Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

April, 2007

Our Mission is to assist Northwest tribes to improve the health status and quality of life of member tribes and Indian people in their delivery of culturally appropriate and holistic health care.

Remembering Rodney E. Smith

Rodney E. Smith
May 1, 1950 - March 9, 2007
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In This Issue

From the Chair:
Linda Holt

January through April always seems to be the most important for Indian health matters and this has certainly been the case this year. It has been particularly important as the new Democratic controlled Congress sets its legislative agenda for Indian health issues and takes up appropriation bills that will affect our health programs. By the time this issue is released, the Board will have testified before Congress on at least three occasions and conducted a number of lobbying visits to the Hill.

This past quarter saw four Congressional hearings conducted on Indian health issues. The Senate Indian Affairs and House Resources Committees both conducted hearings on the reauthorization of the Indian Health Care Improvement Act (IHCIA). Congressman Frank Pallone (D-NJ) introduced a bill (H.R. 1328) in the House to reauthorize the IHCIA, which the Resources Committee will mark-up on April 24. The Senate Committee on Indian Affairs (SCIA) is expected to introduce a bill in the Senate any day. The Senate Finance Committee also held a hearing on Indian health and child welfare issues in Indian Country. Our former Chair and Quinault Delegate, Pearl Capoeman-Baller will testify in April on the IHS budget before the House Interior Appropriations Subcommittee.

I was fortunate to testify on behalf of the Board before the House Resources and Finance Committees. The emphasis of my remarks highlighted the inequities associated with the health facilities construction in the Indian health system. Our hope is that Congress will provide us some relief on this issue by amending a section of the IHCIA to provide for the establishment of an Area Distribution Fund. Our proposal would bring equity to a system that is completely unfair to those Areas with small, CHS dependant user populations. We have had follow up meetings with the Indian Affairs and Resources Committees and are hopeful that our proposal will be included in the bill.

The SCIA also held a hearing on diabetes issues in Indian Country which highlighted the need for reauthorization of the Special Diabetes Program for Indians (SDPI). The SDPI will expire in October 2008. Efforts are underway to renew the program for an additional five years and increase the authorization from $150 million to $200 million per year. The National Indian Health Board is leading the reauthorization effort and partners include the Area Health Boards, the American Diabetes Association, and the Juvenile Diabetes Research Foundation.

We also completed regional and national Tribal consultation sessions this past quarter. This year's Region X consultation meetings in Portland,

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From the Executive Director:

Joe Finkbonner

The Perfect Storm: Are conditions right for Universal Health Coverage?

It seems that every quarter I say that this quarter is busier than the last. A review of the Board's activities over the last few months confirms it. This past quarter, I attended and participated in the National Congress of American Indians winter session; the National Indian Health Board in Washington DC; the Affiliated Tribes of Northwest Indians meeting in Portland, OR; the Tribal Consultation Advisory Committee in Albuquerque; and an Oregon Tribes meeting in Lincoln City, OR.

The Oregon Tribes meeting was of special interest due to its focus on a discussion of resuscitating the issue of Universal Health Insurance that is becoming a broader discussion in communities, States, and the Nation. With over a million people un-insured or under-insured in the Portland Area (Idaho, Oregon, and Washington), the policy makers representing the Region are focusing their efforts on remedying this problem by working on establishing affordable, accessible health care coverage for all.

Washington Governor Christine Gregoire has proposed a "Healthy Washington Initiative," which includes a five year plan to provide Universal Health Coverage for all residents of Washington and to all Washingtonian children within three years. The initiative is certainly gaining momentum, but the fundamental issue is financing of the health plan.

The "Healthy Washington Initiative" includes measures to substantially increase access to care and contains provisions to reduce unnecessary emergency room visits by directing patients to local clinics. The Initiative would also direct the Health Care Authority to establish public-private "connectors," similar to the Massachusetts plan; however, it stops short of mandating that all residents purchase insurance.

This movement for Universal Health coverage is not unique to Washington or Massachusetts. The State of Oregon also has two options circulating in the State Legislature. One, the Archimedes plan, is proposed by former Governor John Kitzhaber. The second universal health coverage bill is co-sponsored by Oregon Senators Ben Westlund and Alan Bates. There is also a considerable movement to combine "the best" of both plans.

The co-sponsored bill from Westlund and Bates would establish the Oregon Health Fund program which, if it passes, would be administered by a Board whose membership is still being defined. The Oregon Health Fund Board would be required to develop enrollment procedures and a defined set of essential health

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Northwest Portland Area Indian Health Board

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Northwest Tribal Cancer Control Project
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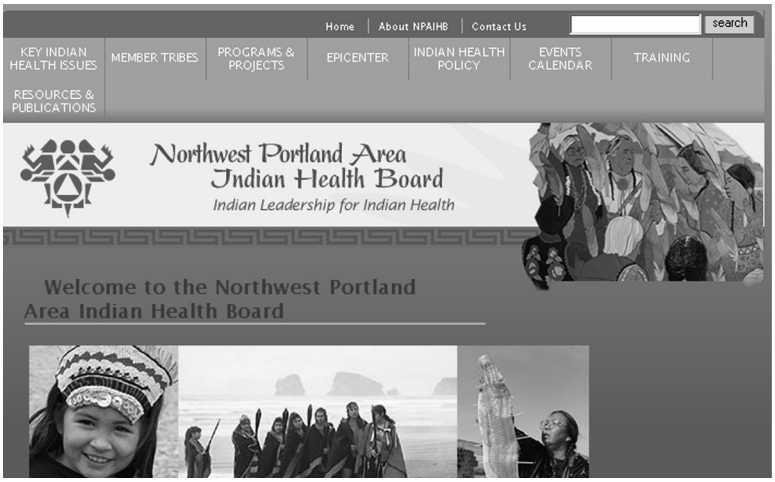
NPAIHB's New Website

by Sonciray Bonnell, Health Resource Coordinator

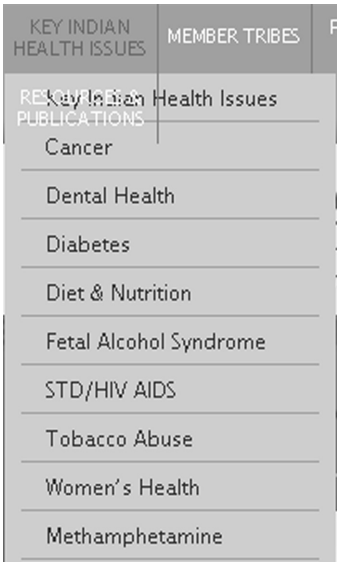
On February 20, 2007, NPAIHB's Information Technology (IT) crew launched our new website. Although the website address remains the same (www.npaihb.org), we hope the improvements are obvious. In addition to a new look, improvements include consistent page format, a search tool, an upcoming events list that is automatically updated, a larger portion of the front page dedicated to policy and legislation, and content management software (CMS) that allows staff to easily update their web pages.



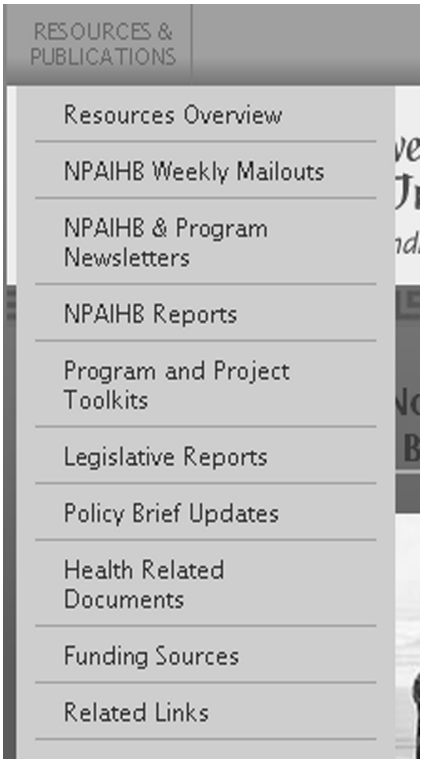
We are especially excited about the content management software. Staff are able to update their web pages by simply sending an email to the Board's IT staff, who are responsible for authorizing updates and then posting them on the appropriate web pages. Updates occur as they are received. In the past, staff who were trained in the web software (Dreamweaver) could update their own pages, but the problem was consistent page format and correct use of the software. Centralizing web postings eases the pressure from projects to have someone from their staff versed in using web software, it provides consistent formatting, and provides needed management of proposed updates.

Many NPAIHB project web pages include additional information particular to their project, but all project pages have a consistent format that contains: a brief project description; history and goals; data/statistics; reports, publications, and media materials; meetings and training events; and related links.

We've changed a few of the menus, including the "Key Indian health Issues" and "Resources and Publications" menus. You may find NPAIHB projects under the health issues menu. We have a wealth of information to share with the public and our goal is to make our website more intuitive to the user.



The NPAIHB's website was first introduced in 1996, followed by upgrades in 1997 and 2002. We continually find ways to improve our website, but the value of a website is best determined by the benefits it provides to its users, so do provide feedback on what you like, don't like, or would like to see.



From the Executive Director: continued

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services. Certain persons would be required to participate in the program, including the uninsured whose income is greater than 250 percent of federal poverty levels and those who do not, would lose state income tax exemption.

What is consistent among the plans is that they propose to take existing resources allocated to health care and create efficiencies and economies of scale enhancing the affordability of health insurance. The plans call for reducing and subsidizing premiums and providing incentives for the plan's use (or disincentives for lack of use). One advantage that the State of Oregon may have over the State of Washington is that if any waivers are necessary to the Medicaid or Medicare programs, Oregon has two Senators in the Finance Committee that can champion Oregon's position.

Unfortunately, also consistent in the plans being discussed in both Washington and Oregon is the lack of discussion with Tribes or the Indian Health Service. This is very much a déjà vu of 1993 when movement toward health care reform in Washington neglected Indian accommodations for Indian health system. In response, the Tribes formed the Indian Health Commission in order to focus the discussion and shape the impacts on the Tribes.

The Oregon influence extends beyond the exterior boundaries of the State. Senator Ron Wyden has championed Universal Health care at the national level by spearheading the "Healthy Americans Act," which stems from efforts in 2003 in which he partnered with Senator Orin Hatch. Wyden's proposal is an outgrowth of work by the Citizens' Health Care Working Group, a fourteen-member panel that visited fifty communities around the country and heard from 28,000 people about how to reform health care.

Senator Wyden said his plan would allow workers to carry their health insurance from job to job without penalty and would cost the federal government no more than it is paying today for health insurance coverage. Wyden's plan would cover all Americans except those on Medicare or those who receive health care through the military.

The plan would require employers to "cash out" their existing health plans by terminating coverage and paying the amount saved directly to workers as increased wages. Workers then would be required to buy health insurance from a large pool of private plans.

Certainly, implementing a National Universal Health Care plan faces numerous hurdles. On the other hand, the proposed State level plans would allow for flexibility and coverage design to fit the States' priorities and demographics. For that reason, I believe that if a workable Universal Health Care system is to be implemented, it will likely occur through the implementation of State-level plans.

Universal Health coverage for either Oregon or Washington is definitely more likely now because of the steadily increasing numbers of uninsured, rising premiums, and increased discontent by Americans about the state of the current market driven health care system. One of the lessons learned from 1993 is that the Tribes must insert their presence early in the process to ensure that the plans include its clinics as providers and maximize benefits to its tribal members to augment provided services.

Remembering

by Ed Fox, Assistant Health and Human Services Director of the Squaxin Island Tribe

I am Edward Fox, Assistant Health and Human Services Director of the Squaxin Island Tribe. I worked with Rod since 1995, first as the Northwest Portland Area Indian Health Board's Policy Analyst and from 1999 to 2005 as the Executive Director. During these years we worked together on many state, Indian health, and national health care issues.

Rod Smith taught many a health director and program staff member how to conduct oneself as a representative of a Northwest Tribe. By example and by direct verbal communication he had a sense of what was effective, what was respectful, and what was true to his own nature. That final point is an important one for those lucky enough to know Rod Smith. Rod had a big heart, a strong mind, and a loud voice. It was his nature to be kind, to be respectful, but also to have an opinion and to have that opinion heard.

By example and by direct verbal communication Rod had a sense of what was effective, what was respectful, and what was true to his own nature.

Those of us fortunate enough to work with Rod were more effective because we watched him at work. We counted on Rod being there listening, listening, thinking, thinking, and if the time was right, speaking. Rod's emotions were self-evident; like his big heart his emotions were there for everyone to see. I guess he thought good manners required him to verbalize to a wayward federal employee, congressional staff, or state employee words like "I'm starting to get mad" despite the fact that his rising voice and redness of face had already communicated that fact. With Rod, "message sent and message received" were a given. I don't think any of us were ever confused after listening to Rod make a point. Although he made many a person uncomfortable with his comments, he simultaneously made them a partner in getting to work on a solution to the problem thus identified.

Rod Smith and I once shared a job: we were appointed co-directors of the Northwest Portland Area Indian Health Board. I'm the only one who thought we were co-Directors. Rod was a heavyweight and I a junior lightweight at the time. The Board's Director, Cheryle Kennedy, had decided to leave the Board and return to her tribe (later to become Chair of the Grand Ronde Tribe) and Rod answered our urgent call to fill in as Director while we conducted our search for a permanent Director. Rod rode in to Portland a stranger to some at the Board, but left as a friend to all the staff. His experience, intelligence, and friends he could call upon for help was just what the Board needed. Rod understood the basics of a good organization: infrastructure like finances, information technology, and human resources and the policies and procedures to manage them. His laughter filled our hallways and meeting rooms. He got to know and promoted the careers of many of the Board's current staff and the management team - a concept he promoted while a delegate to the Board.

After Rod left, the Health Board was a quieter, but better place. I succeeded Rod as Director of the NPAIHB and shared something with Rod that no one is born with but anyone with an open mind and experience can learn. That is the knowledge that working together is better than working alone. And this was true at two levels. All Directors learn the truth that it can be lonely at the top and that bad things and the work of the organization does defy gravity and roll uphill. The workload is great. It is wise to call on others, including Directors, for advice and experience. The other level is the strength Northwest Tribes gain from working together as tribes. Sometimes this

Rod Smith

means working through organizations (and no one is born to love organizations).

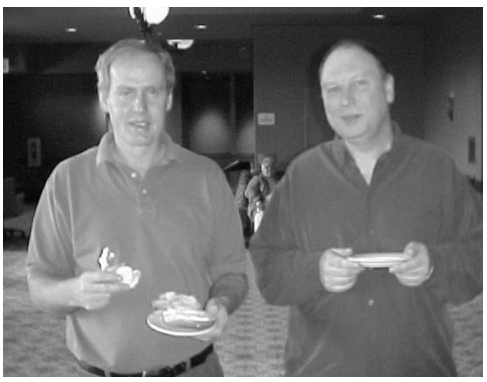
Rod was a stalwart contributor to the American Indian Health Commission since its inception in 1994 and the Northwest Portland Area Indian Health Board since the 1980s. He was on the Executive Committee of both; a rare honor for a non-Indian. With Rod on the committee, lunch meetings were wisely scheduled in a private room lest the good humor and uproarious laughter result in ruffled feathers among the business customers. Rod felt honored to serve with chairs Julia Davis-Wheeler of the Nez Perce Council, Quinault Nation President Pearl Capoeman-Baller, and the other members of the Executive Committee. He was perhaps just as comfortable at the table with the other Board delegates listening, raising his hand, speaking out, volunteering to help, and visiting with people who had become his friends.

Executive Directors share many stories that we tell to no one else. I can share this: through all the hard work, all the disappointments, all the garden variety and greater personnel issues, financial issues and bureaucratic roadblocks to getting health care to the Puyallup people Rod Smith never became callous, never became rigid (set in his ways), never hid in his office to isolate himself, had not an evil bone in his body, not a corrupt instinct or action, nor did he retreat to the simple concerns and pleasures of life while others did his work—the Puyallup's were always on his mind (Tulalip and the Health Board can vouch for that), but also all the Tribes of the Northwest, the Indian people of our cities and Tribes nationwide were on his mind.

You see Rod Smith was a great leader who avoided the pitfalls of those who can't take it in leadership and retreat into a shell of callous disregard of the humanity of staff (even troublesome staff), who refuse to make changes to standard operating procedures as the environment around them changes, who sink into a meanness of spirit in the face of criticism, and those who use their access to resources to enrich themselves when the credit they may deserve is not sufficiently apparent. No, Rod was strong in character and successful in leadership. Unfortunately, he was all too human and perhaps a bit weaker in constitution in a physical sense than was healthy. Rod tried to take a step back several times and revitalize that weakened constitution and I was looking forward to our continued work together to share the load. Many of us saw Rod last month at the Affiliated Tribes of Northwest Indians meeting and he was pleased that he had received so many expressions of love from the Puyallup people and many of us who have worked with him and benefited from his hard work these many years. He was weak, but, we hoped, on the mend.

—the Puyallup's were always on his mind (Tulalip and the Health Board can vouch for that), but also all the Tribes of the Northwest, the Indian people of our cities and Tribes nationwide were on his mind.

Rod's smile, laughter, and the sound of his voice was an embrace to all of his many friends. We ache now for that expression, for the sound, for the fun that it was to work with Rod, but we live with the knowledge that his was a loving spirit that we were blessed to know. We thank those who had a rightful claim to his time and his company for sharing Rod Smith with thousands of us who work in the vineyards of Indian health. We laughed and we cried; we worked and we rested. We are at peace with our friend Rod Smith.



Final FY 2007 IHS Budget Operating Plan:

by Jim Roberts, Policy Analyst

The fourth and final Continuing Resolution funds government operations through the end of the current fiscal year, September 30, 2007. P.L. 110-5, the joint resolution passed by Congress, was signed into law by the President on February 15, 2007. The bill requires that the Indian Health Service (IHS) to submit an operating plan for how it would obligate a $125 million increase in the final continuing resolution, as well as a $13.6 million increase that was provided in the third continuing resolution previously passed on December 9, 2006. This makes the total increase for the FY 2007 IHS budget $134.8 million; an increase of 4.4 % over the FY 2006 enacted level. The law requires the IHS to provide the House and Senate Appropriations Committees an operating plan within 30 days after passage of P.L. 110-5. The details of this spending plan are just now becoming available and it does not look good for the Contract Health Services (CHS) program.

No Increase for CHS Program in FY 2007

While the IHS budget has received an overall increase of 4.4%, there is **no increase for the CHS program**. The reason for this is due to the way the final continuing resolution (H.J. Res. 20) is structured. The resolution requires the Agency to apply its increase based on the language of the FY 2006 appropriation, which caps the level of funding for the CHS program. The final enacted FY 2006 amount was capped at $499.3 million for CHS and an additional $18 million for the Catastrophic Health Emergency Fund (CHEF). The Agency's operating plan held the FY 2007 CHS funding levels to these FY 2006 thresholds. This means there is no increase in the CHS program to cover inflationary costs, which are significant. In fact, the inflation costs associated with the CHS program are much more significant than the inflationary costs associated with other IHS budget line items.

The House (H.R. 1591) and Senate (S. 965) supplemental appropriation bills each amend the IHS FY 2007 appropriation by making $7.3 million available for health facilities, $18 million available for the Catastrophic Health Emergency Fund, and $525.1 million available for the CHS program. The House bill also makes an additional $5 million available for Contract Support Costs. The language would allow the IHS to reprogram a portion of the $134.8 million increase; however, it is not known which budget line items would be tapped to cover the proposed increases.

H.R. 1591 - U.S. Troop Readiness, Veterans' Health, & Iraq Accountability Act:
SEC. 3502. Section 20512 of the Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Law 110-5) is amended by inserting after the first dollar amount: `, of which not to exceed $7,300,000 shall be transferred to the `Indian Health Facilities' account; the amount in the second proviso shall be $18,000,000; the amount in the third proviso shall be $525,099,000; the amount in the ninth proviso shall be $269,730,000; and the $15,000,000 allocation of funding under the eleventh proviso shall not be required'.

S. 965 Language - U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007
SEC. 3502. Section 20512 of the Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Law 110-5) is amended by inserting after the first dollar amount: `, of which not to exceed $7,300,000 shall be transferred to the `Indian Health Facilities' account; the amount in the second proviso shall be $18,000,000; the amount in the third proviso shall be $525,099,000; the amount in the ninth proviso shall be $269,730,000; and the $15,000,000 allocation of funding under the eleventh proviso shall not be required'.

While the language in the supplemental bills is good news, the increase that has been requested is less than adequate to cover inflation costs of the CHS program. The recommended $18 million for the Catastrophic Health Emergency Fund (CHEF) is the same amount that has been requested in previous years. The CHS recommendation of $525.1 million is $7.8 more than what was funded last year. This is only a 1.6% increase over last year's level and is significantly less than other hospital and clinic services accounts. The health services accounts averaged an overall increase of 5.6%; while the Hospital/Clinics line will see a 7.7% increase. If the CHS program were to be funded at those same levels, the proposed increase in the supplemental bills should be at least $28 to $39 million. The President's very own request included a $37 million increase for the CHS program, so it is not known why a similar increase wasn't recommended to the Congress as it developed its funding thresholds.

No Increase Contract Health Service Program

Recommended Increase fails to Maintain Current Services

This year, the President recommended an increase of $49 million in FY 2008 for the CHS program. The Senate Committee on Indian Affairs (SCIA) further recommended an additional $51 million be added to the President's request, for a total recommended increase of $100 million in FY 2008. Clearly, the President's request and the SCIA recommendation underscore the importance in funding legitimate increases for the CHS program. Unfortunately, the same priority was not applied in developing recommendations in the supplemental request for the CHS program. The Northwest Portland Area Indian Health Board estimates that the level of unmet need in the CHS program is at least $301 million. The Board recommended that it would take at least $64.6 million to maintain current services in FY 2007. The recommended levels will fall short of maintaining current serves by $56.8 million and there is no guarantee that the language will even be approved.

At this point it is questionable whether the language included in the supplemental bills will be signed by the President. Congress is currently in recess for Easter break and when they return, will conference to reconcile the differences in the supplemental appropriation bills. The House approved amount is $124 billion, while the Senate approved amount is $123.2 billion. Early indications by the White House are that the President will veto the supplemental spending bill due to troop withdrawal proposals and not enough

IHS Contract Health Service Program
Summary of Unfunded Need

Category	Number of Services	Estimated CHS Resource Need
Deferred Services within Medical Priorities	158,884	$152,687,524
Eligible But Care not within Medical Priorities	33,106	$31,814,866
Eligibile But Alternate Resources Available	65,398	$62,847,478
Emergency Notification Not within 72 Hours	9,434	$9,066,074
Non-Emergency No Prior Approval	19,259	$18,507,899
Patient Resides Outside CHSDA	8,612	$8,276,132
Unfunded CHEF Cases (actual amount)	802	$17,971,608
TOTAL:	**295,495**	**$301,171,581**

funding to support operations in Iraq. At a recent press conference President Bush indicated, "If either the House or Senate version of this bill comes to my desk, I will veto it and it is also clear from the strong support for this position in both houses that the veto would be sustained." The White House has issued Statements of Administrative Policy to both Senator Byrd and Representative Obey that the President will veto the legislation when it is presented to the White House.

Because of the timing of the Easter break and the Conference committee meeting, Tribes will have some time to advocate for the CHS program. It is expected that the House and Senate will pass the supplemental conference report on April 26 or April 27, or possibly early in the following week—meaning that the White House will receive the bill to sign or veto no later than May 1, if not a few days earlier. If there is to be a respectable increase for the CHS program, one that will maintain current services, it is imperative that Tribes contact Congressional members sitting on the Conference committee. The Senate has announced to its conferees while the House has not.

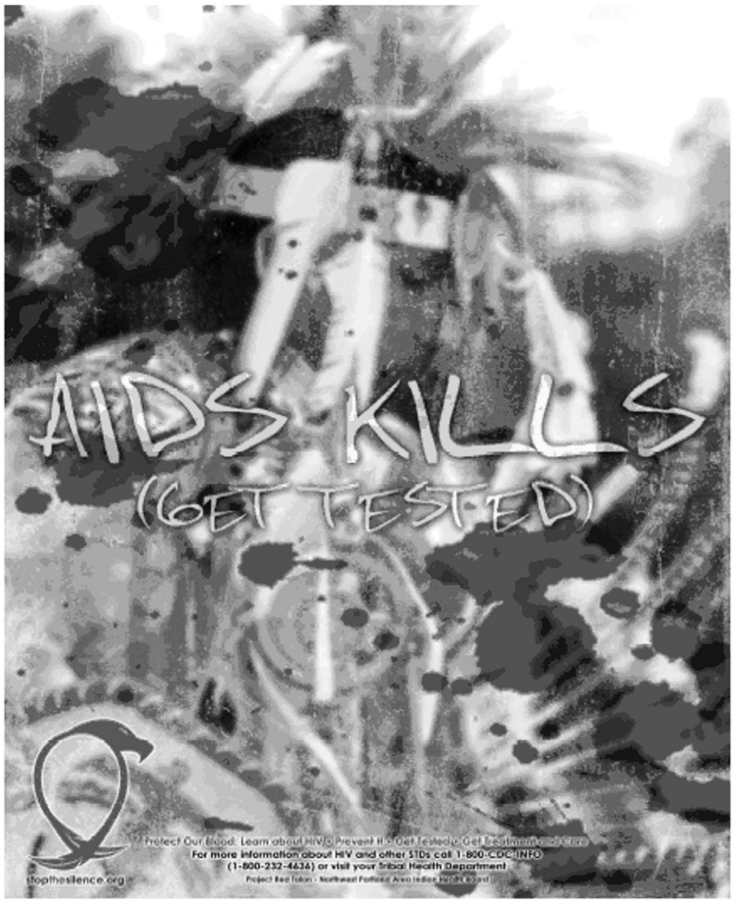
On March 29, the Senate appointed their conferees to meet with members of the House, which included: Robert Byrd (WV), Daniel Inouye (HI), Patrick Leahy (VT), Tom Harkin (IA), Mikulski (MD), Herbert Kohl (WI), Patty Murray (WA), Byron Dorgan (ND), Russ Feinstein (CA), Richard Durbin (IL), Tim Johnson (SD), Mary Landrieu (LA), Jack Reed (RI), Frank Lautenberg (NJ), Ben Nelson (NE), Thad Cochran (MS), Ted Stevens (AK), Arlen Specter (PA), Pete Domenici (NM), Christopher Bond (MO), Richard Shelby (AL), Judd Gregg (NH), Robert Bennett (UT), Larry Craig (ID), Kay Baily Hutchison (TX), Sam Brownback (KS), Wayne Allard (CO), Lamar Alexander (TN), and Charles Grassley (IA).

National Native HIV/AIDS

by Stephanie Craig Rushing, Project Red Talon Director

Stop The Silence. That is the message Indian Country will soon be seeing. For many of us, talking about sex is an uncomfortable topic. Because of this, we have remained silent. In turn, our children and grandchildren have grown up not knowing how to talk about these issues. The time has come. Our silence will not stop the devastating impact of sexually transmitted diseases on our tribes.

In response, the Red Talon STD/HIV Coalition has come together to increase community awareness about the impact that sexually transmitted diseases can have on our Native communities.



The Campaign: To commemorate National Native HIV/AIDS Awareness Day, celebrated on Wednesday, March 21, 2007, the Northwest Portland Area Indian Health Board and G&G Advertising launched a HIV & Sexual Health campaign targeting the Northwest Tribes.

The Campaign includes:

- 2 Teen Posters
- 6 Teen STD/HIV Magazines, including three versions for younger teens, and three versions for older teens.
- 2 Adult Public Service Announcements for placement in Tribal papers
- An Adult Tip-Sheet for talking to teens about sex and STDs
- 2 T-Shirt designs
- A Website - Visit **www.stopthesilence.org** for more information about HIV, STDs, testing services, and ways to improve community awareness.

All materials are available for download at: http://www.npaihb.org/epicenter/project/prt_reports_publications_media_materials/

Campaign Funding: Funding for this project was awarded by the Library of Medicine through their Office of Outreach & Special Populations, as part of the AIDS Community Information Outreach Program (Purchase Order Number: 467-MZ-501808).

Media Dissemination: Project Red Talon will distribute campaign products to our current Tribal Health contacts at each of the 43 NW Tribes. If you would like additional copies of any of the products (or are not on our contact list), please contact Lisa

Awareness Day

Griggs at: lgriggs@npaihb.org or 503-228-4185 to determine product availability.

Some startling statistics:

- When compared by ethnicity, AI/AN men and women had the third highest HIV/AIDS rate in 2004.
- Among American Indian and Alaska Native males, the HIV/AIDS case rate increased 2.4% from 2001 to 2004, the most significant increase observed among any reported racial/ethnic group. Among American Indian and Alaska Native females, the HIV/AIDS case rate increased 4.8% from 2001 to 2004, an increase that was second only behind Asians/ Pacific Islanders (A/PIs).
- In 2004, American Indians were nearly five times more likely than non-Natives to have chlamydia, four times more likely to have gonorrhea, and twice as likely to have syphilis. These infections compromise not only individual well being, but the well being of the community as a whole, and direct medical costs associated with STDs can cause a substantial economic burden to Tribal healthcare budgets.
- Each year, 1 in 4 sexually active teens will get an STD, and 1 in 5 sexually active teen females will get pregnant. Two U.S. teens are infected with HIV every hour of every day.
- STDs interact with reproductive health on a variety of levels:
  - o High rates of sexually transmitted diseases not only signify high-risk behavior, but also indicate a vulnerability to the transmission of HIV. People infected with an STD are 2 to 5 times more likely to become infected with HIV.
  - o Untreated STDs can cause severe health consequences for women, including pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. Up to 40% of females with untreated chlamydia infections develop PID, and 20% of those may become infertile.

These are the kinds of statistics that Indian Country should not be apart of. We must stand up and have a voice -- StoptheSilence!

National Tribal Steering Committee (TSC) for Injury Prevention Seeking Members and Alternates

The National Tribal Steering Committee for Injury Prevention is seeking members and alternates to serve on their committee. Currently members or alternates are needed from: Aberdeen (1), Albuquerque (1), Billings (1), California (1), Nashville (2), Oklahoma, (1) Portland (1), Phoenix (1) and Tucson (1) Areas. TSC for Injury Prevention maintains open recruitment for enthusiastic new members and/or alternates for all Indian Health Service Areas with vacancies.

Objectives:

- On a national level: raise awareness of, and support for injury prevention (IP) activities in Native American communities;
- Enhance the ability of Tribes to address injury problems in their communities;
- Provide advice and guidance to the Indian Health Service (IHS) Injury Prevention Program;
- Compile area-specific information on injury problems and activities for the IHS IP website, and promote increased funding for injury prevention programs in Native American communities.

Membership requirements:

1. Be an enrolled tribal member.
2. Not an Indian Health Service employee.
3. Serve as tribal employee in any health arena (including police/EMTs/nurses) or tribal community member with an interest in injury prevention as well as involvement with community injury prevention activities.
4. Completed at least one course in injury prevention or have at least 2 years experience in injury prevention (e.g., as a project manager of an injury prevention infrastructure grant).
5. Submit a letter stating their qualifications, reasons for wanting to join the TSC, and commitment to fulfilling the core roles of the TSC. Include a short biography.
6. Provide letters of support from the Area Injury Prevention Specialist and a tribal official.

Core Role of committee members

A. Work with Tribes:

1. Make a list of Injury Prevention contacts for each Tribe in your area
2. Conduct at least 2 calls (phone or in-person) per year with Tribal contacts to obtain feedback on IP programs and provide information on IP activities and opportunities
3. E-mail or fax TSC minutes to each Tribal contact

B. Work with IHS Area/Tribal Injury Specialists:

1. Meet at least quarterly with the Area/Tribal IHS Injury Prevention Specialist to:
   a. Review the Area IP budget; discuss feedback from Tribal IP contacts; identify funding and training opportunities for Tribal IP programs
2. Participate in the Area's annual IHS/Tribal budget formulation process to increase funding for IP. Tribal leaders make recommendations at the Service Unit/Health Board and Area Office levels.

C. Participate on a regional/national level:

1. Participate in monthly TSC conference calls (1st Thursday at 2:00 p.m. EST).
2. Attend at least two national TSC meetings per year (Alternates attend in the TSC member's absence). The TSC covers members travel and related expenses.
3. Timely respond to TSC communications.

For more information, please contact Angela Maloney, Chair at (928) 283-2844, angie.maloney@tcimc.ihs.gov or any TSC member. A list of all TSC members is available on the Internet at: www.ihs.gov/medicalprograms/injuryprevention.

Please mail or e-mail application items to:
Angela Maloney
Tuba City Regional
Health Care Corp.
Office of Environmental Health
167 N Main Street
PO Box 600
Tuba City, AZ 86045-0600

Selection Committee members are: Dennis Renville, Luella Azule, Elaine Boyd , Jennifer Falck and Nancy Bill (Navajo), IHS Hdqtrs

From the Chair: continued

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Oregon were well attended by Portland and Alaska Area Tribes. Key issues discussed during the session included: Medicare like rates remain held up in the HHS, CMS, and IHS internal clearance process; the status of the Susanville case; continued shortfall of IHS budget appropriations, and; the ongoing fight to get federal agencies to consult with tribes when making any changes that might affect us (specifically, federal regulations imposed on tribes without tribal consultation). I also participated in the HHS Department-wide Budget Consultation session in Washington, D.C. testified on CDC, HRSA, and SAMHSA issues affecting Tribes. The format of this year's session was a bit different and seemed to allow for more dialogue on issues than previous years. It was the first time in many years that Tribes actually got to meet with the HHS Secretary's Budget Council.

The release of the President's FY 2009 budget next year will test the effectiveness of this year's Tribal consultation sessions.

Finally, we are very concerned about this year's IHS budget. At the time of this writing, the appropriations provided in the final continuing resolution does not include an increase for the Contract Health Service program. This is very troubling since the Agency did receive an overall increase of 4.4%. The comparable program to CHS's is the services provided under the hospital and clinics line item, which received a 7.7% increase. Language in the Iraq emergency supplemental bills will correct this, however, the amount of funding is not adequate. The language provides an additional 1.6% for the CHS program and simply is not enough funding to maintain current service levels. We are working with our Congressional delegation to address this issue and hopefully Congress will provide more funding for our programs in FY 2007.

We should all be proud of the work of our Board on behalf of Northwest Tribes and Indian Country. Our invitations to testify before Congress are a testament to the hard work and reputation that NPAIHB has as a national leader on Indian health issues. It is because of your work, willingness to attend quarterly Board meetings, and commitment to participate in our process that allows us to accomplish the things we do.

Keep up the good work!

In closing, I'd like to say good bye to our dear friend and colleague, Rod Smith. Indian Country has lost a true champion.

New NPAIHB Employees

Hello, I am Jenine Dankovchik, and I am very excited to have recently joined NPAIHB as a Project Specialist with the Northwest Tribal Cancer Navigator Program. I was raised on the Saanich Peninsula of Vancouver Island, Canada and attended the University of Queensland in Australia where I received a degree in Mathematics and Statistics. For the past few years, I have been working in Hawaii, conducting research in a wide range of studies with a local company. Some the projects I worked on included a comprehensive evaluation of the Ke Ola Pono No Nā Kūpuna program, which provides nutrition and support services to Native Hawaiian Kūpuna on all six islands. I have also been involved with the Hawaii Health Survey, particularly using the data to analyze trends, identify health disparities, and identify needs among Native Hawaiians. In my new role as Project Specialist with the Navigator program, I will be supporting Matt in the evaluation of the Cancer Navigator model in our Northwest Tribal communities. I am very happy to be back in the area in which I grew up, and excited to start work on this important project!

Hi, my name is Carrie Sampson and I am an enrolled member of the Confederated Tribes of the Umatilla Indian Reservation. I joined the NPAIHB as the Prevention of Toddler Overweight and Tooth Decay Study Project Assistant. My parents are Trisha, Ronnie Lansford, and the late Curtis Sampson of Pendleton, Oregon. My grandfather is Carl Sampson, Chief of the Walla Walla Tribe.

I was born in Missouri and spent many endless summers in Pendleton, Oregon. I graduated from Belle High School in Belle, Missouri in 2002. I attended the University of Missouri and East Central College. I received my Practical Nursing License in 2004. I am currently a student at Portland State University pursuing a degree in Community Health Education with a minor in Native American Studies.

Prior to joining the Board, I was employed as the Prevention of Toddler Overweight and Tooth Decay Site Coordinator at Yellowhawk Tribal Health Center in Pendleton, Oregon. My previous experience also includes working as a Licensed Practical Nurse throughout Oregon and three years experience in at a long-term care facility.

I have always been interested in tribal health issues and I feel very honored to have this opportunity to give back to my.

New NPAIHB Employees

Hi, I'm Dr. Linda Frizzell, and I am the new Methamphetamine Data Director for the EpiCenter. I have extensive practice in rural and Indian health care administration. I hold a Doctorate degree in Physiology, Education Administration, and Gerontology. My endeavors include a broad range of professional preparations both in medicine and education, dedicated to the improvement of the quality of life across the life span. I have provided numerous testimonies in regard to health care policy, health issues, and tribal consultation. My specialties include: Health Services Administration, Clinic Management, Rural & Indian Health Policy and Legislation, Health and Education Research, Behavioral Health, Community Assessment, Evaluation, Exercise Physiology, Health Education, Physical Rehabilitative Therapy, Service Learning Administration, Senior Corps Administration, and Therapeutic Recreation.

Additionally, I was chosen to be a part of the first class of Rural Health Fellows, a program initiated by the Office of Rural Health Policy. I continue to serve as a technical adviser for the Indian Health Care Improvement Act. I am currently the Co-chair of the National Rural Health Association's Minority and Multicultural Health Committee; Member of the International Suicide Prevention work group for American Indians and Alaska Natives (Canada-USA); Member of the National Medicare and Medicaid Policy Committee; Advisory Council member, State of Minnesota Minority and Multicultural Health; and a member of the Corporation for National and Community Service Tribal Advisory group.

NPAIHB – Locks of Love Effort

by Kerri Lopez, Cancer and Diabetes Project Director

Kerri Lopez, Verne Boerner, Clarice Hudson before hair cuts.

5:00 p.m. usually marks the end of the work day for most employees at NPAIHB. But, on this particular Thursday night, for three of the Native women at NPAIHB, it was a time to get together, enjoy great enchiladas, refried beans, and have ten inches of their hair brushed, braided, and cut off. It is not a new idea. Two women have donated hair in the past. Once again, the time was right and the hair was long enough to be cut.

Motivated by circumstances of a colleague, Clarice Hudson, recently diagnosed with breast cancer, it seemed like the right thing to do. In many Native cultures, there is ceremony and protocol established to brushing, cutting, and disposing of hair. People make their own decision about this sacrifice, however, the personal choice of contributing to a child in need of a wig just felt good.

It takes ten braids to make one wig, a little known fact. All of the braids were donated to the Locks of Love program In total, Kerri Lopez contributed two braids, Verné Boerner contributed two, Clarice Hudson contributed one, Tam Lutz contributed two from a previous cut, and one braid from a friend Holly Guiterrez. Altogether, we sent eight braids - - darn, almost enough to make one wig. Next time!

The Locks of Love program has been around for a while. It began as a small operation in the garage of founder, Ms. Coffman. In 1997, it became a public non-profit organization that provides hairpieces to financially disadvantaged children suffering from long-term medical hair loss from any disease. The prostheses provided helps restore self-esteem and confidence to children, enabling them to face the world and their peers.

The number of hairpieces produced has increased significantly since its inception, from 21 the first year to over 2,000. Locks of Love has recipients in all 50 states and Canada, and is working toward its goal to help every financially disadvantaged child suffering from long-term hair loss.

Special thanks to the stylist, Erin Russel, who donated her time, skills, and hair products for the beautiful new hair-dos she gave Verné, Kerri, and Clarice. Erin would not accept payment as she is a strong supporter and believer in the Lock of Love program. We presented Erin with a beautiful beaded necklace bag and earring set. Thank you Elaine Dado, our own Executive Assistant who beaded the set, she loved it.

For more information about the Locks of Love program, please visit: www.locksoflove.org.

Clarice Hudson (and hairstylist) displaying her newly cut braid

Kerri Lopez (and hairstylist) displaying her newly cut braids

Verne Boerner (and hairstylist) displaying her newly cut braids

Identity Theft

by Chandra Wilson, Human Resource Coordinator

Identity Theft[1]
What facts do you know about Identity Theft (ID theft)? Have you heard any horror stories about Identity Theft? Maybe you are a victim of it!

Since 2004, ID theft has been the country's number one consumer fraud issue. Recently, the Federal Trade Commission (FTC) issued new rules governing employer disposal of applicant and employee records Fair and Accurate Credit Transactions Act ((FACTA) derived from consumer reports under the Fair Credit Reporting Act. [1]

What are the outcomes of being a victim of Identity Theft

This type of fraud can be considered the most vicious and damaging that an individual can experience. The repercussion this action has on both the victim and the economy is a costly one in time, money and stress.

It can take weeks or even months before a person might find out that they have been a victim of ID theft. Once the victim becomes aware that this crime has occurred, they must report the crime within two days. Generally, the victim is not responsible for the debts; however, the victim can be left with bad credit ratings, and spend a long period of time trying to recover from the fraudulent transactions.

1

Identity Theft Toolkit, Society for Human Resources (SHRM) Website April 2004

How can one avoid ID Theft

First, most ID theft is considered "low tech", meaning that the thief has retrieved your identify through a lost or stolen wallet containing your personal information. The thief has an opportunity to call credit card companies and conduct a change of address, which in turn prevents the victim from knowing that any recent charges have taken place in their credit card or line of credit accounts.

Here are some simple steps provided from the Society of Human Resource Management SHRM on-line toolkit that anyone can take to reduce his or her risk of ID theft .

- Always protect personal information.
- Stealing wallets and purses to obtain credit card numbers is the most common way ID thieves get your information. For this reason, avoid carrying birth certificates, Social Security cards and passports.
- Don't give credit card numbers out over the telephone.
- Ask to have your name removed from credit card company solicitors. You can call the three main credit bureaus Equifax, Experian and Trans Union to make this request.
- Always make an extra effort to destroy or shred, pre-approval or pre-screened credit card offers.
- Sign up with the Direct Marketing Association (DMA) to have your name and telephone number deleted from telephone solicitations lists.
- Reduce the number of credit cards you use.[2]
- Keep a copy of credit card numbers, expiration dates and customer service numbers in a safe place in the event your wallet is lost or stolen so you can notify the company immediately.
- Order a credit report once a year from each of the three credit bureaus to check for inaccuracies and fraudulent use of accounts. Some individuals choose to stagger their request a few months apart from the credit bureaus to keep tabs throughout the year.
- Always take credit card receipts with you after a purchase.
- Memorize PIN numbers and passwords; do not keep them in your purse of wallet.
- When thinking of a PIN or password, never use your birth date, mother's maiden name or the last four digits of your Social Security Number. These are too easy for a thief to discover, especially if they have your wallet or purse.
- Ask your financial institution to add extra security protection to your account.

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When Research Results Are Surprising

Guest Editorial, Kathy Kinsey
Guest editorial previously published in the "Minority Nurse" Winter 2007

Research is critical in the fight to eliminate racial, ethnic and geographic disparities in health. But sometimes research can produce unexpected findings. Chen, Fryer and fellow researchers in 2005 found that African Americans and Hispanics were more likely than whites to receive optimal cancer screening. This is surprising because African Americans and Hispanics are less likely to receive an annual physical exam or have optimal care for chronic illness.

Chung in 2006 identified that the economically vulnerable Hispanic community does not suffer from some of the same health disparities as other minority populations. Infant mortality and overall mortality rates for Hispanics approach those for Caucasians—and are sometimes lower. This is surprising because:

* Diabetes is two to three times higher among Mexican Americans than in non-Hispanic whites and is one of the leading causes of death among Hispanics.
* Hispanics have the highest school dropout rate of all racial and ethnic groups. Higher education levels have been closely linked to positive health outcomes.
* The number of Hispanics living at poverty level with no health insurance is almost
one-and-a-half times that of non-Hispanic whites (40.8% compared to 29%).

A study by Eberhardt and Pamuk published in 2004 revealed that rural residents and most urban residents share similar health disparities. This is surprising because on the surface these two populations seem very different. Another paradox is that rural residents were found to have higher rates of obesity and to be more sedentary than their suburban counterparts. This is surprising because we often imagine rural residents as physically active, engaged in farming, ranching, fishing and other outdoor activities.

Zuckerman, Haley et al (2004) found that over half of low-income uninsured American Indians/Alaska Natives (AI/ANs) have no access to health care services through the Indian Health Service. This would be a surprise to the many people who believe that AI/ANs are the one minority group in the U.S. with universal health care access, and that all AI/ANs have excellent access to care because they have an established health system dedicated to meeting their needs.

Schoen et al (2005) identified that the U.S. ranks poorly in many health care indicators compared to other industrialized nations. This is surprising because we in the U.S. view ourselves as world leaders and we spend a significant portion of our gross national product on health care. Yet overall, we fall behind in basic quality and access measures. The U.S. ranks 25th in life expectancy and spends 42% of all worldwide health care expenditures on its 5% of the world's population.

In her recent autobiography, Sen. Hilary Clinton describes how she once told then-President George H.W. Bush that the U.S. was a great place for high-tech care but not to have a baby. The president did not get her point. She told him the U.S. ranking in infant mortality. The president did not believe her. He was unaware of this statistic. I was appalled that our national leaders can govern without knowing this basic indicator of our nation's health. This speaks volumes about why this health disparity exists. When our national leaders are confronted with the facts about health disparities and their reaction is surprise, these are the kind of surprises we don't need.

Retired U.S. Public Health Service Captain Kathy Kinsey, BSN, RN, MPA, a Suquamish Indian, is currently working on an online MSN/MPH combined degree from Oregon Health & Science University.

Identity Theft continued

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- Protect your Social Security Number

What to do if you are a victim of ID Theft

Once an ID theft crime has been reported to the authorities, it still can have a negative impact on the victim. It is proven that ID theft will destroy ones credit scores. Second, the victim spends time and money on investigations with credit bureaus and government agencies working on repairing their damaged credit. Finally, the emotional affect that an individual privacy has been invaded creates an uneasy morale of trust on society.

Below is a list of Identity Theft Resources for more information on credit report monitoring, reporting fraud and other ID theft crime incidents. Some of these services may require a fee.

Credit reporting bureaus (to report fraud)

Equifax: (800) 525-6285, or
P.O. Box 740250
Atlanta, GA 30374

Experian: (888) 397-3742, or
P.O. Box 1017
Allen, TX 75013
Trans Union: (800) 680-7289, or
P.O. Box 6790
Fullerton, CA 92634

Report stolen checks or forgeries to
Telecheck: (800) 710-9898
International Check Services: (800) 631-9656
Equifax: (800) 437-5120

For removal from mail marketing lists, write
DMA Mail Preference Service
P.O. Box 9008
Farmingdale, NY 11735-9008
or
Experian (marketing lists number): (800) 407-1088

To stop pre-screened credit card offers: (888) 567-8688

For removal of phone numbers from telephone solicitations, write
DMA Telephone Preference Service
P.O. Box 901
Farmingdale, NY 11735-9014

Identity Theft Hotline
Federal Trade Commission
Washington, DC 20580
(877) 438-4338

Social Security Administration: www.ssa.gov
Fraud Hotline: (800) 269-0271
Verification of SSN: (800) 772-6270, or fax (410) 966-4407
Earnings reports: (800) 772-1213

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

Resolutions

Resolution #07-02-01
Research on Rural Mental Health and Drug Abuse Disorders

Resolution #07-02-02
Community-Based Participatory Research at the National Institute of Mental Health (NIMH)

Resolution #07-02-03
Refining and Testing Mental Health Interventions and Services for Youth with Mental Illness who are Transitioning into Adulthood

Resolution #07-02-04
Supporting the Dental Health Needs of Indian Country

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