Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

April, 2008

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.

2008 Native Vote article on page 3

NPAIHB supports the National Congress of American Indians (NCAI) 2008 Native Vote campaign. NCAI has compiled a comprehensive, non-partisan website (http://nativevote.org/index.html) that includes everything from National Party Platforms to the top Presidential candidates' Native American policies.

In This Issue

From the Chair:
Linda Holt

As the Chairperson of our Board, I am often called upon to sit on advisory committees that provide advice and guidance to federal agencies on Indian health issues. These committees make recommendations and decisions on important issues that impact the operations of our health programs. While my participation on committees requires a national perspective, I often draw on our Northwest experience and continually advocate for the well-being of our Tribes.

In light of this work, I want to take this opportunity to provide you with an update on the work of these committees. Some of the committees that I serve on include the Tribal Leaders Diabetes Committee (TLDC), the Center's for Disease Control and Prevention (CDC) Tribal Consultation Advisory Committee (TCAC), the Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Advisory Committee, and the Indian Health Service (IHS) National Budget Formulation Committee.

The TLDC was developed to assist the IHS Director in carrying out the Special Diabetes Program for Indians (SDPI). The SDPI provides funding for diabetes treatment and prevention services at 399 IHS, Tribal, and urban Indian health programs. Every one of our Tribes has a SDPI grant that serves its members with diabetes treatment and prevention strategies, such as patient education, quality diabetes care, and culturally-appropriate physical activity, nutrition, and weight management activities. My participation on the TLDC helps to establish program and funding priorities that directly benefit our Tribal diabetes programs.

CDC is responsible for conducting and supporting public health protection through promotion, prevention, preparedness, and research activities. The Board has been very outspoken about the fact that CDC can and should be doing more in Tribal communities. When CDC's Tribal Consultation Advisory Committee (TCAC) was organized I was elected to serve as one of its co-chairs along with Lieutenant Governor Jefferson Keel, of the Chickasaw Nation of Oklahoma. Together we have elevated Indian health issues within the CDC and the TCAC continues to work to promote programs that serve Indian Country. CDC can and should be doing more in Indian Country. For example, CDC is leading emergency and pandemic flu planning and needs to reach out to Indian Tribes to make sure that our needs are taken into consider-

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From the Executive Director:

Joe Finkbonner

It is an unprecedented year to vote, and it is not too late to register! Whatever your affiliation, whoever is your preference, one thing is certain, your vote is crucial to your candidate's success. Our experience in 2000 made it very clear the importance of every vote and it is anticipated that November will be another tight race. This is an opportunity for you to participate in what is expected to be a very exciting election, but more importantly to have an impact of the US agenda. 2008 marks a year where the top candidates for President have released official Native American Agendas. Each candidate's position supports many American Indian and Alaska Native issues.

The major Presidential candidates, Senator Hillary Clinton, Senator John McCain, and Senator Barack Obama, listed in alphabetical order, address his or her support of and belief in tribal sovereignty and the importance of government-to-government relationships between tribes and the federal government; each believe in the trust responsibilities and are obligated by those responsibilities; and each policy statement is comprehensive including issues such as law enforcement and economic development. (A link to each candidate's policy can be found at http://nativevote.org/candidateforum.html.) Selected highlights for each candidate's (again, in alphabetical order) official policies are:

Senator Clinton

In Senator Clinton's address on Tribal Sovereignty, she indicates that she will sign an Executive Order that supports regular and meaningful consultation and collaboration with Indian tribal governments. She continues on to commit to appointing a senior official in the Office of Intergovernmental Affairs as well as appointing Native Americans to other key position in other federal departments and agencies. She acknowledges the need to have federal judges that understand tribal sovereignty and government-to-government issues and will seek to nominate such qualified judges. Senator Clinton makes a distinct point of her commitment to elevate the Indian Health Service Director to the Assistant Secretary level within the Department of Health and Human Services. She addresses the disparities in health status and funding levels and commits to meaningful increases to the Indian Health Service Budget and points to her co-sponsorship of the Indian Health Care Improvement Act of 2007.

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Northwest Portland Area Indian Health Board

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IHS FY 2008, 2009, 2010

by Jim Roberts, Policy Analyst

This is that time of the year when we begin discussions on three different budgets for the Indian Health Service (IHS). If you are not careful about which budget your discussing it is very easy to become confused. We are at that point where we are executing the FY 2008 IHS budget. Meanwhile, Congress is currently deliberating on the FY 2009 appropriations for next year. And finally, we recently completed submitting our Tribal recommendations to the Department of Health and Human Services (HHS) for formulating the FY 2010 IHS budget. The following provides a recap of the three different budgets.

FY 2008 IHS Budget

December 18, 2007 Congress wrapped up its work on the federal budget by sending a $2.9 trillion package (H.R. 2784) to the President. The FY 2008 budget included $933 billion in discretionary spending, precisely what the Bush Administration requested in its February budget submission to Congress. Discretionary spending is vital to Indian programs as it represents most all federal funding to Tribes. Previously, Congress approved a budget that called for $955 billion in discretionary spending, however, backed off its request when President Bush threatened to veto any bill that contained more discretionary funding than its own request. The omnibus appropriation provides $3.34 billion for the IHS budget (a 5.2% increase) and as in past years includes 1.56% rescission that was applied to the final appropriation. This rescission resulted in a loss of $53 million for the IHS budget. The final approved amount, after the rescission, is $75 million more than the President's request.

FY 2009 Budget

The President's FY 2009 request for the IHS includes $3.32 billion, which is a $21.3 million dollar cut from the previous fiscal year's budget. This makes the President's request the worst budget in twenty years! The health services accounts received $2.97 billion, which is the same amount as last year. The facilities construction accounts will take the entire $21.3 million cut. The President only recommends $353 million in FY 2009 for the health facilities accounts. There are number program increases and decreases within the various budget lines items. The request makes $56.3 million in cuts to various IHS budget accounts to fund $25 million for staffing new facilities and provides $10 million for the Indian Health Care Improvement Fund (IHCIF). The net loss to the IHS budget is $21.3 million. The most notable cut is the Urban Indian Health Program (UIHP), which has been zeroed out for the third straight year by the Bush Administration.

As shown in Figure 1, program increases and decreases for the health services line items account for $32.8 million; equal to the funding of current services increases that include staffing at new facilities and the Indian Health Care Improvement Fund (IHCIF). Those budget line items that received decreases are as follows: $11.3 million Alcohol and Substance Abuse, $34.6 million UIHP, $14.4 Indian Health Professions, and $1 million Direct Operations.

Figure 2 illustrates the facilities accounts, where there were $23.5 million in program decreases as follows: $20.8 million cut from Facilities Construction and $2.7 million cut from Facilities and

Figure 1

President's Request for IHS FY 2009 Budget
Detail of Changes

(Dollars in Thousands)	FY 2008 Enacted	President's Increases/ Decreases to Base Budget	Current Services & Program Increases		Total President's Request
			Staffing New Facilities	IHCIF	
Hospital Clinic Srvs	$2,439,762	$10,748	$22,824	$10,000	$2,473,334
Preventative Hlth	$127,587	$2,021			$129,608
Other Services	$410,185	($45,595)			$364,590
Sub-total, Services	$2,977,534	-$32,826			$2,977,532
Facilities Accounts	$374,646	($21,493)	$2,176	$0	$353,329
Total	$3,348,180	-$56,319	$25,000	$10,000	$3,324,861

Budget Updates

Figure 2

President's Request for IHS FY 2009 Budget
Detail of Changes

(Dollars in Thousands)	FY 2008 Enacted	Base Adjustments	Current Services & Program Increases: Staffing New Facilities	Current Services & Program Increases: IHCIA	Total President's Request
Health Services Account	$2,971,533	($32,826)	$22,824	$10,000	$2,971,531
Facilities Account	$374,646	($23,493)	$2,176	$0	$353,329
Total	$3,346,179	-$56,319	$25,000	$10,000	$3,324,860

Environmental Health Support. Program increases for facilities include $2.2 million for phasing in staffing at new facilities. This demonstrates the negative effect that phasing-in staff at new facilities has on the IHS budget. To fund $25 million for staff at new facilities, the IHS cut other Tribal health budgets by over $56 million. While a portion of the cut was directed toward some program increases, clearly funding $25 million could not have been financed without decreasing funding to established health programs.

The proposed FY 2009 budget request is the worst budget submission in the last fifteen years. The last time the IHS appropriation was decreased was in FY 1995 when the Agency's budget was cut by $247 million during the Clinton Administration. Appropriations in 1995 were slashed to offset federal spending on natural disasters, to fund tax cuts, and to make progress toward balancing the budget under the Clinton Administration. President Clinton's subsequent budget requests did restore lost funding to the IHS by providing some of the best increases that the Agency has ever received. Unlike the Clinton Administration, President Bush will not get another opportunity to restore lost funding. It is unfortunate that this budget will serve as President Bush's legacy to address the health care needs of American Indian people.

At the March 10, 2008 All Tribes meeting, Northwest Tribes estimated that it will take at least $355 million to fund pay increases, inflation, and population growth in order to maintain current services. An additional $158 million is required to fund the backlog of Contract Support Costs that are owed to Tribes and for expanded Tribal Self-Determination. This brings the total amount needed to fund current services to $513 million. This year's recommendation to fund current services may seem inflated, but is due to the fact that there is not an increase requested for the IHS budget. Northwest Tribes recommended an additional $574 million for program enhancements to address the significant Indian health disparities and priority needs. This amount exceeds $1 billion and may seem politically unfeasible, but when the desperate health needs of Indian country are considered, it is appropriate. It is not coincidence that Senator Dorgan has recommended that the IHS budget be increased by $1 billion and that the IHS Budget Formulation Work Group recommended a budget increases of over $900 million in FY 2010.

FY 2010 Budget Submission

On March 11-12th, Linda Holt and Darryl Red Eagle, Co-Chairs of the IHS Budget Formulation Work Group, presented Tribal recommendations for the FY 2010 IHS budget. Both Linda and Darryl were elected as the two new co-chairs of the budget work group at the IHS National Budget Formulation Meeting in February. For FY 2010 Tribes recommended $449 million to fund current services and an additional $459 in program increases to fund other high priority needs for Indian Country. This year marks the tenth anniversary in which Tribal leadership has been presenting their recommendations to HHS. In their message, Tribal leaders communicated their frustration in the budget formulation process testifying that each year they come to Washington and make recommendations that are not taken seriously because they are not funded adequately. Because of this, Tribal leaders have become cautious about

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NativeTruth Film Project. . . Fades In This Spring!

by Terresa White, Western Tobacco Prevention Project Coordinator

Nationally, American Indian and Alaska Native (AI/AN) youth (12-17) report having smoked a cigarette in the last month at a higher percentage than any other racial or ethnic group—at 23.1%, compared to 14.9% for white youth and 6.5% for black youth[1]. Smoking among AI/AN youth in Idaho and Washington is higher than in the general youth populations in those states and in 2004 cigarette smoking among 10th grade Native American youth was significantly higher than the non-Hispanic white population and for both boys and girls separately in the state.[2,3,4] High smoking rates continue into adulthood, as AI/AN adults also have the highest prevalence across all racial and ethnic groups, amounting to nearly 37% of AI/ANs in Washington[5] and 36% of AI/ANs in Idaho[6]. It can be surmised that the Native youth prevalence disparity is at least as large as the adult disparity in both states.

The voices of Native youth are underrepresented in popular media. Likewise, the stories of their unique relationships to tobacco and the cultural realities affecting the disproportionately high rates of commercial tobacco use in their communities have not been told in popular tobacco prevention film media. The **truth**® model of empowering youth to make informed choices about smoking behaviors by educating them to think critically about tobacco industry marketing tactics and by engaging them in tobacco prevention activism will be used by the NativeTruth Film Project to give voice to Native youth in three Tribal communities in Idaho and Washington. The NativeTruth Film Project will empower youth to express themselves by telling the truth about tobacco industry advertising targeting their people and to provide vocal leadership in their communities through commercial tobacco prevention activism. This project will counteract the tobacco industry's misuse of Native images targeting American Indians by creating literate media consumers and active producers of counter-marketing media, and will reduce Native youth smoking rates through peer-to-peer challenges of the social norm of commercial tobacco use.

The NativeTruth Film Project will introduce a youth-directed, culturally competent media campaign into three communities with successful Tribal Tobacco Prevention Programs in place. The project will compliment current youth prevention activities in Washington and Idaho. Tribal sites will be identified based on the strength of their existing tobacco prevention programming and on the commitment of the Tribal Tobacco Prevention Coordinators to serve as resources for participants of the NativeTruth Film Project.

Media instruction and filmmaking support will be provided by Northwest Film Center. Filmmaker mentors will empower Tribal youth and adults to explore their creative talents and raise their voices in a public way against tobacco industry marketing targeting youth and American Indians. The Northwest Film Center is a regional media arts resource and service organization founded to encourage the study, appreciation and utilization of the moving image arts, foster their artistic and professional excellence. The films developed as a result of this project will be of professional quality and together with the anticipated outcomes of the program will demonstrate persuasive evidence of the efficacy and impact of youth media projects.

For more information, contact Terresa White, NPAIHB Tobacco Projects Coordinator, 503.406.3272 or twhite@npaihb.org.

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Access to American Indian Recovery (AAIR)

by Erik Kakuska, AAIR Project Specialist

Welcome to the Access to American Indian Recovery (AAIR) program! AAIR is a substance abuse treatment and recovery support program, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The grant is administered by the California Rural Indian Health Board, Inc. (CRIHB) and the Northwest Portland Area Indian Health Board (NPAIHB) is a partner. CRIHB and NPAIHB are working together to empower American Indian/Alaska Native people in California, Oregon, Idaho and Washington to break the on-going cycle of drug and alcohol addiction in hopes of achieving long-term recovery.

The AAIR program is an expansion of the California American Indian Recovery (CAIR) program, which began offering services in May 2005 under SAHMSA's Access to Recovery (ATR) initiative. The CAIR program was one of fifteen grantees throughout the nation and the only Tribal organization to receive funding. CRIHB was recently awarded a new three-year grant to continue to offer voucher funded services. This service, called the Voucher Management System (VMS), provides clients with the necessary funds to find the help they need. This system is now being brought to the Pacific Northwest.

AAIR, which is part of the ATR program, provides clients the option to independently select from a statewide network of native and non-native health centers and recovery support services. Funding, via vouchers, are provided to enrolled clients. AAIR recognizes that AI/AN, tribes, and tribal communities have the capability to identify their own needs and solutions for substance abuse problems. In supporting this idea, AAIR will coordinate a network of community-based providers to help individuals access quality treatment and recovery support services.

If your health care center wishes to become part of the AAIR program, you are encouraged to visit AAIR's website and apply online (www.crihb.org/aair). All new applicants are required to complete and submit a Provider Enrollment Application to apply for enrollment in the AAIR program. Once you have submitted the application, along with the supporting documents, it will then be reviewed by AAIR. Within a few weeks, your center will be notified with a decision. Keep in mind that the vouchers are distributed on a "first come first served" basis. I urge your health clinics to get online and submit an application as soon as possible.

AAIR providers are among the most dedicated and experienced providers in the Northwest and each must meet these provider qualification standards before being enrolled in our program:

- Clinical provider qualification standards
- Traditional healer/spiritual advisor qualification standards

To obtain a provider application, your health care center can go online and submit at: www.crihb.org/aair under "provider enrollment application."

If you would like to learn more about the AAIR program or the SAMHSA grant, please feel free to visit the following websites: www.atr.samhsa.gov, www.crihb.org/aair. I look forward to meeting you all and if I can be of any assistance, please don't hesitate to call ekakuska@npaihb.org or (503) 228-4185.

IHS Budget continued from page 5

the effectiveness of the IHS budget formulation and HHS budget consultation process. Many Tribal leaders have lost faith and question the Administration's commitment to uphold the responsibilities of the Federal trust relationship. Ms. Holt testified, "For Tribes, the ultimate policy document to uphold the Federal trust relationship is the Administration's budget and clearly our requests are not heard nor have they received adequate funding to meet the needs of Indian Country and do not honor the Federal trust relationship." A copy of the FY 2010 IHS budget recommendation is available at www.npaihb.org.

Short-term Initiatives

by Tom Weiser, PAO IHS Medical Epidemiologist and Donnie Lee PAO IHS Diabetes Consultant

The Portland Area Office Indian Health Service (PAO-IHS) encouraged IHS/Tribal/Urban (I/T/U) sites to take on an extra task last December. The short-term initiative was aimed at increasing the proportion of eligible adults over age 65 to receive a flu vaccine if they hadn't had one yet this season. The initiative was developed by Chief Medical Officer, Dr. Clark Marquart, and supported by Mary Brickell of the Department of Information Resource Management, Dr. Thomas Weiser, Medical Epidemiologist and Stephen Poitra, Office of the Director. Prior to announcing this initiative, flu vaccination rates ranged from 50.2% to 64.8% (See Figure 1) for adults ≥65 years of age. With the help of information provided to all I/T/U sites, immunization coordinators and clinic staff were able to identify those who had not been vaccinated and coordinate efforts to get patients vaccinated. While the initiative targeted the Government Performance and Results Act (GPRA) indicator, adults ≥65 years, we also encouraged vaccination for <u>all</u> populations for whom seasonal influenza vaccination is recommended.

At one site, more than fifty staff members were involved in planning and giving vaccines. This included many who are not traditionally involved in vaccination efforts, such as, optometrists, dentists, and pharmacists.

The initiative was not just confined to the clinic- the assisted living center, local nursing home, schools, and early child education programs (where FluMist was offered to every child) also helped by sharing vaccination information with the clinic.

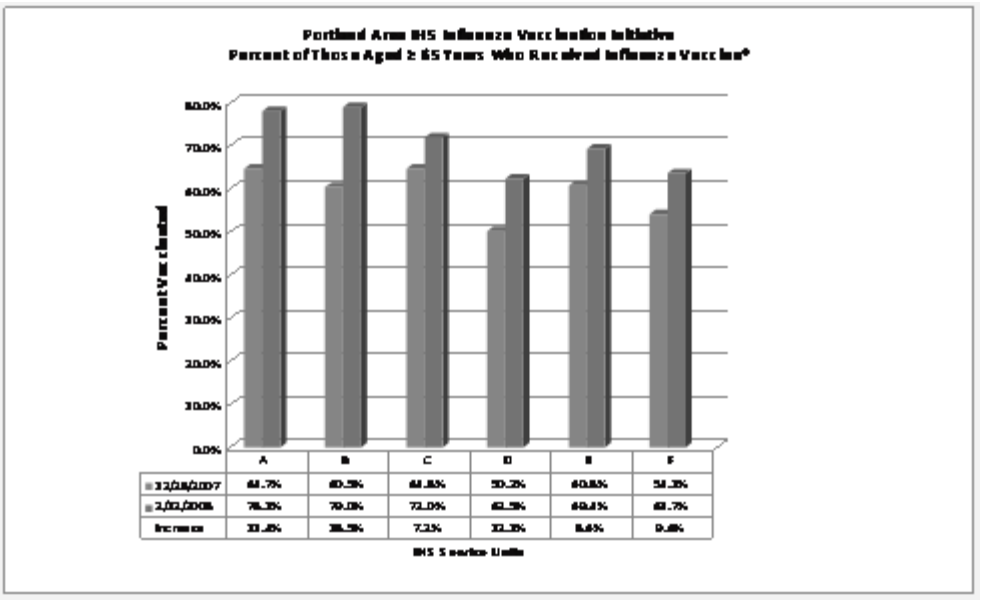
What did it take to achieve success? A new RPMS (Resource Patient Management System) application, iCare, was used to generate lists of patients and track those who would be coming to clinic for care in the following weeks. Nurses reviewed the lists of patients generated by iCare and called those that had not been vaccinated. Historical data was also gathered from community partners to identify other opportunities to vaccinate.

The short-term flu vaccination initiative wasn't just about giving flu shots to people who needed them. It also encouraged and assisted sites to become familiar with two new RPMS applications, iCare and CPHAD (Computerized Public Health Activity Data system). With iCare, a panel of patients meeting specific criteria can be created and interventions can be planned for the next scheduled visit or patients can be contacted by phone or mail to make a special visit. Instructions for using these two applications were developed and sent to all I/T/U sites in the Portland Area.

CPHAD can be used to track the amount of time spent by clinic staff in planning and executing public health activities, such as the flu vaccination initiative. Activities are entered using a graphic user interface (GUI) with drop-down menus to record the time spent, the type of activity and the type of public health issue being addressed. Reports can be generated and sorted by each category- the individuals involved, the type of activity (group meeting, individual meeting, etc) and the specific area (infant health, injury prevention, immunizations, etc) that was addressed.

Make a Difference

Figure 1



PAO-IHS Influenza vaccination rates for those ≥ 65 years of age

When the initiative was completed, the immunization rates for the IHS sites had increased by a range of 7.2% to 18.5%. The final immunization coverage rates for adults ≥ 65 years of age ranged from 62.5% to 79%. Moreover, the positive response from those sites that used the tools, iCare and CPHAD, proved that the initiative yielded dividends far greater than flu vaccination alone. Of the six IHS sites, three began using iCare for the first time and one initiated use of CPHAD. We documented 184 hours of public health activities at the six IHS sites plus an additional sixty-five hours at the area level.

Short-term Initiative to Improve Diabetes Care

What's next? On March 17, 2008 the Portland Area Office announced its second short-term initiative that aims to build on the skills developed using iCare and CPHAD to improve two GPRA standards for diabetes care: the proportion with blood pressure controlled (<130/80) and the proportion who received a detailed eye examination to screen for diabetic retinopathy. The GPRA reporting year will end on June 1, 2008, leaving a scant three months in which to make improvements in any of the thirty-five diabetes care standards that are measured. The two measures chosen as the focus for this second initiative represent achievable goals that will play an important role in maintaining or improving the health of people with diabetes. To aid sites in gearing up for this initiative, a small sum of money will be awarded to the first twenty sites to demonstrate willingness to participate in the initiative and report their activities through CPHAD.

Diabetes Eye Examination

Complications of diabetes include several visual disorders, such as retinopathy, cataracts, and glaucoma, which may lead to blindness. Approximately 15–28% of people with type 2 diabetes have retinopathy at the time diabetes is diagnosed. Adults with diabetes should have

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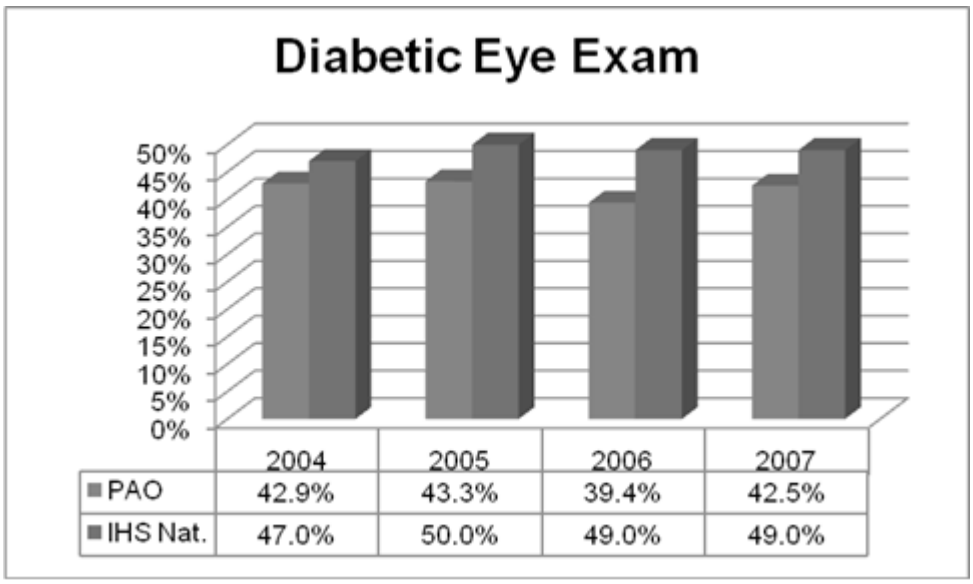
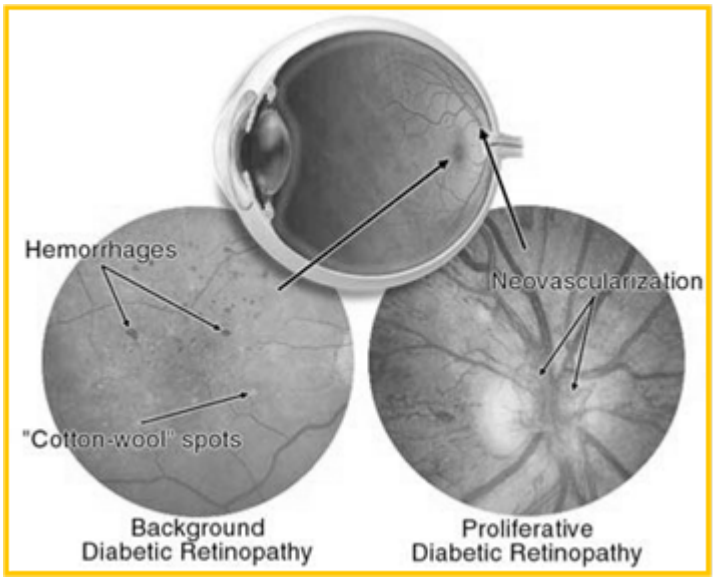
Figure 2



Proportion of Patients with Diabetes Current Retinopathy Assessment

a comprehensive dilated examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. Re-examinations should be repeated annually. Examinations will be required more frequently if retinopathy is progressive.

Figure 2 shows the proportion of PAO-IHS patients who have diabetes and have had a diabetic eye examination by year. The PAO-IHS has been below the national level each year for this measure with only 42.5% of patients having a current eye examination in 2007 compared to the IHS total (and GPRA goal) of 49%.



Blood Pressure Control

Controlling blood pressure to < 130/80 is the other GPRA measure focus for the second short-term initiative. Figure 3 shows the proportion of patients with diabetes who have an average of the last three blood pressures <130/80. Again, PAO-IHS has been below the IHS national level for this measure (39%) and for the past two years has not met the GPRA standard of 37%.

Controlled Blood Pressure for adults with diabetes is <130/80 mmHg. Lowering BP to <120/70 can offer additional protection against kidney disease.

Importance of Assessment and Management of Blood Pressure in Diabetes

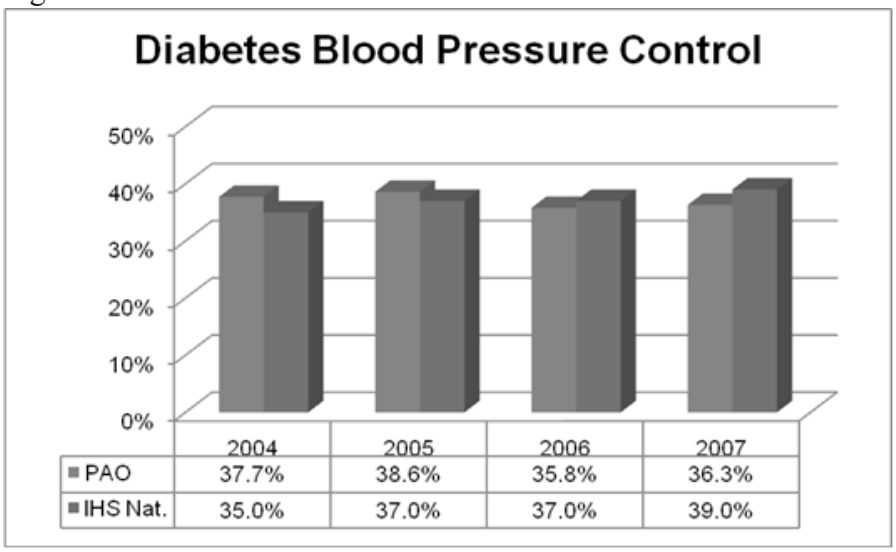
Blood Pressure (BP) control reduces risk for diabetic microvascular and macrovascular complications and is a priority for America Indians and Alaska Natives with diabetes.

Accurate BP measurement in the office is essential for diagnosis and treatment of elevated BP. Ambulatory and home monitoring should be considered if the diagnosis or control of hypertension is in question by office readings.

Major lifestyle modifications have been shown to lower BP. These include weight reduction in overweight or obese individuals and adoption of the Dietary Approaches

Make a Difference (continued)

Figure 3



Proportion of Patients Who Achieved Blood Pressure Control (<130/80)

to Stop Hypertension (DASH) eating plan. The DASH eating plan emphasizes consuming foods rich in potassium and calcium, reducing dietary sodium, increasing physical activity, and cutting down on alcohol consumption.

Treatment with two or more antihypertensive agents is frequently required to achieve BP targets. Antihypertensive agents are initiated in a step progression and selected based on the patient's coexistent conditions and desired secondary benefits as outlined in JNC VII. Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) offer renal protection and improve insulin sensitivity.

What Can You Do?

To participate in the Short-term Diabetes Initiative, contact Donnie Lee, PAO-IHS Diabetes Program Coordinator at donnie.lee@ihs.gov or call: 503-325-2017.

Learn more about:

iCare and CPHAD
http://home.portland.ihs.gov/training/online_courses.asp

Diabetes eye care best practice

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From the Chair (continued)

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ation. Just like other communities, our Tribes require disease surveillance, vaccines registries to track, distribute, and administer influenza vaccines.

SAMHSA recently organized a Tribal Advisory Committee (TAC) to provide advice in carrying out programs that affect Indian people. I was fortunate to be nominated and appointed by the SAMHSA Administrator to serve on the TAC. Northwest Tribes have always been concerned about our ability to access important SAMHSA block grant funds administered by States. We have also had concerns with our ability to access SAMHSA's discretionary grant funding. There are significant mental health needs that go untreated in Indian Country and we need to do more to address this need. These growing issues are a concern for Tribes nationally and if we're going to address them effectively, then we need more access to SAMHSA resources. The TAC will work with SAMHSA to develop solutions so that Tribes can get our people the help they deserve and need.

The SAMHSA Tribal Advisory Committee will also play an important role in identifying Tribal priorities for reauthorizing the SAMHSA programs. The Board, along with the National Congress of American Indians, and the National Indian Health Board, has worked to develop legislative objectives for SAMHSA's reauthorization. The recommendations developed by the Board will allow greater opportunities for Tribes to receive SAMHSA funding and require States share more resources with Tribal programs.

Finally, the last committee that I will tell you about is probably the most important. The IHS National Budget Formulation Committee is responsible for reviewing all twelve of the IHS Area budget recommendations and developing one final budget submission for the Agency. On February 13-14th, the group met in California to complete its work on the FY 2010 IHS budget. I was honored to be voted as one of the new Co-Chairs of the Committee. In March, we presented our recommendations to the Department of Health and Human Services. This committee's recommendations will determine what gets funded in the President's FY 2010 budget to be released next February.

The FY 2010 budget will be one of the most important IHS budgets in the last nine years. We all know that the IHS has been receiving meager budget increases during this Administration. The FY 2010 budget will be the very first budget of the incoming Administration and it will be important to get off to a good start with the new President. Likewise, if the composition of Congress stays the same, we could see one the best IHS budgets in the last 20 years. I am very excited about this opportunity and look forward to the work ahead.

Participating in these committees takes a great deal of time, preparation, and work. The Board does an excellent job of providing me with support to participate on these committees. The fact that we are called upon to participate in this work speaks to the reputation and our organization. Many important decisions within these committees and it is important that the Board participates.
It is important to keep you informed so that we all understand how these committees benefit and impact our health programs.

Correction:

In the January 2008 *Health News and Notes*, "NPAIHB Celebrates 35th Anniversary" article, there is a photo of Charolotte Herkshan. Her name is misspelled and NPAIHB apologizes to her and her family for the mistake.

NARCH

Northwest Native American Research Center for Health (NW NARCH)

The NW NARCH program at the Northwest Portland Area Indian Health Board (NPAIHB) is recruiting three American Indian/Alaska Native summer interns for Health Related Research. **Application deadline is May 1, 2008**. Under mentorship, they will research a health related topic of their choice. Depending on education, salary ranges from $12.50 to $18.50 an hour for up to two months. Priority is given to graduate students studying biomedical fields including medicine, public health, biostatistics, and epidemiology. From June 9-27 2008, they will attend the Summer Research Institute for American Indian and Alaska Native Health Professions in Portland, Oregon: http://www.npaihb.org/training/page/summer_research_training_institute/.

For more information about this opportunity and application forms, please contact Luella Azule at 503 228-4185 x 275, or email lazule@npaihb.org.

The overall goal is to increase the number of well-trained AI/AN researchers who are capable of conducting biomedical, clinical behavioral, or population-based research in diverse settings.

Native Vote (continued)

Native Vote continued from page 3

Senator McCain

Senator McCain's address relies on his record of twenty-five years of support for Indian issues, including two terms as the Chair of the Senate Committee on Indian Affairs and his sponsorship of Indian-friendly legislation, including his principle sponsorship of Tribal Self-Governance Act of 1994 (Title II, P.L. 103-413). Senator McCain stands on his record of support for the reauthorization of the Indian Health Care Improvement Act and his work to address diabetes and chronic mental health and substance abuse problems in tribal communities. Senator McCain also authored legislation to increase attention to the unique and pressing health needs of Indian populations by designating an Assistant Secretary for Indian Health to prioritize and simplify health services within the U.S. Department of Health and Human Services.

Senator Obama

A significant commitment is made by Senator Obama to appoint an American Indian Policy Advisor on his Senior White House Staff in recognition to the government-to-government relationship. Furthermore, Senator Obama will host a White House "Tribal G8" meeting annually with Native American leaders to develop a national Indian policy agenda. He also points to his original co-sponsorship of the Indian Health Care Improvement Act of 2007 and his voting record, including his support of a $1 billion dollar increase to the Indian Health Service budget as evidence and commitment to trust responsibilities and to Indian health issues.

Each candidate provides greater detail to his/her policies and positions. These excerpts are brief statements of what will be decided in 2008. Your vote will have impacts far beyond the time it takes to read the various positions or even to get to the polls. It will have impacts on the quality of life and the health status of you, your family, your community and your tribe. YOUR VOTE COUNTS.

2008 Native Vote
NPAIHB supports the National Congress of American Indians 2008 Native Vote campaign. NCAI has compiled a comprehensive, non-partisan website (http://nativevote.org/index.html) that includes everything from National Party Platforms to the top Presidential candidates' Native American policies. It provides resources and curriculum on a Native Vote "Get Out The Vote (GOTV)" community effort and even includes key dates for registration for target states, including Washington and Idaho. Oregon and Overseas and Military registration and ballot request information can be found at http://bluebook.state.or.us/state/elections/elections01.htm and www.OverseasVoteFoundation.org respectively.

BEMAR

by Mathew J. Martinson, Acting Director, Division of Health Facilities Engineering PAO

Q: What is BEMAR?
BEMAR is a total cost/value of the deficiencies that are deferred or "overdue". The acronym stands for backlog of essential maintenance and repair. BEMAR includes deficiencies that could render a building unsuitable for occupancy or could accelerate the facility's loss of value. BEMAR excludes deficiencies resulting from lack of program space or proposed improvements to enhance the efficient operation of the facility. BEMAR does not and should not include planned maintenance or predictive maintenance activities.

Q: How is BEMAR useful to managers?
BEMAR is an asset management tool. It provides a quantified snapshot of the condition. Typically, it is contrasted with the facility's estimated replacement value to make informed and strategic management decisions.

Examples of BEMAR Deficiencies:
An HVAC system that has notable operational problems and needs to be tested and balanced is an example of a BEMAR deficiency. A bad roof is an example of a BEMAR deficiency.

Examples of Other Deficiencies (that don't count towards BEMAR):
A need for additional exam rooms is not a BEMAR deficiency. A need for a new boiler in 5-years is not a BEMAR deficiency, although it can be included in the database as a predictive (i.e. anticipated) deficiency. It is not a BEMAR deficiency because it has not manifested itself.

Q: How is BEMAR Reported?
The deficiency is a description of the needed repairs associated with a budgetary cost estimate. Indian Health Service maintains a database called the Facilities Engineering Deficiency System (FEDS), and the database includes all the deficiencies and their associated remedy and budgetary cost.

Q: What is the Impact? Why should anyone care that the BEMAR is understated?
This data is utilized to report the Portland Area tribes' needs to IHS Headquarters. The Healthcare Facilities Construction Priority System (priority system), developed nationally, in consultation with the tribes, will determine how IHS's new facilities construction appropriations are prioritized. The BEMAR deficiencies are not the only factor that will be considered in the priority system, but they will be an important influence. Underreporting BEMAR essentially under-represents the Portland Area tribes' funding needs related to healthcare facilities.

Currently, the FEDS database reflects the deficiency data for those tribes who both retain some portion of the Area Office facilities functions and choose to provide us with the results of facility condition assessments. Currently, the deficiencies reported reflect about $5 million of BEMAR deficiencies, in aggregate, for Portland Area tribally-owned facilities. We know that the FEDS database has data for less than ½ of the facilities in Portland Area.

Q: What would it take to submit reports?
Portland Area tribes will benefit from complete and accurate data in the Indian Health Service facilities data systems, but we are presented by a challenge working in a decentralized Indian Health System. Consequently, it will take a collaborative solution. There are several challenges to overcome. The first challenge is how to gather deficiency data and characterize it in a consistent manner. The second challenge is how to report and represent the data so it can be consistently coded and entered in the Indian Health Service facilities data system (FEDS). The third challenge is workload related. Who will actually enter the data? For situations where Indian Health Service's Area Office facilities function is retained, entering the data in the Indian Health Service database could be accomplished by Indian Health Service staff. However, that leaves the data entry question unaddressed for tribes that have chosen to compact or contract all functions and services of the facilities program. I suspect that this will need to be resolved through collaborative conversations.

New NPAIHB Emloyees

Hi my name is Casandra Frutos and I am the new Project Assistant for the National Tribal Tobacco Network. I am an enrolled member of the Confederated Tribes of Warm Springs. I grew up on the Warm Springs Reservation and moved to Portland with my family, but frequently visit back home. My children and I are active participants with the native culture and beliefs. We attend NAYA and local Pow Wows so I may teach my kids to carry on our traditions. I am also going to school studying Paralegal / Environmental Health with the goal to someday return to Warm Springs and use my education for the benefit of our people and community. My long term goal is to become a judge in Warm Springs. I am an active volunteer for Rotary International. I am a proud Granddaughter of the first Native American President of The Oregon School Board and will work hard to walk in my Grandfather's footprints to serve our community and set a good example for generations to come.

What an exciting time this is! My name is Erik Kakuska, the new Access to American Indian Recovery (AAIR) Project Specialist for the Northwest Portland Area Indian Health Board (NPAIHB).

I was born on the Zuni Pueblo reservation in New Mexico where most of my extended family lives today. While growing up the on the Zuni reservation, I was able to have the privilege of learning the old ways taught by tribal Elders. Unfortunately, some of the Elders are finding it hard to teach the younger generation their old ways due to the use of alcohol and drugs. Methamphetamine use is one of the main drugs readily available to the Zuni Pueblo, also the Pacific Northwest. I took on this job to further my involvement and education for my Tribe and for the 43 Pacific Northwestern Tribes. I am excited to be a part of this great program that is dedicated to bringing methamphetamine and other substance abuse to a close.

My mother, who resides in New Mexico, is the first American Indian to own and operate the only "Native Owned" jewelry store in Ruidoso. My father also resides in New Mexico where he is a superintendent for the Roswell school district. I have one older brother who lives in Albuquerque, NM, a younger sister who is currently living in Thailand and a little brother (actually no longer little), who just finished up his last season with the N. Alabama football team. My wife is currently in Albuquerque, NM finishing her teaching position at Sierra Vista Elementary where she teaches the fifth grade

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.

January 2008 NPAIHB Resolutions

RESOLUTION #08-02-01
Support for the Increase in Dental Services Funding in the Indian Health Service Budget

RESOLUTION #08-02-02
Northwest Tribal Registry, Seattle Indian Health Board and Seattle-Puget Sound Surveillance Epidemiology and End Results (SEER) Racial Misclassification Linkage Project

RESOLUTION #08-02-03
Opposition to Unilateral Changes to Indirect Cost Rate Calculation Policies and Practices by the National Business Center.

RESOLUTION #08-02-04
Social Security Eligibility for Tribal Council Members

RESOLUTION #08-02-05
Support Development of a Comprehensive Community Mental Health Services for Children & Families Project under the SAMHSA Child Mental Health Initiative

527 SW Hall Street • Suite 300 • Portland, OR 97201

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