Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

February, 2010

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.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release — January 27, 2010

Obama's State of the Union Adresses National Health Reform

REMARKS BY THE PRESIDENT
IN STATE OF THE UNION ADDRESS

Article on page 4.

"But I also know this problem is not going away. By the time I'm finished speaking tonight, more Americans will have lost their health insurance. Millions will lose it this year. Our deficit will grow. Premiums will go up. Patients will be denied the care they need. Small business owners will continue to drop coverage altogether. I will not walk away from these Americans, and neither should the people in this chamber. (Applause.)

Here's what I ask Congress, though: Don't walk away from reform. Not now. Not when we are so close. Let us find a way to come together and finish the job for the American people. (Applause.) Let's get it done. Let's get it done. (Applause.) "

In This Issue

From the Chair:

Andy Joseph, Jr.

Northwest Portland Area Indian Health Board

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Happy New Year! I hope our hard working delegates and staff were able to spend time with family and friends during the holidays. I would like to send out a special thanks to those in the armed forces and their families who had to be apart this past holiday season. They sacrifice to benefit all of us.

At the time of this printing, it is still unclear how the President will proceed with national health reform given the recent election of Senator Brown from Massachusetts. We have worked over ten years to get the Indian Health Care Improvement Act reauthorized and saw some hope when the IHCIA was included in both the Senate and House versions of health care reform legislation. Regardless of whether health care reform legislation is passed, we will continue to work towards reauthorizing the IHCIA and closely monitor activity on the hill.

On November 6th, along with the Portland Area Facilities Advisory Committee, I participated in a meeting with the Dr. Roubideaux to discuss the Portland Area concept to develop regional referral specialty centers. The meeting provided an opportunity to review our recently completed pilot study that demonstrates that the demand for a Regional Specialty Referral Centers offering specialty care/diagnostics and ambulatory surgery care are economically feasible. We requested that the IHS Director provide funding that will allow Portland Area tribes to demonstrate that regional referral centers will work in the IHS system. We look forward to partnering with the Director on this effort and will keep you advised of the project's progress.

On November 12th, along with our Executive Director and Policy Analyst, I attended the winter session for the National Congress of American Indians. The health committee meetings were very important in preparing our national organizations for health reform issues that were making their way through Congress. We also had an opportunity to meet with Congressional staff to discuss Board priorities in health reform.

On November 16th, I testified before the Senate Veterans Affairs Committee. As an Indian veteran myself, veterans health issues are very important to me and the work at the Board. My recommendations to Congress were that the IHS-VA must renew and reinvigorate their memorandum of agreement to serve Indian veterans. We also recommended that the IHS should be able to conduct compensation examination for Indian veterans on behalf of the VA. I also recommended that the VHA outstation mental health workers in IHS

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From the Executive Director:

Joe Finkbonner

Every decade a census is conducted in the United States as mandated by the U.S. Constitution. There is a lot at stake in the upcoming 2010 census beyond the demographic information that it provides to your grant writers or tribal epicenters. The census data will directly affect how more than $200 billion in federal grant funding is distributed to state, local and tribal governments each year. In addition, the census data will be used to ensure proper apportionment of seats in the U.S. House of Representatives and that federal and state funding is distributed fairly. Therefore, if we want a fair and equitable distribution of federal funds directed at our populations as well as better congressional representation, the participation of tribal populations in the 2010 census is critical.

In past decades, tribal populations have often avoided participation in the census data collection for a variety of reasons including lack of trust in an external government as well as lack of trust in the person asking the questions, historically a non-Indian. In the last census of 2000, Tribes have undertaken aggressive efforts to try to improve participation. These efforts have included advertising in tribal newspapers that census takers will be on the reservation and stressing the importance of participation as well as encouraging tribal members to become census takers for the reservation. Tribes have also placed on General Council meeting agendas the issue of the importance of participation in census data collection. These actions were taken so as to increase tribal participation

The 2010 census, unlike the censuses of past decades dating back to the first census in 1790, will have one of the shortest questionnaires in the history of the United States. The Questionnaire, consisting of only seven or so questions, will take most households about ten minutes to complete and will likely result in a simpler, less costly and more accurate census.

The shortened census questionnaire is the result of the removal of the bulk of the demographic questions which are now included in the American Community Survey (ACS) which was fully implemented in January of 2005. The ACS is a large, continuous demographic survey that produces annual and multi-year estimates of the characteristics of the population and housing. Each year the ACS is administered to 3 million addresses throughout the U.S. and Puerto Rico.

To facilitate more accurate census taking, the Census Bureau is also embracing new technology to count this nation's growing and changing population. The census Bureau anticipates using 500,000 hand-held computers for data collection in the 2010 census. These secure devices will be used to update

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Northwest Portland Area Indian Health Board

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National Health Reform

by Sonciray Bonnell, Health Resource Coordinator and Jim Roberts, Policy Analyst

Indian Country recognizes that our nation's health care system must be reformed in order to make health insurance and health care available to more Americans. Indian people know from their own experience that many Americans, especially low-income individuals, often find it impossible to obtain the health care they need.

In addition to carefully crafting legislative language, Indian Country has also articulated guiding principles for the new Administration and Congress to follow in the development of health care reform. Health care reform initiatives must be consistent with the federal government's trust responsibility to Indian Tribes, acknowledged in treaties, statutes, court decisions, and Executive Orders. Indian Tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. Based on the federal trust responsibility and the government-to-government relationship with the federal government, it is rational for the Congress to include Indian specific provisions in health reform.

Tribes need to be at the table in any discussions on health care reform initiatives that affect the delivery of health services to AI/AN people. It is the policy of the United States, in fulfillment of its legal obligation to Tribes, to meet the national goal of achieving the highest possible health status for AI/ANs and to provide the resources necessary for the existing health services to affect that policy. The legal authority of Tribal governments to determine their own health care delivery systems, whether through the Indian Health Service (IHS) or Tribally-operated programs, must be honored. A community-based and culturally appropriate approach to health care is essential to preserve Indian cultures and eliminate health disparities. The extremely poor health status of Indian people demands specific legislative provisions to increase funding in order to break the cycle of illness and addiction that began with the destruction of a balanced Tribal lifestyle. Indian health care services are not simply an extension of the mainstream health system in America. Through the IHS, the federal government has developed a unique system based on a public health model designed to serve Indian people in remote reservation communities and in urban areas. This system must be supported and strengthened to enhance access to health care for AI/ANs. Because of the location, small size, and poor populations, private insurance plans often refuse to contract with Indian health providers. Some Indian providers cannot meet private health plan contracting terms. Whether through public or private health coverage programs, Indian health providers need special mechanisms to receive reimbursement for services and AI/AN must be guaranteed plan options or exemptions to make sure they are allowed to use their IHS, tribal, and urban providers without financial penalty.

The Northwest Portland Area Indian Health Board has consistently urged Congress to pass American Indian/Alaska Native (AI/AN) provisions and the Indian Health Care Improvement Act in Health Reform Legislation. The Indian Health Care Improvement Act (IHCIA) is in both the Senate and House national health care reform bills. The House passed their health reform bill, Affordable Health Care for Americans Act, on November 7, by a vote of 220 to 215. Senate passed their health reform bill early in the morning on December 24, the Patient Protection and Affordable Care Act (H.R. 3590), by a vote of 60-39. Both bills included many of the provisions developed at the NPAIHB-ATNI Health Reform Roundtable held in June. 2009. Although we've been working toward passage of the IHCIA for over ten years, we're often talking to the same constituents in Congress. National health care reform has provided us the opportunity to educate a broader audience on the complexities of the Indian health system and how it should systematically be included in national health care reform.

in Indian Country

The Indian health system is very different from the mainstream health system. The Indian health system is not health insurance; it provides direct care to Indian patients and referral services for care that the system itself is not able to provide. In essence, it is the health care home for most Indian people. The federal trust responsibility to Indian people and the Indian health system often requires specific legislative language to prevent unintended adverse consequences to this health care delivery system. Health care reform legislation must support and strengthen the current Indian health care delivery system, a comprehensive system that provides culturally competent health care to 2.2 million American Indians and Alaska Natives (AI/ANs), especially those in remote areas not served by the mainstream health care system. NPAIHB has recommended the following concepts be included in health care reform in order to protect the Indian health system.

- Health care reform legislation should require tribal consultation during the development and implementation of federal and state regulations.
- Health care reform legislation must include Indian-specific provisions to assure that reform options can work in the unique Indian health delivery system.
- Health care reform legislation must acknowledge and take into account the multiple roles of Indian Tribes as providers, payors, employers, and governmental entities.
- Health care reform legislation that expands public or private health care coverage programs to the uninsured must ensure that AI/ANs have a meaningful opportunity to enroll and access their health care through Indian health providers.
- Health care reform legislation must address the chronic underfunding of the Indian health system and must include full funding and/or mechanisms to achieve full funding.
- Health care reform legislation and stimulus package initiatives that include new health funding must, in a meaningful way, explicitly include Tribes as governments and Indian health providers as eligible recipients.
- Health care reform legislation that proposes premiums or cost sharing requirements should include an exemption or 100% subsidy for AI/ANs.

Indian Country certainly has a stake in national health reform, as it will affect our programs to our benefit or detriment depending on the legislative language. A simple solution is to include tribal representation on key commissions, boards, and other workgroups created by health reform legislation. Only by engaging tribal leaders before policies are evaluated, refined, and implemented can health reform to improve the IHS system and health status of AI/ANs.

While health care reform holds great promise for ensuring coverage for all Americans, in Indian Country it will create a short term financial burden on the already seriously underfunded Indian health system. Tribes need to be involved in policy analysis and rule making, but there are no new resources for such work. At the tribal level staff will need training and the resources to build the local systems that are needed to effectively educate, enroll and coordinate patient participation in a reformed system. If new funding is available for implementing health reform in Indian Country, ensure that it is available to Tribes.

ARRA Medicare & Medicaid

by Jim Roberts, Policy Analyst

It been a year since President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) on February 17th, 2009. The stimulus bill is unprecedented in its level of funding and an extraordinary response to the economic crisis unlike any since the Great Depression. It included measures to modernize our nation's infrastructure, enhance energy independence, expand educational opportunities, preserve and improve affordable health care—including $19 billion for health information technology (HIT) initiatives.

The $2 billion will be used for grants to states and other entities for HIT infrastructure, training, dissemination of best practices, telemedicine, and inclusion of HIT in clinical education. The remaining $17 billion will be used to establish *temporary* Medicare and Medicaid HIT incentive payments for hospitals and physicians over several years. These incentive payments represent additional funding for IHS and Tribal health programs and it's important that Tribes begin to prepare to access this funding.

Electronic Health Record (EHR) Incentive Payments

The largest allocation of ARRA-HIT funding provides $17 billion in Medicare and Medicaid incentive payments and grants to encourage providers and hospitals to implement EHR systems. The incentive payments are triggered when a provider or hospital demonstrates it has become a "meaningful EHR user." The incentive payments will be phased in over time, with larger payments in the early years and lower payments later in the implementation process. These payments could total as much as $48,400 for eligible professionals and up to $11 million for hospitals. In addition to the incentives, the legislation establishes penalties through reduced Medicare reimbursement payments if they do not become meaningful users of EHR by 2015. Meaningful use of EHRs will be defined by CMS during a rulemaking process (currently underway) and may include reporting requirements on quality measures. ARRA also authorizes the Department of Health and Human Services (HHS) to provide competitive grants to states to make loans available to health care providers to assist them with HIT acquisition and implementation costs.

Medicare Incentives

Beginning January 2011, physicians (non-hospital based) are eligible for Medicare incentive payments based on an amount equal to 75% of the allowed Medicare Part B charges, up to a maximum of $18,000 for early adopters whose first payment year is 2011 or 2012. The HHS Secretary will define the reporting period(s) with respect to a payment year. Incentive payments would be reduced in subsequent payment years, eventually phasing

Medicare EMR Incentives

The following table shows how the incentives and potential reductions are expected to work from 2010-2017:

	If the First Qualifying Year is:						
Payment Year	2011	2012	2013	2014	2015	2016	Maximum Potential
2011	$18,000	$12,000	$8,000	$4,000	$2,000	-	$44,000
2012		$18,000	$12,000	$8,000	$4,000	$2,000	$44,000
2013			$15,000	$12,000	$8,000	$4,000	$39,000
2014				$12,000	$8,000	$4,000	$24,000
2015	Reduction in Fee Schedule for Non-Adoption/Use: -1% of Medicare Fee Schedule						
2016	Reduction in Fee Schedule for Non-Adoption/Use: -2% of Medicare Fee Schedule						
2017 and thereafter	Reduction in Fee Schedule for Non-Adoption/Use: -3% to a maximum of -5% of Medicare Fee Schedule						

Note: Physicians in med health professional shortage areas who adopt/use HITs are eligible to receive a 10% increase on the incentive payment amounts described above. Eligibility=Medicare billable/year =75% of the $44,000 max=$33,000. "Meaningful Use" is yet to be defined.

Incentive Payments

out in 2016. Physicians who do not implement an EHR system before 2015 will face a reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. The HHS Secretary has the authority to make exceptions to this reduction on a case-by-case basis for physicians who demonstrate significant hardship (e.g., a physician who practices in rural areas without sufficient Internet access). It is likely that the IHS and Tribal health system will experience hardships in implementing EHRs and it's important that Tribes start to document these circumstances.

Medicaid EMR Incentives *

Payment Year	Adoption Year 2011	2012	2013	2014	2015	2016	2017	2018	Maximum Potential
2011	$25,000	$10,000	$10,000	$10,000	$10,000				$65,000
2012		$25,000	$10,000	$10,000	$10,000	$10,000			$65,000
2013			$25,000	$10,000	$10,000	$10,000	$10,000		$65,000
2014				$25,000	$10,000	$10,000	$10,000	$10,000	$65,000
2015					$25,000	$10,000	$10,000	$10,000	$55,000
2016						$25,000	$10,000	$10,000	$45,000

* **MEDICAID**: Available to Physicians whose caseloads include at least 30% Medicaid patients are eligible to receive up to $65K over the course of 5 years.

* Available only to non-hospital based physicians, clinicians, including dentists, certified nurse midwives, and physician assistants practicing in rural health clinics or FQHCs.

* Minimum for Medicaid participation: 30% of a physician's/clinician's patients must use Medicaid, with the exception of pediatricians, who only need 20% of their patients using Medicaid.

* Startup incentive: State will pay up to 85% of the average allowable cost ("average allowable cost" has not been defined yet) of a EHR not to exceed $25,000 for implementation.

* After receiving startup funds, providers who can prove "meaningful use" can receive up to $10,000 annually for an additional four years.

* No penalties have been defined by Medicaid for lack of adoption.

Medicare incentives will be paid on a phased-out schedule over a set number of years, for a maximum of five years. The first year in which physicians can qualify for incentive payments is 2011. Physicians that can demonstrate that they qualify in 2011 or 2012 will qualify to receive phased-out incentive payments over a five-year period. Physicians that qualify in 2013 or 2014 will receive phased-out incentive payments for four or three years respectively. No incentive payments will be paid for physicians first qualifying after 2014.

Medicaid Incentives

ARRA also establishes 100 percent Federal Financial Participation (FFP) for States to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate (including support services and training for staff) certified EHR technology. It also establishes 90 percent FFP for State administrative expenses related to carrying out this provision. Eligible professionals include physicians, dentists, certified nurse midwives, nurse practitioner, and physician assistants practicing in rural health clinics or Federally-Qualified Health Centers (FQHC) led by a physician assistant. Providers will have to elect to be reimbursed by Medicare or Medicaid, but not both. Medicaid providers will be required to sign an affidavit certifying they are not also collecting Medicare incentive payments.

Since most IHS and Tribal health facilities are designated as FQHCs they will be eligible for Medicaid incentive payments. Many IHS and Tribal health programs have also begun to implement EHR systems and can now qualify for funding to off-set costs associated with implementing EHR systems. In order to be eligible, health professionals must have at least a 30% patient volume enrolled in the Medicaid program. The legislation does not indicate how CMS or the State will determine or calculate an eligible professional's patient volume percentage. The Medicaid incentive payment program begins January 1,

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Disparities in Hospitalization

by Megan Hoopes, MPH; Project Director, Northwest Tribal Registry

Many public health statistics – such as mortality, births, immunizations, cancer, injuries, and health spending – are derived from administrative records where American Indians and Alaska Natives (AI/AN) are often misidentified as white, Hispanic, or Asian. This racial misclassification leads to rates that are artificially low for AI/ANs.

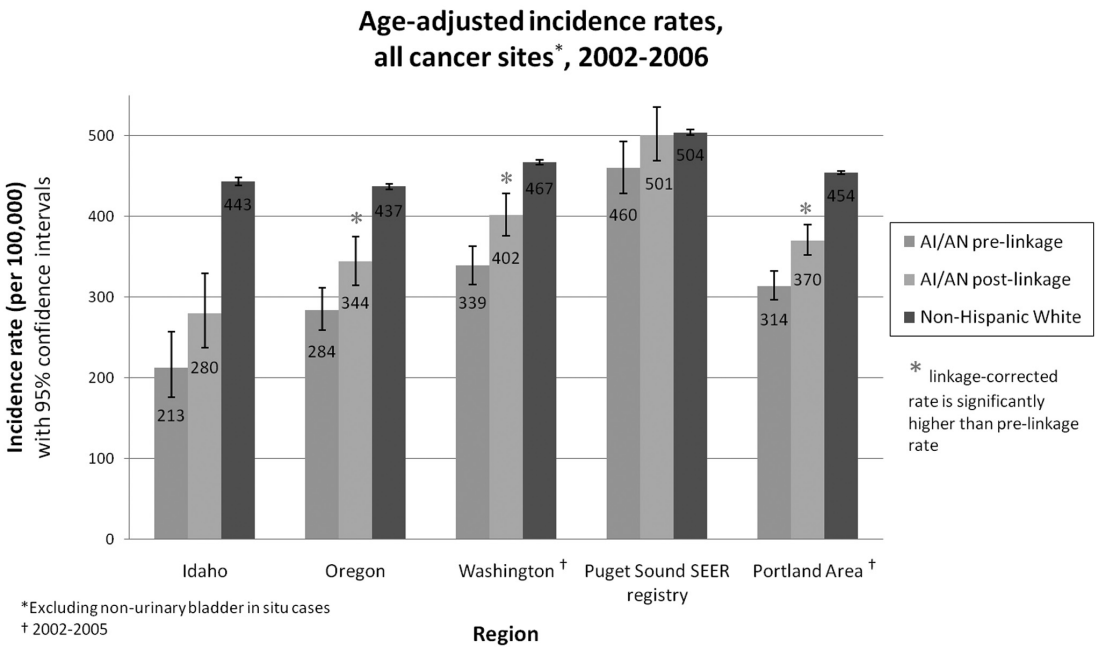
What is record linkage?

Record linkage studies provide an effective means to identify and correct racial misclassification, ultimately improving the accuracy of health surveillance data. The Northwest Tribal Registry, a project of the Northwest Tribal EpiCenter, has been conducting record linkages with various public health datasets since 1999, with the aim of more accurately characterizing health status for northwest tribal people.

The process of correcting race data involves temporarily "linking" the Northwest Tribal Registry – a dataset of American Indian and Alaska Native people who have used an IHS facility in Idaho, Oregon, or Washington – with an outside data source such as a cancer registry. Using LinkPlus, a specialized linkage software developed by CDC, we compare several characteristics such as name, date of birth, and social security number, between the two files to identify matches. When a match is found, we look at the coding of race in the outside dataset; if the individual is coded as something other than AI/AN, the record is racially misclassified. Throughout the process, we adhere to strict Institutional Review Board (IRB) approved protocols to assure the confidentiality of individual and tribal-specific health related data.

Recent linkages with state and regional cancer registries in the Portland Area have resulted in improved cancer estimates for AI/ANs. As Figure 1 shows, AI/AN cancer incidence rates would be substantially underestimated in each state and across the region (left bar), if not for correction of AI/AN race through the linkages (middle bar).

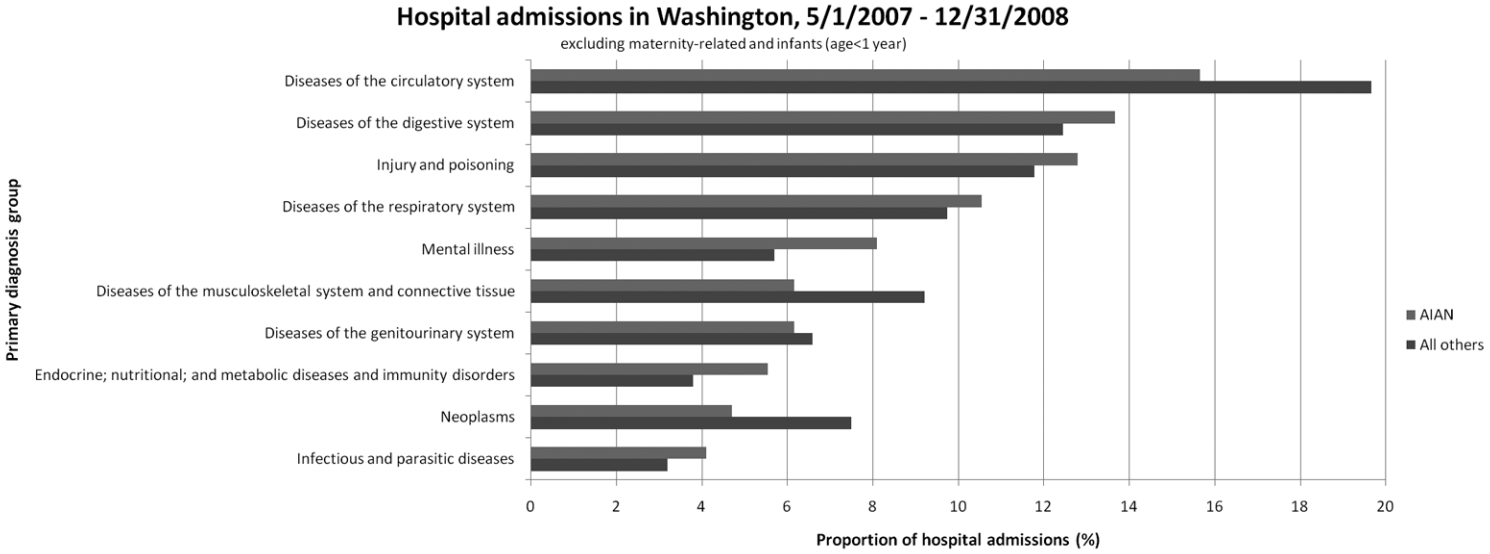
Figure 1



Partnerships with individual tribes and urban Indian organizations have further improved our ability to identify racial misclassification, and to provide accurate regional or tribe-specific disease estimates in the northwest (e.g., the latest Washington cancer linkages were in partnership with Seattle Indian Health Board/Urban Indian Health Institute).

Revealed Through Record Linkage Study

Figure 2



New data on hospitalizations in Washington

Although it is commonly believed that AI/ANs experience high rates of hospitalization and injury, causes and trends of AI/AN hospitalization in the northwest are insufficiently understood, due in part to the lack of an IHS hospital in the Portland IHS Area. Washington's Comprehensive Hospital Abstract Reporting System (CHARS) has collected data on every patient admitted to every community hospital in Washington State since 1987. Until recently, race/ethnicity was not collected in CHARS, but mandatory race reporting was implemented in mid-2007. We conducted a record linkage with the Northwest Tribal Registry and Seattle Indian Health Board to evaluate the completeness and accuracy of the newly collected race data and to examine disparities in hospitalization for Washington's AI/AN population. The time period under study was 5/1/2007 – 12/31/2008.

Among the CHARS records sent for linkage, approximately 26% had a race specified. There were 3,743 AI/AN records in the dataset prior to the linkage; 7,849 additional AI/ANs were identified through the linkage, representing an increase of over 200%. We combined all records that were not identified as AI/AN into an "all other races" category for comparison.

AI/AN hospital patients tended to be younger than other races (average age at admission=45.0 years, vs. 53.8 years for all other races, excluding newborn and infant admissions; $p<0.01$). The overall rate of hospitalization was lower for AI/ANs versus all other races (614 vs. 746 per 10,000 population per year, respectively), but the rate of hospitalization due to avoidable causes[1] was significantly higher for AI/ANs (92.3 vs. 84.8 per 10,000 population, respectively; $p<0.01$). Diabetes with complications was listed as the primary diagnosis in 3.0% of non-maternity AI/AN cases, compared to 1.5% of all other races ($p<0.01$).

1 Avoidable causes of hospitalization are conditions that can usually be avoided with effective and timely use of primary care, and can serve as an indicator of primary care access and utilization. They include: ruptured appendix, asthma, cellulitis, congestive heart failure, diabetes with ketoacidosis or coma, gangrene, hypokalemia, immunizable conditions, malignant hypertension, pneumonia, pyelonephritis, and perforated or bleeding ulcer. For more information see: Weissman JS, et al. JAMA. 1992 Nov 4;268(17):2426-7.

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Disparities in Hospitalization

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Figure 3

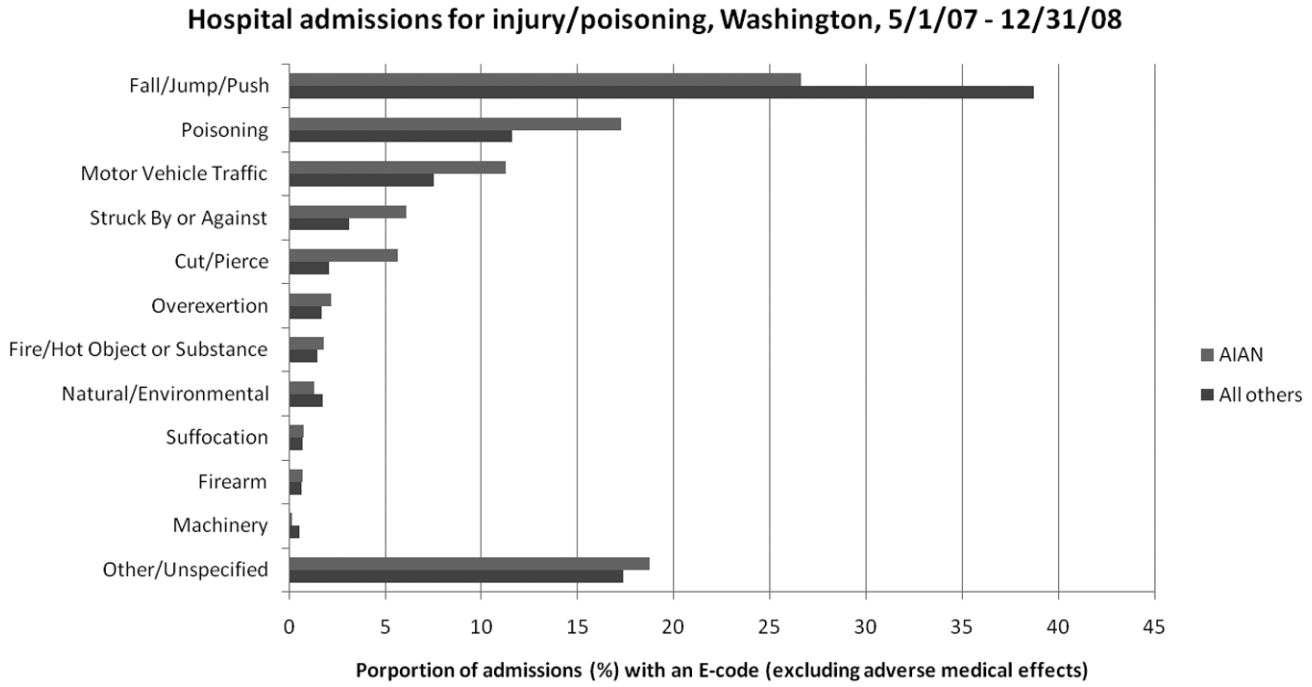

Figure 2 presents the ten leading causes of hospital admission, for AI/ANs compared to all other races combined. AI/ANs were disproportionately admitted for digestive system conditions, injury and poisoning[2], respiratory conditions, mental illness, and endocrine/metabolic conditions. The most common injuries experienced by AI/ANs were fall/jump/push, poisoning, and traffic accidents (Figure 3).

The results of this linkage confirm much of what we already know about health disparities, but the data shed new light on the actual differences in hospitalization trends between AI/ANs and other races in Washington. An understanding of the leading conditions and causes of injury that result in hospitalization can be used to direct health priorities for northwest tribes and throughout Indian Country.

Note - The Northwest Tribal Registry Project can provide health data for your community, and is available for data partnerships with northwest tribes. Please contact Megan Hoopes at mhoopes@npaihb.org or 503-416-3261 for more information.

2 Injuries are from all types, including unintentional, self-inflicted, assault, and operations of war. Poisoning injuries include drug overdoses, other misuses of drugs, and injuries associated with solid or liquid biologic substances, gases or vapors, or other substances such as pesticides or unspecified chemicals.

Administration on Native Americans

The Senate Committee on Indian Affairs conducted it confirmation hearing on January 28th for Lillian Sparks to serve as the Commissioner for the Administration for Native Americans within the Department of Health and Human Services. Ms. Sparks is a member of the Rosebud and Oglala Sioux Tribes and has served as Executive Director of the National Indian Education Association (NIEA) since 2004. Prior to joining NIEA, Ms. Sparks was a staff attorney with the National Congress of American Indians where she worked on international indigenous rights, sacred sites and religious protection, and issues related to youth and health care. She also previously served as a law clerk for the National Indian Gaming Commission in the Department of the Interior where she, among other duties, reviewed tribal gaming regulations to ensure compliance with the Indian Gaming Regulatory Act. Ms. Sparks is a member of the National Congress of America Indians, the Native American Bar Association, and the National Trends & Services Committee. In 2004, she was named one of seven young Native American Leaders by the USA Weekend magazine. She received a Bachelor of Arts degree from Morgan State University and a Juris Doctor degree from Georgetown University Law Center.

Annual Diabetes Audit

The Annual Diabetes Audit is May 15, 2010. Are you ready for the Annual IHS Diabetes Care & Outcomes Audit? For your diabetes data needs, such as updating your registry, populating your taxonomies, inputting new medications, capturing lab values, etc., call your WTDP project specialist at 800-862-5497.

The Annual IHS Audit season is approaching fast, with a due date of May 15, 2010. The Western Tribal Diabetes Project is busy scheduling and conducting site visits to assist Northwest tribes prepare to submit the audit. Specialists are also available for trouble shooting via phone and email for technical assistance. The annual audit reports all care delivered to patients with diabetes between January 1, 2009 and December 31, 2009, and is a required component for the Special Diabetes Program for Indians grants awards. It will be a tight window for submission, the new patch for DMS is due to be released in early March. Once the patch is installed, WTDP specialists can conduct site visits to assist you and your staff in running and submitting the audit.

Audit data is also converted to the Health Status Report, and used in the NW aggregate tribal report. These reports can assist NW tribes in utilizing tribal specific data to improve case management, track diabetes care, identify data gaps, and secure new funding. Act now to prepare for the audit. WTDP staff is available to assist in chart audits and technical assistance for preparation for the audit and web audit submission. To request a site visit or technical assistance, please call 800-862-5497.

Native Youth

by Stephanie Craig Rushing, Project Director

Media technologies, including the Internet, cell phones, and video games, are increasingly being used by health educators to reach tech-savvy youth on sensitive health topics. While several studies have informed the development of media interventions targeting mainstream youth, no such data has been reported for Native youth. To fill this gap, Project Red Talon collected surveys from over 400 Native youth living in Oregon, Washington, and Idaho in 2009, to better understand how they use media technologies. Our goal is to use this information to develop technology-based health resources for Native teens and young adults.

Media Use Findings

- AI/AN youth in the Pacific Northwest use media technologies at rates similar to other teens in the U.S. AI/AN youth (ages 13-21 years) reported using a wide variety of media technologies in their daily lives, including: computers (74%), the Internet (75%), cell phones (78%), iPods and MP3 players (75%), video games (36%), and digital cameras (37%). Less than 3% of respondents reported *never* using computers or the Internet and only 6% reported *never* using cell phones.

- Like other U.S. teens, AI/AN youth engage in a wide variety of online activities. The vast majority of youth reported having a profile on a social-networking site (SNS) like MySpace or Facebook (87%), watching videos on sites like YouTube (77%), and posting photos online (71%). A significant proportion of youth also reported using the Internet to get news or information about sports or entertainment (68%), and to get news or information about American Indian events, politics, culture, or their tribe (63%). Most youth reported using the Internet ½-2 hours per day (55%), and access the Internet from home (50%), school (47%), or their cell phone (36%).

- Cell phone use is particularly common in the NW. Nearly 67% of AI/AN youth reported talking to friends on a cell phone on a daily or weekly basis. Only 17% reported not having a cell phone. Over one-third sent and received more than 40 text messages per day. This is similar to national figures - On average, teens with cell phones send over 2,880 text messages per month!

- AI/AN youth reported using the Internet to get a wide array of health information, including on: diet, nutrition, exercise, or fitness (50%); a specific illness or medical condition (47%); drugs or alcohol (42%); sexual health, STDs, or HIV (32%), and depression, anxiety, stress, or suicide (32%)

Risky Online Behaviors

- 32% of AI/AN youth reported that they've communicated with strangers (people that they haven't met in person) using email, IM, or chat rooms, and 14% reported having been contacted by a stranger online who made them feel scared or uncomfortable.

- One-third of respondents (34%) indicated that they do not restrict access to their online profile so that only their friends can view it.

Sexting - What is it? Sending or receiving sexually explicit messages or pictures electronically, usually between cell phones.

Why all the fuss? In some cases, sexting is illegal. If you forward a sexual picture of someone underage, you could face child pornography charges, go to jail, or have to register as a sex offender.

Media Survey

- Sexting. Over half (53%) of respondents reported that they've *received* a sexually suggestive message, image, or post from someone else. And 20% reported that they've *sent* a sexually suggestive message, image, or post. These sext messages and images were most often sent to a boy or girlfriend (24%).

The Truth about Technology

Nothing is truly private on the Internet. Other people can gain access to your online profiles or any content you upload to the Internet. Text, pictures, videos, posts, tweets, and other electronic information can be unknowingly copied or recorded, and shared with others. Deleting material from your profile, computer, or digital camera doesn't necessarily mean that it's gone forever. Once created, these images can live in cyberspace forever.

Tips for Parents and Teens

- *Don't assume that anything you send or post is going to remain private*. Since anything can be downloaded and forwarded, ask yourself if you want the whole world (including parents, teachers, friends, enemies, future colleges, and potential employers) to see what you post.

- *Never take images of yourself or post messages that you wouldn't want everyone to see*.

- *Nothing is truly anonymous*. Even if someone only knows you by your screen name, online profile, phone number, or email address, they can probably find you if they try hard enough.

- *Don't give in to peer pressure, even in cyberspace*. Many teens say that "pressure from friends" is the reason they send sexually suggestive messages or photos. It's easier to be more provocative or outgoing online, but whatever you write, post, or send will shape the real life impression that other people have of you. Don't say or do anything online that you wouldn't say or do in person.

- *Report nude pictures or anything that makes you feel uncomfortable to an adult you trust*. Do not delete the message until you show it to an adult.

- *Parents – Monitor your kid's cell phone and Internet use, and try to know who they're communicating with and what they're posting*. If they have an account on a social networking site like MySpace or Facebook, ask to see or join their profile, and talk to them about what they see and do online.

For more information about the Native Youth Media Survey or Project Red Talon, please contact Stephanie Craig Rushing at: scraig@npaihb.org or 503-416-3290.

Tips From: The Institute for Responsible Online and Cell Phone Communication: www.iroc2.org/page/parents-educators & SexTech: www.thenationalcampaign.org/sextech/

The IHS FY 2011 Budget:

Jim Roberts, Policy Analyst

On January 26th, the White House Office of Public Engagement and Rob Nabors, Deputy Director of the Office of Management (OMB), announced the Administration's three year plan to freeze non-security discretionary spending for some domestic programs beginning in FY 2011. The objective is to cut $250 billion out of the federal deficit over ten years. President Obama in his state of union address to Congress requested they support his proposal in the appropriations process. This puts funding for Indian programs in jeopardy over the next ten years as almost all funding for Indian programs is discretionary—including health care.

The Administration's proposal follows one of the best budget increases that the Indian Health Service (IHS) has ever received. In the President's FY 2010 request the Administration included a $453.5 million increase for the IHS, with over 98% of the funding directed to hospital and clinic services and preventive health programs. When Congress passed the final IHS appropriation it added an additional $17.8 million to the President's request putting the final increase at $471.2 million. The budget included funding for neglected IHS programs by the previous Administration, such as an increase of $145 million for the Contract Health Service program. Congress added an additional $9 million to the President's request for Contract Support Costs, bringing the total increase to $116 million. The Administration's proposal to freeze non-security discretionary spending leaves in question the status of the IHS budget in FY 2011.

Tribal leaders anticipated a very good budget increase for the IHS in FY 2011 given the funding provided this year and following the Administration's commitments at the White House Tribal Nations Conference held on November 5, 2009. During her opening remarks, Kathleen Sebelius, HHS Secretary, underscored the Administration's commitment to Indian health issues by highlighting the sizeable increase that the IHS received in FY 2010. Secretary Sebelius remarked, "we took a big step forward last week when the President signed the Interior Appropriations bill into law giving more than $4 billion to the IHS for the 2010 fiscal year. Now that's a 13% increase over the last year and the largest increase in the Indian Health Service's in the last twenty years." Tribal leaders have testified before HHS and Congress that it is going to take some sizeable investments in the IHS budget to make up for the budget neglect of the previous Administration.

It seemed like an uncomplicated effort to garner support of the Administration for sizeable budget increases in the first two years of the President's term given his support in Congress to the IHS budget. While in Congress, the President voted to provide an additional $1 billion for IHS to address the abhorrent health disparities in Indian Country. He was an original co-sponsor of the Indian Health Care Improvement Act of 2007 and fought against the Bush Administration's attempt to eliminate urban health care for Indians not living in reservation communities. He also opposed a federal land acquisition program that would have diverted funds from the Special Diabetes Program for Indians and the Alcohol and Substance Abuse program. The President also campaigned on a commitment to uphold the responsibilities of the federal trust relationship and to address Indian health issues.

> *"So let me be clear, I believe treaty commitments are paramount law, I will fulfill those commitments as President of the United States. That's why I've cosponsored the Indian Health Care Improvement Act and that's why I am fighting to ensure full funding for Indian Health Care Services…"*
> Senator Barack Obama
> Crow Agency, Montana
> May 20, 2008

Looking Ahead

While the details of the President's budget are still pending, the Administration's proposal to freeze discretionary spending now puts at risk it's intended policy to support and fund Indian programs. While the White House Indian nation's conference was held two months prior to the Administration policy to freeze discretionary spending, it holds promise for continued support for Indian health programs by the Administration. Secretary Sebelius followed her comments on the IHS budget stressing, "...we see that as an important first step [2010 IHS budget] and that is not the end of the story. It is the beginning of a commitment to make sure there are excellent health services in this Country and we're going to continue to look for ways to continue that. I want to tell you that IHS is a priority in my FY 2011 budget which we are currently in the process of discussing."

Last year's President's budget of $3.6 trillion included $1.4 trillion in discretionary spending, with Congress finalizing its discretionary spending package at $1.37 billion. This amount includes supplemental spending unlike past practice of the previous Administration, which was to not include it[1]. While it's expected that the spending freeze would apply to a relatively small portion of the federal budget, it will likely impact IHS budgets—if not this year, then in the following. Of the $1.37 billion in last year's discretionary funding, approximately $477 billion was available for domestic agencies. The Pentagon, veterans programs, foreign aid and the Homeland Security Department would be exempt from the freeze. The three-year plan will be part of the budget that President Obama will submit on February 1st, and will begin by cutting $10-15 billion in the first year. The White House is under considerable pressure to cut deficits that hit a record $1.5 trillion this year.

Some programs may already know their budget fate. In May 2009, OMB released its "Terminations, Reductions, and Savings" report, which puts forward more than 120 cuts and reductions, totaling $17 billion. The report recommends cuts for programs that are duplicative, ineffective, or outdated. At the time, cynics said that we'd never be able to eliminate these programs – some of which had been around for decades. Fortunately, there were no Indian health programs contained in the OMB report.

Generally, Tribal leaders will agree that the report card on President Obama's Indian health and fiscal policy has been a solid "A". The discretionary freeze will certainly complicate the ability of the Administration to provide budget increases for IHS and Bureau of Indian Affairs' programs. And most likely we will not see the size of budget increase that the Administration and Congress provided the IHS in FY 2010. Tribes stand ready to assist the President to achieve fiscal responsibility, but at the same time, it is critical that current services of Indian health programs are maintained. Failing to fund inflation and population growth in health programs only translates to health service cuts. This means less care to address Indian health disparities. The FY 2011 budget will be a test of President's commitment to honor his campaign speeches and the commitments made at the White House meeting. Tribes are hopeful they can continue to give the President a high grade for his budget in FY 2011.

1 Congressional Budget Office, "FY 2010 House Current Status of Discretionary Appropriations", Jan. 1, 2010.

Northwest Portland Area Indian

by Sonciray Bonnell, Health Resource Coordinator

Delegates from Quinault, Chehalis, and Siletz visitng in the Oregon Conference Room

After twenty-two years in the same office building, the Northwest Portland Area Indian Health Board is happy to announce that we have moved our office from the Portland State University (PSU) campus to the Broadway Plaza building, just a few blocks from our old office. The Board would like to thank Phillip Archambault and Leroy Bigboy from the Native American Rehabilitation Association of the Northwest for blessing our new office – an essential part of preparing our new space.

NPAIHB occupies the entire third floor. Prior to moving in, we removed walls to provide an open work space for staff. Although there are some offices, most employees are in open work space units and clustered by project. After much research, we decided to purchase the open work space stations from Smith CFI and we are quite happy with the modern look of the units.

Some of the improvements we now enjoy include a working heating and cooling system; a shower; and spectacular views of downtown, Mount Hood, Mount St. Helens, and lots of green space. We increased our office space from 15,500 square feet to 16,000 square feet. As in the past, we recruited staff to serve on our Art Committee. This group collaborated and selected the carpet and paint colors, and the placement of our artwork.

The Board hosted an open house on Friday, January 22, 2010 for our delegates, partners, neighbors, and community members. We had about 100 guests show up with a steady stream of guests coming in at 2:30 till 6:00. We felt it was a good turnout. A lot of people and families came in and filled the lobbies and hallways with positive comments and a lot of smiles throughout the evening.

Special thanks to Board staff who planned the event, selected the food and beverages, provided assistance in the parking lot, shuttled guests to and from parking lots, provided tours, and greeted our guests. Teamwork at its best! Beautiful flowers arrangements were received by Jim Mears and Yellow Hawk Indian Health Center & Health Commission.

Please come by for a visit if you missed our open house. We continue to encourage our tribal Delegates and Board partners to consider using our conference rooms for trainings and meetings. And if you've ever been to the Board, you know our staff is friendly, we enjoy occasional bursts of loud laughter, and we welcome visitors.

Health Board Has Moved Offices

Regardless of where we are located, we will continue to fulfill the mission of the Northwest Portland Area Indian Health Board: "To assist Northwest Tribes to improve the health status and quality of life of Northwest tribes and Indian people in their delivery of culturally appropriate and holistic health care."

NPAIHB
Broadway Plaza Building
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Steve Kutz from Cowlitz in front of the 43 NW tribal logos.

Chair's Report

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facilities to address the needs of our veterans.

On November 19th, I was in Portland for our Portland Area Budget Consultation meeting. This meeting provides us the opportunity to identify our health and funding priorities that will be presented at the IHS National Budget consultation meeting in February. I will serve as the Portland area representative and Eric Metcalf will serve as our alternate. The meeting is the same week as our Quarterly Board Meeting being held in Alexandria, VA, and I hope that some of our delegates can make it over to this meeting to see how the budget is developed at the national level.

On December 8, 2009 Julia Davis Wheeler and I attended Dr. Roubideaux's IHS Tribal Consultation meeting as your Portland Area representatives. During our meeting, we conveyed that the IHS has done an effective job at Tribal consultation, but there is always room for improvement to make the consultation process more meaningful. While IHS headquarters does an effective job at identifying issues that might require Tribal input, this process does not seem to be consistent at the Area Office level. A key concern that I brought to the table and you've heard me talk about before is that the Executive Agency budgets are embargoed by OMB. The IHS Director must bring back transparency to the budget formulation process. It's impossible to conduct effective Tribal Consultation without it.

How can Tribal leaders make recommendations on funding issues without knowing completely what the Department, OMB, or the Agency guidelines are or what the funding limits will be? We cannot just accept such requirements when they are not consistent with tribal consultation.

The nice thing about the holiday season is that travel does wind down but not completely as my report shows. It is calm before a storm of travel that will begin in January through May as we gear up for HHS consultations and appropriations. While I enjoyed it, I am ready to go in 2010 and I hope you all are too!

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2011 and spreads payments over a 6-year period with a first-year payment of up to $21,250 and five subsequent annual payments of up to $8,500. The eligible professional must demonstrate meaningful use of a certified EHR by the second payment year. A Medicaid payment schedule is displayed below.

In addition to the Medicaid provider incentives, certain professionals can receive a one-time incentive payment for up to 85% of net average allowable costs (not to exceed $25,000 or less based on HHS studies of average costs) for the purchase, and initial implementation and upgrade of a certified EHR technology, including support services and training. After acquiring an EHR and receiving the first incentive payment, eligible professionals can then receive incentive payments for up to five years for the net average allowable costs to operate, maintain, and use their EHR (allowable cap per year is $10K or less based on HHS studies of average costs) if they meet the definition of a meaningful EHR user in accordance with regulations to be established. A Medicaid provider who has completed adopting and implementing, or upgrading to a certified EHR technology prior to 2011 must be a meaningful EHR user to receive the first payment as well as subsequent payments.

RPMS Certification

The IHS Resource Patient Management System (RPMS) has received provisional certification for meeting the 2007 testing criteria by the Certification Commission for Health Information Technology (CCHIT), which prior to the HITECH Act was the sole certification body for EHR systems. The continued certification of RPMS as a certified EHR technology will be driven largely by the "Meaningful Use" criteria that is currently being developed. The criteria will establish the Secretary's adoption of an initial set of standards, implementation specifications, and certification criteria for EHRs. Certifying RPMS will mean that it has met the minimum government requirements for security, privacy, and interoperability, and that it can produce the meaningful use results that the CMS expects.

The IHS website (www.ihs.gov/recovery/index) states that, "in order to ensure that its customers - IHS Federal/Tribal/Urban hospitals and clinics - are positioned to be eligible in 2011 for financial incentives based on meaningful use of certified EHR, the IHS intends to seek recertification of RPMS as an ambulatory EHR, as well as initial certification of RPMS under the inpatient EHR criteria, both in 2010. Certification of RPMS as a behavioral health add-on to ambulatory EHR is planned in 2011. In addition, IHS will seek certification for health information exchanges (HIE) when it is available." Many anticipate that the RPMS system will meet the certification requirements and can produce meaningful use results required.

Incentive Payments: State Administration

CMS has issued guidance to State Medicaid Directors (SMD Letter #09-006) on funding and initial planning for State administration of Medicaid provider incentive payments. The CMS guidance includes a description of the process by which States can receive the 90 percent match for initial planning activities related to the administration of incentive payments. CMS advises that States can immediately request the 90 percent match for initial planning regarding the design and development of a State Medicaid HIT Plan (SMHP), and should submit and receive approval of a HIT Advance Planning Document prior to initiating planning activities and expending funds. The guidance in the Letter is described as "preliminary" and focuses on the planning aspect rather than the actual implementation of the SMHP.

Incentive Payments

States have applied and received 90% FFP funds to begin administrative planning for the Medicaid incentive payments. It is important for the Tribes to engage with State Medicaid programs on how IHS and Tribal EHR systems and providers will meet the meaningful use requirements and to ensure that they are able to track such use, consistent with federal rules. For example, Oregon's Health Information Technology Oversight Council (HITOC) has been charged with developing a statewide strategic plan for electronic health information exchange, coordinating public and private efforts to increase adoption of electronic health records, setting technology standards, ensuring privacy and security controls, and creating a sustainable business plan to support meaningful use of health information technology. It is anticipated that this work will in part be financed by the 90% FFP funds under the Medicaid incentive payments. Similar activities are underway in Washington and Idaho.

It is important that Tribes work with their States at the front-end of implementing the Medicaid payment incentives. The states have already begun working to gather information on barriers to the use of EHRs, provider eligibility for EHR incentive payments, and the creation of State Medicaid HIT Plans, which will be used to define the state's vision for its long term HIT use. It will be important for Tribes to request that States address this issue over the next year in our State/Tribes meetings as implementation gets underway.

HIT - Upcoming Meetings

"Second Annual Multi-State Health IT Collaborative for E-Health Conference": February 8, 2010, Washington, D.C., Grand Hyatt Hotel. State-Tribal Affairs Panel focusing on how States can effectively include IHS and Tribal health partners in HIT planning and implementation of the Medicaid Incentive Program. www.blsmeetings.net/CMSHealthIT2010/

"Indian Health Information Management Conference": May 11-14, 2010, Scottsdale, AZ, Scottsdale Plaza Resort. Meaningful Use Track will provide information on the new standards, implementation specifications, and certification criteria for EHR set forth by the Office of the National Coordinator for HIT and requirements to achieve meaningful use of certified EHR technology.

H1N1 Grant for Oregon

Portland, January 29, 2010 - The Department of Human Services has awarded the NW Tribal Epidemiology Center $37,500.00 for 2010 to enhance work on H1N1 preparedness with the Oregon Tribes and thus all hazards preparedness.

The EpiCenter proposed development of an on-going annual strategic plan for effective influenza preparedness including; communicating risk, community preparedness and individual preparedness. Additionally we will collaborate with the State of Oregon, Tribal Health Clinics, and County Health jurisdictions to assist in development of appropriate health messages related to all aspects of pandemic flu awareness and preparedness.

It is our hope that these efforts will enhance our emergency preparedness efforts not only in Oregon, but also Idaho and Washington.

Severe Cuts for STD and HIV

Robert Foley, Executive Director, National Native American AIDS Prevention Center
Stephanie Craig Rushing, NPAIHB Project Director, Project Red Talon

The *National Native American AIDS Prevention Center* (NNAAPC) has worked nationally with tribes, community-based organizations, and health departments across the country to strengthen and enhance their HIV prevention programming for over 22 years. Similarly, *Project Red Talon* has worked for the 43 Northwest tribes for over 20 years to prevent sexually transmitted infections (STDs and HIV/AIDS), as the longest funded health promotion project at the Northwest Portland Area Indian Health Board.

Tragically, funding for both projects was severely cut in the Fall of 2009. These cuts were caused by a disheartening shift in policy by the Centers for Disease Control and Prevention (CDC), which de-prioritized STD/HIV prevention in American Indian, Alaska Native, and Native Hawaiian communities. As a result, NNAAPC and Project Red Talon, which have a strong history of collaboration and partnership, have both been forced to re-evaluate their levels of service, re-allocate funding, and reduce staffing. As a result of this policy-change, Native communities will not be able to receive the culturally-specific training, policy advocacy, outreach and education, and materials that were previously available through NNAAPC and Project Red Talon, and in the future, Tribes will have to rely upon non-Native organizations to obtain many of these services. This shift in policy is particularly surprising given Congress's focus on primary prevention in the national healthcare reform agenda, the CDC's desire to reduce health disparities through the *National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention* (NCHHSTP), and the Indian Health Service's sustained focus on health promotion and disease prevention. Both the Senate and House health reform bills include Medicaid expansions and grants to states and local governments to promote public health and provide services to individuals affected by HIV. Without funding to sustain current STD/HIV programs, Tribal programs like NNAAPC and Project Red Talon will be less competitive when applying for such funds, due to reductions in staffing and organizational capacity caused by core funding cuts.

The CDC had provided the backbone of NNAAPC's funding since their inception, and has allowed them to function effectively as a national resource, meeting the vastly diverse needs of Native communities. For the first time in 2009, the CDC did not fund a Native-specific organization to provide nationwide capacity building assistance on the delivery and evaluation of effective HIV prevention interventions and organizational development. As a result, NNAAPC saw an over a million dollar decrease in its operating budget.
Likewise, Project Red Talon's core funding was administered by the CDC as a result of a FY-2004 Labor-HHS Appropriations bill, which provided $1 million to bolster tribal capacity to prevent, screen for, and treat sexually transmitted infections. Funding and oversight for the project was then transferred to the Indian Health Service in 2007. During this period, Project Red Talon was funded at approximately $200,000 per year, reaching a service population of nearly 100,000 Indian people in the Pacific Northwest – a per capita expenditure of $2. In reality, few other native-specific STD prevention programs exist in the U.S., and Project Red Talon's services and materials were used widely throughout Indian Country.

The Cost of Inaction. Given limited health service budgets, sexually transmitted infections can pose a sizable economic burden if not adequately addressed. Data suggests that each case of chlamydia acquired by a woman in the U.S. costs $244 (accounting for direct medical expenses associated with treatment and sequelae resulting from untreated infections), and each case of gonorrhea costs $266. The lifetime cost of HIV treatment is also substantial, averaging $618,900 per person in 2006. Based on these estimates, the NW Tribes spend over $215,000 on reported chlamydia and gonorrhea cases per year for Native youth. By keeping people from becoming infected, STD/HIV prevention programs not only save lives and protect health, but they also reduce the number of people needing expensive medical treatments.

Prevention in Indian Country

National and Regional STD/HIV Data

American Indians and Alaska Natives are disproportionately impacted by high rates of sexually transmitted infections. In 2007, chlamydia rates for AI/ANs were 4.5 times higher than rates reported among Whites, gonorrhea rates were three times higher, and syphilis rates were twice as high. For all ethnicities, STD rates are highest among young people aged 15-24. In the Pacific Northwest, over 800 AI/AN youths age 10-24 were diagnosed with chlamydia in 2005.

While many STDs can be easily treated or cured with medication, the consequences of untreated STDs can be severe, including: infertility, pregnancy complications, cervical cancer, pelvic inflammatory disease. STDs also increase vulnerability to HIV. People infected with an STD are 2-5 times more likely to become infected with HIV when exposed.

Altogether, more than 3,200 AI/ANs have been diagnosed with AIDS since the beginning of the epidemic, and currently have one of the highest rates of new HIV infections (14.6 per 100,000 persons). In 2007, young people under the age of 25 made up 19% of all AI/AN HIV/AIDS diagnoses. Due to late testing and suboptimal treatment, AI/ANs currently have one of the lowest survival rates of any ethnic group, with just 1 in 4 individuals living more than 3 years after their diagnosis. Washington is among the five states with the highest numbers of reported AI/AN AIDS cases, which together account for more than half (53%) of the AIDS diagnoses in Indian Country.

Act Now. In September, seven U.S. senators (Daniel K. Akaka [D-HI], Max Baucus [D-MT], Mark Begich [D-AK], Maria Cantwell [D-WA], Tim Johnson [D-SD], Lisa Murkowski [R-AK], and Jon Tester [D-MT]) sent a letter to the CDC, urging the agency to create a distinct funding stream for a *National Native HIV/AIDS Resource Center* that would support prevention programming, data collection, training, and technical assistance activities in Native communities. The same must be done to support STD prevention and treatment in Indian Country, creating a *National Native STD Resource Center*.

Please speak to your elected officials in Washington, DC, and urge their support for the creation and funding of Native-specific STD *and* HIV prevention programs.

New NPAIHB Employee

Hello! My name is Colbie Van Eynde and I am the new Suicide Prevention Coordinator at NPAIHB. I recently earned a Master's degree in Public Health at Portland State University. I have prior work and volunteer experience focusing on sexual and reproductive health, but am interested in suicide prevention, diet and nutrition, and adolescent health as well. Over the past month and a half I have thoroughly enjoyed my time at NPAIHB, and am excited to be a part of your future successes. On a personal note - I grew up around the Seattle area and have lived in the Pacific Northwest my whole life. I love to travel (primarily to developing countries), listen and dance to good music, cook and eat good food, and spend time with my family, friends, and two dogs.

Oregon Health Information Exchange and Oregon Tribes

2010 Census
continued from page 3

address lists and to conduct follow-up interviews with people who fail to complete and return a census questionnaire by mail.

An important aspect of tribal members' participation in census data collection or the American Community Survey is the proper record keeping of addresses on the reservation. With the success of tribal governments, came the housing boom meant to move our tribal members back on the reservation (home). Lack of accurate tribal housing record keeping will lead to under representation of American Indians in either the ACS or census count. Tribal governments can ensure their new housing developments are included in the potential houses to be surveyed by registering with the Local Update of Census Addresses (LUCA). LUCA allows participating governments to review, correct and update the Census Bureau's address list. The information contained in the address list is confidential by law. Governments participating in the LUCA program and reviewing the Census Bureau's address list must take an oath to protect the information they review. Like all census employees, those who review and update confidential address lists are subject to a jail term, a fine or both if they disclose any protected information.

To ensure that our membership receives the proper allocation of federal resources and legislative representation, stand up and be counted.

The State of Oregon is currently negotiating its Cooperative Agreement with the Office of the National Coordinator for Health Information Technology (ONC). Oregon has been awarded $8.58 M over four years for use in the planning and implementation of a statewide Health Information Exchange (HIE).

It's expected that OCHIN and OHSU will be chosen as Oregon's Regional Extension Center (REC). The REC will be charged with identifying and providing the myriad of services and support required by providers in order to ensure they can meet the Meaningful Use standards as defined by ONC and the Centers on Medicaid and Medicare Services (CMS).

The State's current planning process is being overseen by the Health Information Technology Oversight Council (HITOC). This is an eleven member, Governor appointed, Senate confirmed council that meets monthly to develop recommendations for the establishment of a statewide HIE. Sharon Stanphill, Cow Creek Tribe, is a member of this committee.

The State is also working with public and private partners to develop loan programs to assist providers in the start-up funds for Electronic Health Record (EHR) purchases.

Tribal Community Status

To date, the state has surveyed all nine Oregon Tribes regarding their EHR adoption, usage and status. We are still awaiting a few responses, but we have begun to analyze and synthesize the information we have received.

The state wants to ensure we include the nine Oregon Tribes as part of our strategic planning efforts and that all nine Tribes have access to the services and supports they need in order to meet the Meaningful Use standard. To this end, we would like to meet with the Tribes in order to determine:

- Tribal needs with respect to EHR adoption and implementation;
- Tribal access to ARRA funds set aside specifically for Tribal EHR adoption and implementation
- Likelihood of Tribes qualifying for Medicaid/Medicare incentives under ARRA
- Best communication strategies
- Other issues of concern

HITOC will continue to seek tribal input via the Northwest Portland Area Indian Health Board. For more information about HITOC visit their website at http://www.oregon.gov/OHPPR/HITOC/index.shtml

Suicide Prevention

by Stephanie Craig Rushing, Project Director

The Northwest Portland Area Indian Health Board is pleased to announce the receipt of new funding from the Indian Health Service (IHS) to provide regional support for the *Methamphetamine and Suicide Prevention Initiative* (MSPI).

These funds will be used to implement the *Northwest Suicide Prevention Tribal Action Plan* which was collaboratively written in 2008, with input from the NW Tribes, IHS, Youth Treatment Centers, Tribal and Public Schools, OHSU, PSU, UW, State agencies, NARA, and the Education Development Center – Suicide Prevention Resource Center.

To read the *Northwest Suicide Prevention Tribal Action Plan* in full, please visit: www.npaihb.org/health_issues/suicide/.

The mission of the action plan is to: **reduce suicide rates among American Indians and Alaska Natives living in the Pacific Northwest by increasing tribal capacity and improving regional collaboration.**

In carrying out its work for the MSPI project, NPAIHB will develop and disseminate culturally-appropriate prevention materials and resources, provide suicide prevention training and technical assistance, and offer financial support to NW tribes who are interested in implementing suicide prevention activities in their local communities. An application for suicide prevention "mini grants" will be released in the next few months, and will total $100,000 per year for the NW tribes.

This award money has allowed NPAIHB to hire a part-time Suicide Prevention Coordinator, Colbie Van Eynde, MPH. Colbie was hired and began her journey at NPAIHB on November 30, 2009. She is a recent graduate from Portland State University, and has a background in reproductive and sexual health outreach, in addition to interests in suicide prevention and healthy lifestyles. Welcome aboard Colbie!

Contact information for the MSPI project is: (503) 228-4185

Stephanie Craig Rushing x 290
Project Director
Lisa Griggs x 269
Project Coordinator
Colbie Van Eynde x 284
Suicide Prevention Coordinator

Suicide is an issue of great concern to many NW tribes. In recent data from the CDC, suicide was the second leading cause of death for American Indian and Alaska Native teens and young adults. In many cases, Native suicide rates more than double the state and national average. According to the Indian Health Service (IHS), the Oregon, Washington, and Idaho region has one of the higher AI/AN suicide death rates among IHS service areas. From 1996-1998, the age-adjusted suicide death rate for the Portland Area was 22.0 per 100,000, a rate exceeded only by the Aberdeen, Alaska, Bemidji, and Tucson areas.

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.

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Northwest Portland Area Indian Health Board
October 2009 Resolutions

RESOLUTION #10-01-01
Support for Western Tribal Diabetes Projects' Application to the Special Diabetes Program for Indians Request for Applications to Receive Continued Funding under the SDPI Program

RESOLUTION #10-01-02
Recommendation for Andy Joseph, Jr. and Julia Davis to sit on the IHS Director's Tribal Consultation Workgroup

RESOLUTION #10-01-03
Hold Harmless Protections at Section 192 of the Reauthorization of the Indian Health Care Improvement Act (S. 1790)

RESOLUTION #10-01-04
Recommend the Endorsement of a Demonstration Project or Projects for a Regional Specialty Care Facility for the Portland Area