthen the Legislative Plan. It is never a final document and always being updated by our Board staff.

Andy Joseph, Jr.

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 webpage **www.npaihb.org**.

Contact Lisa Griggs (503) 228-4185 or lgriggs@npaihb.org., *Health News and Notes* Editor, to submit articles, comments, letters, and requests to receive our newsletter via mail.

Help prevent:

Elder Falls

Car Crashes

Fires & Burns

Unintentional Drug Overdoses

Help promote:

Home Safety

Child Safety

Pedestrian Safety

Bicycle Safety

Firearm Safety

Safe and Sober Driving

Seatbelt Use

Helmet Use

Join with others who are making a difference in tribal communities across the Northwest. Become a member of NPAIHB's **Northwest Tribal Injury Prevention Coalition.**

Coalition members participate in monthly or quarterly conference calls to collaborate on planning, implementation and evaluation of Injury Prevention projects in Northwest tribal communities, and receive up-to-date information on training opportunities, injury prevention meetings and conferences, and available project funding.

The Coalition welcomes membership, input, ideas and participation from:

- Tribal members and leaders
- health program staff
- primary care providers
- public health nurses
- CHRs
- physical therapists
- social workers
- Head Start program staff
- child care providers
- home health aides
- injury prevention coordinators
- law enforcement
- firefighters and EMTs
- senior center staff
- elders
- youth
- teachers and parents
- Tribal/Urban Indian organizations

…and anyone else who would like to share resources and expertise, and to work to prevent injuries within tribal communities.

If you or your tribe is interested in participating in the coalition, or in more information about preventing injuries, please contact:

Luella Azule (Yakama Nation/Umatilla), Injury Prevention Project Coordinator
Email: lazule@npaihb.org
Phone: 503-416-3263

Continued from....

EXECUTIVE DIRECTOR'S NOTE

Continued from page 3

option. And finally what I feel is the most unlikely to be successful strategy is to push Congress and the Administration to develop some other means of spending cuts without the "across the board" slashing.

I think the Congressional option is the least likely to be successful for the following reasons. First, if sequestration was "so bad", then why did it pass in the first place? It passed because both sides of the political spectrum will achieve something from it. One side is able to say, "Look at how much we cut from Federal spending" and the other side can say "look at the safety net programs that they cut". Each party being able to appeal to the political base.

What about the possibility of congress passing the authority to allow each of the Departments to cut the amount required by sequestration, but providing flexibility to the Director to make the cuts to match Federal priorities or to trim some of the "pork" out. I don't believe that would work either for the simple reason that if it were possible, we would not have passed the threshold that resulted in sequestration.

Across the board cuts, caps, or freezes will be the new norm. In dedication to someone that passed this week, that created a new norm with his movie critiques, I give the sequestration "two thumbs down."

CONGRESS WRAPS UP FY 2013 APPROPRIATIONS PROCESS AND ADMINISTRATION BEGINS IMPLEMENTATION OF SEQUESTRATION: IHS BUDGET TO LOSE $228 MILLION

Continued from page 4

resources to provide health care to American Indian and Alaska Native (AI/AN) people. This estimate factors the $403 million needed to maintain current services in FY 2013 and lost funding from the sequestration and rescission of $228 million. This is an unprecedented reduction in the history of the IHS budget and an abrogation of the federal duty of the United States to provide health care to AI/AN people under the federal trust relationship. Congress and the Administration are both responsible for this failure and should be ashamed of this legal and ethical violation.

In a letter to the Senate Committee on Appropriations, HHS Secretary Kathleen Sebelius, explains that the effect of sequestration will leave over 30,000 children in America without health care, and over 373,000 seriously mentally ill adults and seriously emotionally disturbed children. The result of this will mean increased hospitalizations and homelessness that ultimately drives up the costs of health care when hospitals pass on this uncompensated care to consumers and employers. Secretary Sebelius further explains that the sequestration cuts will reverse gains achieved by IHS and slow the efforts to improve the delivery of health care to Indian people. HHS estimates that sequestration will result in 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits provided in IHS and Tribal hospitals and clinics.

NPAIHB Policy Brief is a publication of the Northwest Portland Area Indian Health Board, 2121 S.W. Broadway, Suite 300, Portland, OR 97140. For more information visit www.npaihb.org or contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email jroberts@npaihb.org.

Upcoming Events

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APRIL

Sexual Assault Awareness Month

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

MAY

May 3
SPIPA Annual Medical Update Conference
Shelton, WA

May 13
National Children's Mental Health Awareness Day

May 13 -16
ATNI Mid-Year Conference
Spokane, WA

May 14 -16
HHS Region 10 Tribal Consultation
Seattle, WA

May 20 -23
California Best Practices & GPRA Measures Continuing Education
Sacramento, CA

May 21-23
2013 CMS-IHS-NPAIHB Outreach & Education Training
Seattle, WA

May 27
Memorial Day

JUNE

June 3 -7
2013 Nurses Leaders in Native Care Conference

June 17 - 19
NIHB Annual National Tribal Public Health Summit
Hollywood, FL

June 17 – 18
Regional Sexual Assault Responses & Resources (SARRC) Training
Worley, ID

June 24 - 27
2013 NCAI Mid-Year Conference
Reno, NV

June 26 – 27
2013 Tribal Public Health Emergency Preparedness Conference
Spokane, WA

JULY

July 4
Independence Day

July 8-12
NPAIHB – CRIHB Joint Quarterly Board Meeting
Spokane, WA

July 30 – 31
Nike Native Fitness
Beaverton, OR

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S JANUARY 2013 RESOLUTIONS

Resolution #13-02-01

Recommendation that CDC Administrator Rescind the CDC Tribal Consultation Policy Adopted on January 8, 2013 and Send the Proposed Policy Out for Tribal Consultation

Resolution #13-02-02

Recommendation that a Financial Conflict of Interest Policy be Added to the Program Operations Manual and Posted to the NPAIHB Website, in Order to Comply with Federal DHHS Regulations Impacting Grantees and Contractors