Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

January, 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.

Delbert Frank *Violet Hillaire* *Mel Sampson*

Original signers of the Northwest Portland Area Indian Health Board 1979 Articles of Incorporation. NPAIHB Celebrates its 35th Anniversary.
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In This Issue

From the Chair:
Linda Holt

It seems as it was just yesterday that we were in Muckleshoot celebrating our 30th birthday and here we are celebrating our 35th Anniversary. Imagine that for a moment, since 1972, the Board has provided thirty-five years of continuous service to Northwest Tribes and is still going strong. This accomplishment could not have come without the support of Northwest Tribal leaders and our Delegates. We should all take pride in our support of the Board and the fact that we have all worked hard for thirty-five years to make this organization what it is.

One of the simplest things to gauge commitment and support of the Board is attendance at our Quarterly Board Meetings. I am proud of the fact that for at least the last nineteen years we have never failed to establish a quorum for our meetings. This isn't an easy feat when you consider that we have forty-three Tribes as members of the Board. How often have you attended meetings of smaller bodies and had difficulty establishing a quorum? It is not easy but you all have done it! This is a very simple example of your commitment to our organization but it speaks for itself. It's this type of commitment that has allowed our organization to accomplish its work and develop programs to the point were we are recognized as a national leader on Indian health issues.

For thirty-five years now, the Board and Northwest Tribes have worked diligently to promote Indian Self-Determination and consensus on health issues nationally. It is no coincidence that early initiatives to promote Indian self-determination on issues like contract support costs, the self-governance movement, and development of key Indian health legislation have their roots in the Northwest. Many of the health policy issues that we work on today have evolved through the course of Indian self-determination as Tribes have taken over management of health programs.

Our priority areas for work are guided by our strategic plan and include Legislative and Policy Analysis, Technical Assistance and Training, Health Promotion and Disease Prevention, and Surveillance and Research. I am proud of the fact that the Board and its staff have worked hard to advance Indian health concerns under these priorities. On every priority area we have made progress and continue to grow and develop new opportunities for Tribes.

For example, our presence in Washington D.C. and in state capitols has served positively to influence health policy and budget issues affecting Tribes. Our annual budget analysis is often cited in many government and Congressional reports and is used by Tribal leaders nationally to develop their own recommendations. Three years ago the Board convened a National Roundtable on Medicaid Reform in conjunction with key health policy organizations

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From the Executive Director:

Joe Finkbonner

During the final quarter of 2007 I was able to attend a meeting that was particularly noteworthy and I wanted to share some of the information with you. The meeting was sponsored by SAMHSA and CDC for HIV prevention. What caught my attention most during the meeting was the efforts taking place by the tribal programs on HIV prevention. There was a significant amount of discussion focused on the new HIV tests that are rapid response and the role they could play in the clinical and non-clinical settings. This piqued my interest so much that I wanted to gather more information about HIV and the rapid test and the following paragraphs are excerpts from the Pharmacist Letter ® and do cover of the salient issues.

Over the last decade, the HIV epidemic has reached phenomenal global proportions, although the epidemic showed signs of slowing down in 2006. At the end of 2006, the Joint United Nations Programme on HIV/AIDS estimated that worldwide 39.5 million persons, of which 17.3 million are women, 2.3 million are children less than 15 years of age, and 2.8 million are adults aged 50 years or older, were living with AIDS. An estimated 4.1 million new HIV infections occurred worldwide while 2.8 million died of AIDS during 2005. In total, HIV/AIDS has claimed the lives of 22 million people and has infected about 65 million people worldwide.

Approximately 1.2 million people are living with HIV/AIDS in the U.S. for a prevalence of 0.6%. Of these, approximately 6500 are elderly patients aged 60 years or more. In Canada, the epidemic is smaller (0.3% prevalence), affecting about 60,000 people. Of the estimated 40,000 new HIV infections in the U.S. every year, more than half occur in black men and women. Rates of infection are also increasing in the Hispanic, Asian, and American Indian/Alaska native populations.

The most recent statistics available through 2004 indicate that approximately 530,000 people, including 5,515 children less than 13 years of age, have died from HIV/AIDS in the U.S. since the beginning of the epidemic in the early 1980s. In 2004, 16,000 deaths were attributed to HIV/AIDS infection. Since the mid-1990s, the mortality picture has improved dramatically, thanks to the introduction of highly active antiretroviral drug combinations. In fact, since 1995, deaths have declined more than 70% and AIDS is no longer included among the top 15 leading causes of death. However, among 25-44 year olds, it remains the sixth leading cause of death.

Approximately 24% to 27% of HIV-positive people in the U.S. are undiagnosed and unaware of their infection and could spread the infection. Therefore, to identify these individuals sooner, the CDC in September 2006 recommended that all persons aged 13 to 64 years of age, including pregnant women, those starting tuberculosis (TB) therapy, and those seeking treatment for a sexually transmitted disease (STD), receive

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Northwest Portland Area Indian Health Board

Projects & Staff

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Verné Boerner, Administrative Officer
Bobbie Treat, Controller
Mike Feroglia, Business Manager
Debi Creech, Accounts Payable
Chandra Wilson, Human Resource Coordinator
Elaine Dado, Executive Administrative Assistant
Kristyn Bigback, Office Manager

Program Operations
Jim Roberts, Policy Analyst
Sonciray Bonnell, Health Resource Coordinator
James Fry, Information Technology Director
Chris Sanford, Network Administrator

Northwest Tribal Epidemiology Center
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Tom Becker, Medical Epidemiologist
Tom Weiser, Medical Epidemiologist
Ticey Casey, EpiCenter Project Coordinator
Tam Lutz, PTOTS Director
Crystal Gust, PTOT's & MCH Project Specialist
Amanda Wright, PTOTS Project Assistant
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Katrina Ramsey, WTD & Epi Project Specialist
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Lisa Griggs, PRT Project Assistant
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Birdie Wermy, Data Into Action Project Specialist
Jaci McCormack, TECC Project Specialist
Linda Frizzel, Methamphetamine Data Director
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Michelle Edwards, Development Specialist
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Luella Azule, NTRC Project Coordinator

Western Tobacco Prevention Project
Terresa White, WTPP Project Coordinator

National Tribal Tobacco Prevention Network
Gerry RainingBird, NTTPN Project Director

Northwest Tribal Cancer Control Project
Kerri Lopez, NTCCP Project Director
Eric Vinson, Survivor & Caregiver Coordinator

NPAIHB Celebrates

by Sonciray Bonnell, Health Resource Coordinator

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.

Early NPAIHB staff

The Northwest Portland Area Indian Health Board (NPAIHB or Board) is a tribal organization as defined by Public Law 93-638 and a 501(c)(3) non-profit organization that represents the forty-three Federally-recognized American Indian tribes in Washington, Oregon, and Idaho. Formed in 1972, NPAIHB was established to represent tribal health concerns before the Indian Health Service (IHS) and other federal and state agencies. We are proud to be celebrating thirty-five years of working toward improving the health of American Indian/Alaska Native communities, and do not take for granted all that we've achieved thus far.

Northwest tribes have a long shared the value of health, keeping it a high priority and committing resources to improving the health status of their people. From that, they have created an exemplary unified approach when addressing health issues affecting their communities and it is this unity that is the strength of NPAIHB. This unity is supported and facilitated by an institutional memory and trust through NPAIHB, whereby the Tribes might concede on one issue and their concession is considered on the next issue. This allows parity across time as at any given point there may be an individual cost to a tribe, however those tribes are able to keep in mind and have faith in the bigger picture. Northwest tribes, having created and supported NPAIHB through all the challenges, are truly visionary.

Over the past thirty-five years, the keys to NPAIHB's success are: the tribal unity in Indian health issues and our organizational stability in its leadership. The governing board is comprised of a Delegate designated by the tribal government of each of the forty-three member tribes. A five-member Executive Committee works closely with the Executive Director to oversee NPAIHB activities. We have not failed to establish a quorum in nineteen years. Through a resolution process, Delegates vote to approve our activities, thereby providing tribal input on policy that is both regional and national. NPAIHB provides leadership nationally through varied and specialized, in depth workgroups.

In partnership with IHS, NPAIHB works to strengthen and improve the delivery of health services to Indian communities throughout the Northwest. NPAIHB helps identify and rank unmet health needs, then works with tribal leaders and IHS to plan on how to meet those needs.

Board Delegates are progressive and participatory in setting the national agenda for American Indian health care and are nationally renowned for their knowledge and advocacy work on Indian health issues. Specifically, some of our delegates have served as Chair of National Congress of American Indian, Chair of the National Indian Health Board, director of the Native American Research Center, and several who are or have been Tribal Council Chairs for their tribes.

NPAIHB's Strategic Plan maps our priorities, organizational values, mission, and health issues and concerns. With the competing issues to attend to, Delegates and staff use the strategic plan to hone in on issues that our Delegates have named our priority and how best to approach our goals. The document identifies our four

35th Anniversary

functional areas: Health Promotion Disease Prevention, Legislative and Policy Analysis, Training and Technical Assistance, and Surveillance and Research. The document is updated every five years through a series of Strategic Planning meetings where delegates evaluate progress, reaffirm or set new priorities, and revisit the Mission. As consistent leadership has marked this organization over time, so too is that consistency reflected in the Strategic Plan and the Board's Mission; the Strategic Plan and its defined priorities have facilitated the growth of this organization, keeping all activities true to the spirit of the intent of our founders.

NPAIHB has grown from four original contracts to approximately thirty active projects and contracts. NPAIHB also features several archived projects; descriptions of all are available on our website. While our core funding comes from the Indian Health Service PL 93-638 contract, NPAIHB seeks funds from federal and state agencies, as well as private foundations. NPAIHB currently utilizes funds from many sources, each approved via resolution from our Delegates. A current sampling of our funders include: the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), National Cancer Institute (NCI), the Robert Wood Johnson Foundation (RWJF), and Oregon State Health Department.

All policies, procedures, issue papers, and grant applications are approved by our Delegates at our Quarterly Board Meetings or via resolution. Clearly, our Delegates direct and are informed on all activities of the Board.

LtoR: Cheryle Kennedy (Grand Ronde), Joe DelaCruz (Quinault), Nancy Murillo

Advocacy

NPAIHB facilitates consultation between Northwest tribes, IHS, and state and federal agencies; provides information and political advocacy to tribes on health related legislation, regulations, and policy; and contributes to the Indian Health Service budget analysis. We have successfully educated state and federal governments on tribal sovereignty and its benefits in the areas of Medicaid, welfare reform, and health programs. This is particularly meaningful to us as national, state and local goverments as well as federal agencies have been reluctant or slow to recognize tribal sovereignty. In many cases, counties and tribal governments have often had adversarial relationships; however, we are proud of our collaborative relationships with the states of Oregon, Washington, and Idaho. Each state and their respective tribes meet quarterly to discuss upcoming legislation, concerns, and plans for improving health services to Indian communities. More and more, state and federal agencies are recognizing tribes as experts in identifying their own community needs and providing solutions that work for them.

In our role as advocate and analyst, our tribes have made great strides in the administration of Medicare and Medicaid. NPAIHB was a major author of PL 93-638 Indian Self-Determination Act 1992 amendments. We participated in the drafting of PL 94-437 Indian Health Care Improvement Act (IHCIA) and remain integrally involved in the efforts to reauthorize the IHCIA.

EpiCenter

NPAIHB and Northwest Tribal leaders were key players in the conceptualization of tribal epidemiology centers seeking specific appropriations from Congress to establish such centers. In 1997 our efforts were met with success as we effectively competed for one of two grants to establish the Northwest Tribal Epidemiol-

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NPAIHB Celebrates 35th Anniversary

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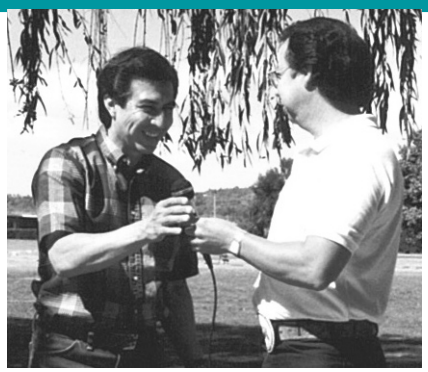
ogy Center (EpiCenter). Since then our EpiCenter has continued to grow and is the largest tribal epidemiology center in the nation. Our EpiCenter provides epidemiological and programmatic support on a variety of health issues and gathers extensive health data from tribes. Tribal projects that engage in capacity building at the local level have access to EpiCenter trainings in data collection and management, surveillance and support, and awareness and prevention strategies. These activities are designed to enable the local sites to continue the work of the projects independently, evaluating and customizing their own programs to best suit the needs of their communities. With the increase and improved quality of data, our tribes can better decide which health promotion and disease prevention programs to engage in.

The EpiCenter also works closely with state and federal agencies to address data and surveillance issues, including assessing how data is used, barriers and limitations of current data, and improvement of data registries to increase accuracy of such state registries that feed national registries. The EpiCenter engages in cutting edge health research, which contributes to all aspects of the Board's four functional areas.

NPAIHB Operations

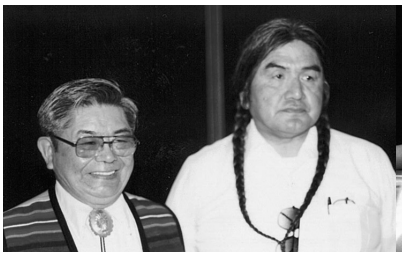
NPAIHB continues to attract some of the best talent in Indian Country with 80% staff either enrolled in or a descendant thereof a federally recognized tribe. We've had many staff return to work for NPAIHB after time away going to school or working for another agency; we have several staff who have contributed over ten years plus years of service; for an entity dependent on grant-funded projects – most with grant periods of one to five years, this is significant. There are several factors that can explain our highly qualified staff. NPAIHB has an excellent benefit package based in the values of Northwest Tribes. NPAIHB operations, policies and benefits are reflective of our tribes' collective values, as demonstrated by the following policies: health care benefits for regular employees, either spouses or domestic partners, and dependents; infant children are allowed to come to work with parents until they are six months of age; wellness time; and education leave just to name a few. Moreover, staff feel appreciated by the tribes and feel their work makes a difference.



LtoR: Don Davis, former Portland Area IHS Director and Mel Tonasket. former Delegate

Awards include Oregon's 100 Best Companies 2004 and 2006, the Harvard Honoring Nations Award 2005, as well as numerous individual staff awards.

Our keen appreciation for our tribes and tribal sovereignty is at the foundation of the work we do and the battle we continue to fight in the arena of Indian health. Exemplary and dedicated staff afford NPAIHB the opportunity to develop and implement award winning health projects and research. So our hats go off to the forty-three tribes of Oregon, Washington, and Idaho, whose vision and dedication allow us to perform such meaningful work. Thank you Northwest Tribes!



LtoR: Raymond Burke and Anthone Minthorne

Judy Muschamp (Siletz)

Charlotte Herkshank (Warm Springs)

Pearl Capoeman-Baller (Quinault)

Norma Peone (Coeur d'Alene)

Tooth Decay – A Significant Health Problem for American Indian Children

by Kathy Phipps, DrPH, Dental Epidemiology Contractor for the Northwest Tribal Dental Support Center

As soon as a baby's first teeth appear – usually by age six months or so – the child is susceptible to tooth decay which usually begins with the upper front teeth, then moves on to the molars. This condition is referred to as Early Childhood Caries (cavities) or ECC. While many people consider tooth decay in baby teeth to be an insignificant problem, severe ECC has been shown to cause pain, premature tooth loss, failure to thrive, plus speech, hearing, eating and sleeping problems. In addition, ECC is one of the major causes of hospitalization in young children. During 2007 two children died because of infection caused by decayed teeth.

ECC is a significant health problem for American Indian preschool children. Approximately 79% of Indian children between 2–5 years of age have tooth decay, making it the most prevalent chronic disease among young Indian children. In addition, Indian children carry a disproportionate burden of ECC compared to all other racial and ethnic groups; with a prevalence of 19% in white, 29% in black, and 41% in Hispanic children of the same age. Worse still, the *severity* of decay (measured by the number of decayed teeth) is 5-times higher in Indian children compared to the general U.S. population. Using data from their 1999 Oral Health Survey, Indian Health Service has estimated that, on average, each American Indian child between 2–5 years of age needs 11 dental services and approximately 3 hours of "chair time" to complete their care. Because of the complex nature of care needed, 36 percent of these young children would require four or more visits to the dentist.

Even though non-Indian children have ECC, it is rarely severe enough to require in-hospital care. For example, in New York State less than 1% of 3-4 year old children have tooth decay so severe that they require in-hospital care. Compare this to one Northwest Indian community were 65% of 3-5 year old children either have had or need in-hospital care. Not only is in-hospital care expensive, about $5,000 per child, it puts the child at risk of complications associated with general anesthesia.

While it is well documented that Indian children have the highest prevalence and severity of ECC, there is no research to determine why Indian children have more tooth decay. It has been speculated, however, that Indian children are at higher risk for three different reasons. First, very young Indian children may have higher levels of the bacteria (mutans streptococci) that cause tooth decay. Second, Indian children may have a more virulent type of the cavity causing bacteria that leads to more severe tooth decay. Lastly, exposure to a diet high in sugar starting early in life increases the likelihood that Indian children will have severe tooth decay.

Preventing ECC in our children is an important, yet complex, issue. To have an impact on the prevalence and severity of this disease we will need to:
1. Increase the number of dentists providing care to our service population. Since most children get the cavity causing bacteria from their mothers, it is important that pregnant women and new mothers have all of their active decay treated.
2. Provide regular, 2-6 times per year, fluoride varnish treatments to all children starting as soon as the child's first tooth erupts
3. Encourage parents to limit their child's intake of foods and beverages that are high in sugar.
4. Encourage parents to begin brushing their child's teeth two times per day with a fluoride containing toothpaste as soon as the first tooth erupts.
5. Encourage parents to take their child to the dentist when the child is 12 months old and every 6-12 months thereafter.
6. Increase the number of dentists who can competently treat very young children.

FY 2008

by Jim Roberts, Policy Analyst

After passing four continuing resolutions, Congress on December 18th finished its work on the federal budget for fiscal year 2008 by sending a $2.9 trillion package (H.R. 2784) to President Bush to sign. The President signed into the law the omnibus appropriation package on December 26th bringing to close an appropriations showdown between the Democratic Congress and the Administration. The FY 2008 budget includes $933 billion in discretionary spending, the amount the Bush Administration preciously 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, the Congress approved a budget that called for $955 billion in discretionary spending, however, backed off its request due to White House threats of a Presidential veto. The Democratic Congress fought bitterly with President Bush over the $22 million difference. President Bush stated that he would veto any spending bill that contained more discretionary funding than its own request and continually labeled the Democratic bills "irresponsible and excessive." Seemingly under the veto threats, the Congress complied with the President's demands and sent a discretionary package that did not exceed his request.

FY 2008 Omnibus Appropriations
Comparing IHS Budget to Five HHS Health Agencies

Agency	FY 2007 Enacted	FY 2008 President's Request	Omnibus H.R. 2764	Increase/ Decrease	Change
IHS	$ 3,180	$ 3,271	$ 3,346	$ 166	5.2%
CDC	$ 6,266	$ 5,983	$ 6,376	$ 110	1.8%
CMS	$ 350,564	$ 401,005	$ 400,517	$ 49,953	14.2%
Medicaid	*$ 168,254*	*$ 206,886*	*$ 206,886*	*$ 38,632*	*23.0%*
NIH	$ 28,809	$ 28,329	$ 29,229	$ 420	1.5%
HRSA	$ 6,482	$ 5,886	$ 6,948	$ 466	7.2%
SAMHSA	$ 3,327	$ 3,168	$ 3,357	$ 30	0.9%

The omnibus appropriation includes $3.399 billion for the Indian Health Service (IHS) budget; however a 1.56% rescission will be applied to the final appropriation. This means the IHS budget will lose $53 million. After the rescission is applied, the final budget for the IHS is $3.346 billion, which is $166 million over the FY 2007 enacted level. This represents a 5.2% increase for the IHS and is much better than its sister agency, the Bureau of Indian Affairs (BIA). The final approved amount is (after the rescission) $75 million more than the President's request. Prior to applying the rescission, the IHS budget increase would have been $219 million or a 7% increase over FY 2007.

The BIA budget will see less than a 1% percent increase for FY 2008. The Centers for Medicare & Medicaid Services (CMS) and Health Resources Services Administration (HRSA) fared much better than the IHS budget. The CMS budget overall received a 14.2% increase—with the Medicaid program alone receiving a 23% increase—while HRSA received a 7.2% increase. Other Health and Human Service (HHS) operating division budgets included the Substance Abuse and Mental Health Services Administration which received less than a 1% increase. The National Institutes of Health received a slight increase of $420 million, a 1.5% increase.

Earlier this year, Northwest Tribes estimated that it would take at least $447 million to maintain current services. This estimate included $65 million for inflationary costs for the Contract Health Service (CHS) program, $174 million for inflation for other health and facilities accounts, $59 million for population growth, and $150 million in Contract Support Costs (CSC) to address past year's shortfalls and funding for new and expanded self-determination

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IHS Budget

Indian Health Service Budget

FY 2008 FINAL Budget

(Dollars in Thousands)

Sub Sub Activity	FINAL FY 2007 BUDGET	FY 2008 President's Request: President's FY 2008 Budget	FY 2008 President's Request: Difference vs. Final FY 2007	FY 2008 President's Request: Percent of Change	FY 2008 Omnibus - H.R. 2764: FY 2008 Omnibus	FY 2008 Omnibus - H.R. 2764: Recession 1.56%	FY 2008 Omnibus - H.R. 2764: FINAL FY 2008 BUDGET	FY 2008 Omnibus - H.R. 2764: Difference vs. Final FY 2007	FY 2008 Omnibus - H.R. 2764: Percent of Change
SERVICES:									
Hospitals & Health Clinics	$ 1,411,387	$ 1,493,534	$ 82,147	5.8%	$ 1,507,534	$ 23,518	$ 1,484,016	$ 72,629	5.1%
Dental Services	125,396	135,755	$ 10,359	8.3%	$ 135,755	$ 2,118	$ 133,637	$ 8,241	6.6%
Mental Health	60,882	64,538	$ 3,656	6.0%	$ 64,538	$ 1,007	$ 63,531	$ 2,649	4.4%
Alcohol & Substance Abuse	148,226	161,988	$ 13,762	9.3%	$ 161,988	$ 2,527	$ 159,461	$ 11,235	7.6%
Contract Health Services	543,099	569,515	$ 26,416	4.9%	$ 588,515	$ 9,181	$ 579,334	$ 36,235	6.7%
(Contract Health Care)	*499,562*	*551,515*	*$ 51,953*	*10.4%*	*$ 561,515*	*$ 8,760*	*$ 552,755*	*$ 53,193*	*10.6%*
(Catestropic Hlth Emg Fund)	*17,737*	*18,000*	*$ 263*	*1.5%*	*$ 27,000*	*$ 421*	*$ 26,579*	*$ 8,842*	*49.8%*
Total, Clinical Services	*$ 2,288,990*	*$ 2,425,330*	*$ 136,340*	6.0%	*$ 2,458,330*	*$ 38,350*	*$ 2,419,980*	*$ 130,990*	5.7%
PREVENTIVE HEALTH:									
Public Health Nursing	$ 52,445	$ 56,825	$ 4,380	8.4%	$ 56,825	$ 886	$ 55,939	$ 3,494	6.7%
Health Education	14,287	15,229	$ 942	6.6%	$ 15,229	$ 238	$ 14,991	$ 704	4.9%
Comm. Health Reps	54,891	55,795	$ 904	1.6%	$ 55,795	$ 870	$ 54,925	$ 34	0.1%
Immunization AK	1,681	1,760	$ 79	4.7%	$ 1,760	$ 27	$ 1,733	$ 52	3.1%
Total, Preventative Health	*$ 123,304*	*$ 129,609*	*$ 6,305*	5.1%	*$ 129,609*	*$ 2,022*	$ 127,587	$ 4,283	3.5%
OTHER SERVICES:									
Urban Health	$ 33,691	$ -	$ (33,691)	-100%	$ 35,094	$ 547	$ 34,547	$ 856	2.5%
Indian Health Professions	31,375	31,866	$ 491	1.6%	$ 36,866	$ 575	$ 36,291	$ 4,916	15.7%
Tribal Management	2,438	2,529	$ 91	3.7%	$ 2,529	$ 39	$ 2,490	$ 52	2.1%
Direct Operation	63,631	64,632	$ 1,001	1.6%	$ 64,632	$ 1,008	$ 63,624	$ (7)	0.0%
Self Governance	5,763	5,928	$ 165	2.9%	$ 5,928	$ 92	$ 5,836	$ 73	1.3%
Contract Support Costs	269,730	271,636	$ 1,906	0.7%	$ 271,636	$ 4,238	$ 267,398	$ (2,332)	-0.9%
Total, Other Services	*$ 406,628*	*$ 376,591*	*$ (30,037)*	-7.4%	*$ 416,685*	*$ 6,500*	$ 410,185	$ 3,557	0.9%
TOTAL, SERVICES	*$ 2,818,922*	*$ 2,931,530*	*$ 112,608*	4.0%	*$ 3,004,624*	*$ 46,872*	*$ 2,957,752*	*$ 138,830*	4.9%
FACILITIES:									
Maintenance & Improvement	54,668	51,936	$ (2,732)	-5.0%	$ 53,727	$ 838	$ 52,889	$ (1,779)	-3.3%
Sanitation Facilities Construction	94,003	88,500	$ (5,503)	-5.9%	$ 95,747	$ 1,494	$ 94,253	$ 250	0.3%
Hlth Care Facilities Construction	25,664	12,664	$ (13,000)	-50.7%	$ 37,164	$ 580	$ 36,584	$ 10,920	42.6%
Facil. & Envir. Hlth Supp	165,272	164,826	$ (446)	-0.3%	$ 172,326	$ 2,688	$ 169,638	$ 4,366	2.6%
Equipment	21,619	21,270	$ (349)	-1.6%	$ 21,619	$ 337	$ 21,282	$ (337)	-1.6%
Total, Facilities	*$ 361,226*	*$ 339,196*	*$ (22,030)*	-6.1%	*$ 380,583*	*$ 5,937*	$ 374,646	$ 13,420	3.7%
SUB-TOTAL, IHS	*$ 3,180,148*	*$ 3,270,726*	*$ 90,578*	2.8%	*$ 3,385,207*	*$ 52,809*	*$ 3,332,398*	*$ 152,250*	4.8%
Additional Funding:									
Meth Treatment & Prevention					$ 14,000	$ 218	$ 13,782	$ 13,782	
TOTAL, IHS	**$ 3,180,148**	**$ 3,270,726**	**$ 90,578**	**2.8%**	**$ 3,399,207**	**$ 53,028**	**$ 3,346,179**	**$ 166,031**	**5.2%**

FY 2008 IHS Budget

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programs. Anything less than $447 million ultimately means that the IHS and Tribes must absorb these mandatory costs by cutting health services, use other Tribal resources to fund, or a combination of both. Most Tribes will absorb these costs by cutting health care services. The final appropriation falls short by over $281 million and means that Indian people will receive less health services than they did in FY 2007.

The health services accounts received $2.96 billion, an increase of $139 million (a 4.9% increase). The health facilities accounts received $375 million, an increase of $13 million (a 3.7% increase). Congress also provided an additional $13.8 million for methamphetamine and suicide prevention and treatment services; with $5 million to be used for mental health issues associated with methamphetamine use. Other budget highlights include:

- $579 million for the CHS program, an increase of $36 million over the FY 2007 enacted level (a 6.7% increase);
- $27 million for the Catastrophic Health Emergency Fund (CHEF), an increase of $9.3 million over the FY 2007 level; CHEF was previously capped at $18 million;
- $14 million for the Indian Health Care Improvement Fund;
- Congress restored $36.3 million to fund the Urban Indian Health Programs, previously omitted in the past two President's budgets;
- Congress provided a slight increase for CSC funding but depending on how the rescission is applied, could lose $2.3 million in base funding;
- All facilities accounts were slated to be cut in President's budget, and all restored with slight increases except the Maintenance & Improvement and Equipment accounts;
- Facilities construction account increased to $36.6 million, an increase of $11 million over FY 2007 (an increase of 43%)

The final FY 2008 IHS budget is included that details the changes. The Agency will have some discretion on how the rescission will be applied, so the final effect on the sub-account activities is not entirely known at this writing. Most concerning on this issue is the impact the rescission will have on CSC funding. Congress included an increase of $1.9 million for CSC funding, but after the rescission is applied the CSC account could lose $2.3 million. This would erode the CSC budget and the final amount would be less than the FY 2007 enacted level. This has happened in previous years (FY 2003 and FY 2004) to both, the CSC and Self-Governance line items. The Office of Management and Budget is required to submit a report to Congress on accounts and amounts of each rescission within 30 days of enactment. We will provide an update on these details when they become available.

HIV

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voluntary HIV testing as part of their routine medical care in the health care setting (MMWR September 22, 2006;55 (RR-14):1-18). A separate consent form and HIV prevention counseling, previously required, has been eliminated to allow easier implementation of these recommendations. However, after being told that testing would occur, the patient could decline such testing. In individuals who are at high risk for HIV infection, HIV testing guidelines remain unchanged and should be done annually.

There is no known cure for HIV infection. Prevention is still the key to controlling HIV infection. Nevertheless, the availability of highly-active antiretroviral therapy (HAART) has improved survival and allowed HIV/AIDS to be managed as a chronic disease.. However, the emergence of drug-resistant virus continues to reduce the efficacy of current agents. In addition, potent antiretroviral agents have ushered in a false sense of security, contributing to an increase in risky behavior that can increase the risk of HIV transmission.

Rapid HIV antibody tests recently approved by the Food and Drug Administration can help reduce unrecognized infections by improving access to testing in both clinical and non-clinical settings and increase the proportion of those tested who learn their results. Four rapid HIV antibody tests are now available in the United States; two are approved for

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Update on Data into Action

by Birdie Wermy, Data into Action Project Specialist

With the New Year already here, the Data into Action (DiA) Project is taking this time to reflect on the first year of a brand new project as well as looking at our objectives in 2008.

The current DiA team consists of Project Director Bridget Canniff and Project Specialist Birdie Wermy (Cheyenne). In January 2007, six Northwest tribes were chosen to participate in the DiA project based on their diverse populations and locations in both rural and urban settings. DiA project staff visited each tribe and interviewed between six and eleven health personnel per site, asking questions regarding data use. Our goal was to observe factors contributing to successful use of health data for program planning and policy development, as well as to look at factors that may lead to less effective use of data. We analyzed the results and have documented major trends and themes that we will share with all Northwest tribes in the near future.

Each site was also given a written survey which allowed health personnel to share their knowledge about available data sources, including what data is actually being collected and used, as well as their collaboration with other health and research agencies such as state health departments, universities and federal government programs. With this information we plan to provide feedback from our research that focuses on areas that may need improvement. We also hope to publish the study results in relevant health journals, to share what we have learned with a wider audience, and most importantly to ensure our findings benefit all tribes of the Northwest and beyond.

The Future of Data into Action

The overall goal of the Data into Action Project is to answer critical questions that affect the translation of health data into health programs, services, and policies that reduce health-related disparities. With the information gathered during the first year of the DiA project, we plan to revisit each site and give a presentation along with a report on the findings of that tribe.

Over the next five years, we look forward to working and building relationships with each of the tribes we worked with in 2007, as well as reaching out to other Northwest tribes interested in developing their data collection and use to make it more effective and more practical.

One of our immediate goals is to support tribes in carrying out a community health assessment, as a way of documenting the overall health status of their community in order to make plans for improving it in the future. In 2005, NPAIHB created and piloted an Indian Community Health Profile (ICHP) Project toolkit. In 2008, we will be offering a series of trainings for tribal sites who are interested in learning about or conducting a local community health assessment using the ICHP toolkit. The complete ICHP project toolkit can be found at www.npaihb.org/resources/program_and_project_toolkits.

To learn more about Data into Action, please visit our project website at http://www.npaihb.org/epicenter/project/data_into_action, or contact us:

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Bridget Canniff, Project Director, 503-416-3302, bcanniff@npaihb.org

HIV continued from page 10

use at point-of-care sites outside a traditional laboratory. All four tests are interpreted visually. Sites offering rapid HIV testing must periodically run external controls (known HIV-positive and HIV-negative specimens) and provide persons who undergo rapid testing a subject information sheet.

Therefore, prevention is still the key and early diagnosis can assist with prevention efforts through awareness of the infection and taking the appropriate course of action to stop the spread to partners.

Tribal EpiCenter

by Jaci McCornack, TECC Project Specialist

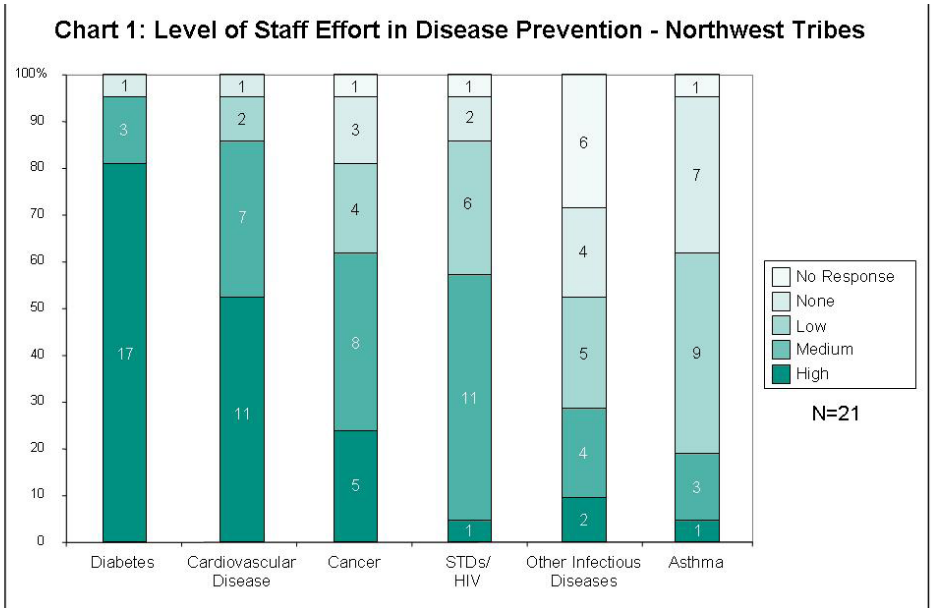
Happy New Year from the Tribal EpiCenter Consortium (TECC) Project. We are focusing on a collaboration between the Northwest Tribal EpiCenter, housed at NPAIHB in Portland, and our two counterparts: Southern Plains Inter-Tribal Epidemiology Center (SPITEC) in Oklahoma City, and the California Tribal Epidemiology Center (CTEC) in Sacramento.

One of the early goals of TECC was to develop a health promotion and disease prevention assessment survey to be distributed to all tribes and other American Indian/ Alaska Native (AI/AN) organizations in the regions served by Northwest, Southern Pains, and California Epicenters. The assessment was designed to help us better understand the strengths and challenges that tribes and urban Indian communities are facing and how EpiCenters can share resources locally and nationally. We fulfilled our goal of developing the assessment and distributed it to the forty three tribes of the northwest, along with tribes and other urban and non-profit organizations served by SPITEC and CTEC. Across the three regions we received a little over a fifty percent return rate covering more then seven states, and more than one hundred and eighty federally recognized tribes.

The Northwest EpiCenter was pleased to receive completed surveys from twenty-one of the forty-three Northwest tribes, which we believe will give us a sense of the efforts, successes, and challenges among our tribes, which we can compare with the results from Southern Plains and California.

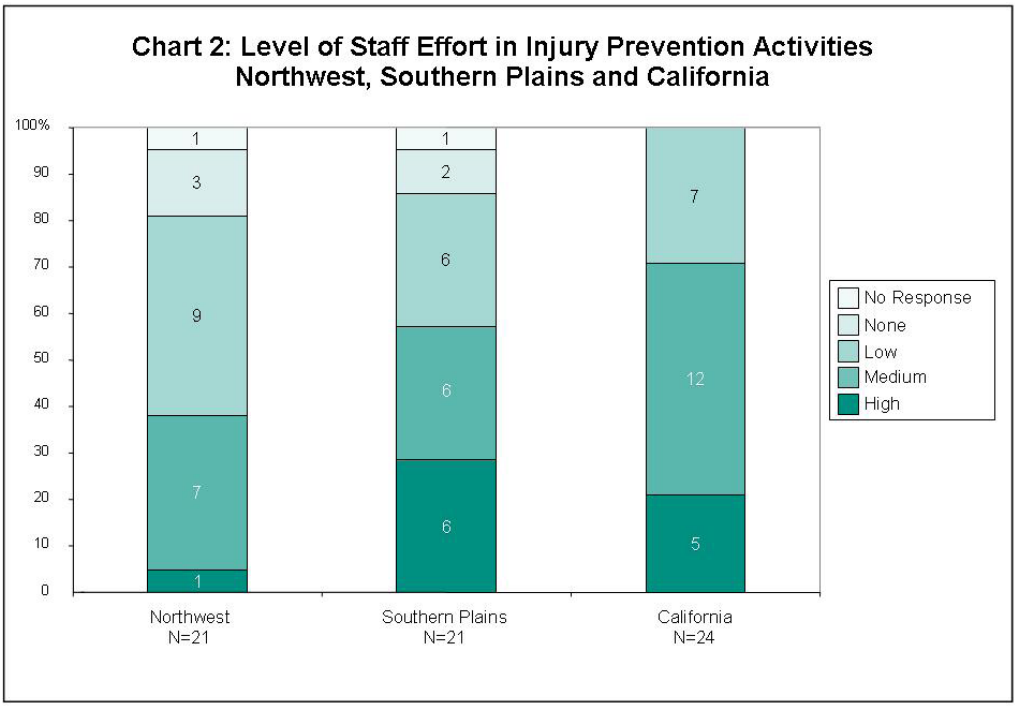
As promised, we will prepare a report summarizing the findings and distribute the report to you and your organization. We presented our results at the Quarterly Board meeting in January being held in Portland, Oregon. No community or individual will be identified or identifiable in any report that is prepared, and all data collected was and will continue to be held in the strictest confidence at all times by TECC staff. The survey results will provide tribes and the TECC partners with summary data on Health Promotion and Disease Prevention programs and activities that will enhance our collaboration efforts to improve the health status of American Indians/Alaska Natives.

We took a couple of examples from the data to give you a preview of the type of reporting that will occur. Chart 1 is a graph representing the level of staff effort in Disease Prevention activities among Northwest tribes. Not surprisingly, the highest level of staff effort within Disease Prevention is in Diabetes. Every tribe who participated indicated they were giving at minimum 'low' levels of staff effort, and in fact, eighty percent of respondents reported 'high' levels of staff efforts in diabetes-related activities, which reflects the high priority of this issue for our communities. Of the six subcategories included within Disease Prevention, Diabetes, Cardiovascular Disease, and Cancer were the areas where the highest level of staff effort is given. As you can see, Asthma is not being addressed as much as other topics, thirty-three percent of tribes report they are giving no staff effort towards Asthma programs. Additionally, eighty percent of tribes fell within 'medium' and 'low' levels of staff effort in sexually transmitted disease and HIV prevention, while only one tribe reported giving 'high' amounts of effort to STD/HIV prevention.



Consortium

Chart 2 allows for comparison across the three regions in the area of Injury Prevention (IP). Nearly sixty percent of the tribes in the Northwest are supplying 'little' to 'no' staff effort in this area. Results from Southern Plains indicate almost forty percent of their tribes are putting 'little' to 'no' staff effort towards IP within their region. On the other hand, Southern Plains has six tribes that reporting 'high' levels of staff effort within IP. Lastly, California reports that their tribes are doing the most with IP, stating nearly thirty percent of their tribes are putting 'high' levels of staff effort toward IP. Along with that, every California tribe who responded stated they were at least putting forth 'low' levels of staff effort, meaning every tribe is putting some staff effort toward IP within the California region.



Not only are we gaining valuable information about what is being done in Health Promotion/Disease Prevention activities across these three regions, we are able to utilize this information and put data into action. Since comparing and analyzing the results of the assessment we decided that injury prevention was indeed an area that was lacking attention. With that, we are currently working on creating an Injury Prevention toolkit with our TECC partners. The California Rural Indian Health Board (CRIHB) Injury Prevention program staff are taking the lead in the development, in collaboration with the California, Northwest, and Southern Plains EpiCenters. Upon completion of the toolkit, it will be immediately made accessible to all tribes served by each of the TECC partners. It will be available via the internet on the new IHS Injury Prevention website as well as on the NPAIHB site under Resources and Publications.

We would like to thank the tribes of the Northwest that took the time to complete the assessment; your participation will help in the growth of our project and increase understanding of important health issues in Indian Country today. We look forward to continuing to work with the tribes of the Northwest.

Thank you and please feel free to contact us with any questions.

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Health care professionals, communities benefit from coalition's HIV/STD training

by Babette Herrman
Previously printed in Indian Country Today December 19, 2007

PORTLAND, Ore. - For nearly two decades, Project Red Talon has provided American Indian and Alaska Native communities numerous resources on the dangers of HIV and sexually transmitted diseases. PRT was born out of the Northwest Portland Area Indian Health Board, an 18-year-old organization that serves 43 tribes in Oregon, Washington and Idaho.

PRT started out as a grass-roots, Native community-involved coalition. But there were challenges involved with getting out to all the tribes that fall under the umbrella of the NPAIHB, also called ''the board.''

About three years ago, under the new directorship of Stephanie Craig Rushing, PRT adopted the ''community readiness model'' theory in hopes of reaching all the tribes, especially in rural areas, about the importance of providing accurate HIV/STD education and testing to their people.

Under the CRM, the coalition shifted gears from direct community involvement to providing health care professionals training and resources to make sure the Native-based clinics they worked for were doing their best to reach out to patients and the community at large. Rushing explained that health care representatives from each tribe had to first focus on their strengths in order to reach their communities.

''The benefit of building on strengths is that it encourages unity and that you're not trying to implement something that is culturally inappropriate or just focuses on weakness,'' she said.

Rushing said the CRM was the brainchild of scholars from the Center for Applied Studies in American Ethnicity at Colorado State University. Under the CRM theory, Native health clinics are surveyed and provided resources and training on how to work with their community on carrying the message.

Just like the model called for, Rushing had surveys sent out to the 43 tribes in order to get an idea of how they were testing and treating for HIV/STDs.

After all, the statistics on the PRT Web site demonstrate a need to educate Natives on issues that seem to grow worse over time. According to its statistics, PRT said that American Indians and Alaska Natives are the fastest-growing minority group to contract HIV/AIDS, with new cases increasing 800 percent from 1990 to 1999.

As for STDs, additional statistics compiled in 2004 reported that Natives ''were nearly five times likely than whites to have chlamydia, four times more likely to have gonorrhea, and twice as likely to have syphilis.''

When PRT administered that first survey to clinics in 2005, Rushing was alarmed by the results. The report stated that ''three-quarters of tribal clinicians reported that their clinic regularly tests for a variety of sexually transmitted diseases, while only 40 percent reported the capacity to treat such conditions.''

Rushing said that she was not sure whether the results missed something, such as if the 80 percent of clinics not treating STDs were referring patients elsewhere. In 2006, PRT amended the survey to help respondents answer questions with greater accuracy.

''We are now feeling much more confident that people are testing and treating STDs,'' she said.

What she found disheartening was clinics' lack of funding to screen individuals annually for STDs. She said the screening is especially important for women under the age of 25, as they are vulnerable to contracting chlamydia. Many who catch it do not know they even have the disease. If left untreated, about 40 percent of those cases go on to be-

come Pelvic Inflammatory Disease, which can lead to infertility.

In addition to surveying clinics, PRT makes sure that tribal health clinics are provided age-appropriate educational pamphlets and media resources to tribes. They also make these resources available for parents and educators on how to talk to teens about sex.

Rushing said that educating teenagers is vital to preventing the transmission of STDs, and that one in 10 sexually active teenagers have contracted chlamydia.

But when it comes down to education, the people most involved with teens, such as parents and educators, have the most difficulty talking openly about prevention and disease.

Rushing said that she was surprised to learn from random surveys that teens wanted their sex education taught to them by a person, such as a parent, educator or counselor, as opposed to a magazine, the Internet or other media. ''It's a hard thing for many people to talk about,'' she said. ''It's a hurdle that we have to get over.''

The whole ideal of education, Rushing said, is not to scare teens or adults about STDs, but to persuade them to ''make educated choices about themselves and their partner.''

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New Webpage for Tribal Tobacco Program Contractors in Washington State!

by Terresa White, WTPP Coordinator

The Western Tobacco Prevention Project (WTPP) recently developed a "Coordinators Only" webpage for Washington State Tribal Tobacco Program Contractors. The webpage serves as an avenue for Tribal Contractors to share their activities, resources, and requests with their Tribal tobacco prevention colleagues around the state.

NPAIHB Tobacco Program Coordinator, Terresa White, posts to the page tobacco-related announcements, opportunities, shout outs, calendar items, resources, and brainstorms & collaboration requests. Below, find a sample of current "Shout Outs" found on the page:

Great work Annette Anquoe, Washington State Urban Indian Tobacco Coalition, for your successful "Honoring the Gift of Tradition" Pow Wow that took place in Seattle Washington, Dec. 3rd. The Pow Wow drew attention to the abuse of tobacco in Indian communities while emphasizing the unique and important role of traditional tobacco use. More than 300 people attended the event!

Diane Mellon, Colville Tribe Keller District CHR, supported and encouraged nine community members in taking the GASO challenge of not smoking for 24-hours. Six were successful and went home with turkeys just in time for the Thanksgiving holiday! One participant is still "quit" and several others are in the contemplation stage of change. Good work Diane.

Tracy Tejano, Makah Tribe, recently conceptualized and implemented an educational "scared straight" tobacco prevention tool. She led a small group of Tribal youth and adults to the Sequim Cancer Treatment Center to see first hand the effects of tobacco use. The group toured the facility and met with the head radiation and chemotherapy technicians, a pharmacist, and other doctors who discussed tobacco-related cancers and the impact of cancer treatment. Several youth experienced the discomfort of being fitted for treatment molds for throat and lung cancer treatment. The event was a powerful prevention effort. . .one participant is currently quitting smoking! Way to think outside the box in providing a meaningful tobacco prevention experience for your community, Tracy.

Also currently posted is the excellent Tribal Report released by the Indigenous Peoples Task Force in August 2007, "Creating Healthier Policies in Indian Casinos."

To view these and other posts, or to submit information for posting, contact Terresa White at the Northwest Portland Area Indian Health Board: 503.416.3272 or twhite@npaihb.org.

Overweight and Obesity in American Indian/Alaska Native Communities

by Peggy Halpern
Article summary by Kristyn Bigback, NPAIHB Office Manager

A Summary of the Article "Obesity and American Indians/Alaska Natives" by Peggy Halpern, Ph.D; summarized by Kristyn Bigback, NPAIHB Office Manager

Overweight and obesity, health problems that can lead to devastating effects on the human body, are on the increase nationwide. Chronic diseases, such as type II diabetes, hypertension, cardiovascular disease (CVD) and problems with lipid levels have all been associated with obesity[1]. While these problems exist in many populations, available data indicate that the prevalence of overweight and obesity in American Indian/Alaska Native (AI/AN) preschoolers, school-aged children and adults is higher than the respective U.S. rates for all races combined[2]. It is apparent that AI/AN populations have been disproportionately affected by overweight and obesity, and more research and plans of action must be implemented to help lower the prevalence in these populations.

Factors that contribute to overweight and obesity are varied, and include nutrition/diet, socioeconomic factors, genetic factors (arguably), and amount of physical activity. In the early 1900's, Indian Country underwent a shift from traditional occupations such as hunting, gathering and farming to a cash economy, which forced many family members to leave home in search of paid employment[3]. As a result, wild and homegrown food in the AI/AN diet decreased. These were replaced with processed and commercially prepared food, which tend be high in refined carbohydrates, fat, sodium, and low in fruits and vegetables[4]. These foods are convenient, but not as healthy as their previous counterparts, and tend to contribute to weight gain.

Racial and ethnic minority and low income communities, including many AI/AN populations, typically have experienced higher rates of obesity. These higher rates are linked to factors such as economic stresses, reduced access to healthful foods, opportunities for safe and varied physical activity, overexposure to targeted advertising, and marketing of energy-dense foods[5]. Although circumstances faced by each tribe are unique, most tribes have been found to experience economic, education, housing, health and other problems at levels of severity rarely seen in most other American communities[6].

One issue of disagreement in the causes of overweight and obesity is the role of genetics. Several researchers have pointed out that genetic and environmental factors may interact in AI/ANs, and that the environment plays a role either by compounding a genetic tendency toward weight gain or by mitigating it. However, neither energy expenditure nor metabolic rate has been found to be significantly different between AI/AN or Caucasian children[7].

Physical activity, which is protective against obesity and other health risks, has been found to be low among those living in reservation-based communities as well as in AI/AN urban youth[8]. In the process of acculturation, AI/ANs have shifted from a traditional subsistence lifestyle to a more sedentary lifestyle that involves much less physical activity[9]. Additionally, there are often barriers to physical activity, including lack of facilities, equipment, and trained physical education staff.

Federal agencies, including the Indian Health Service (IHS), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC) and the United States Department of Agriculture (USDA), all have implemented activities to address this issue[5]. Along with other research activities, these efforts will expose effective ways to combat the epidemic of overweight and obesity in AI/AN communities, and lead to the improvement of thousands of lives.

1 NRCCDH, 1989.
2 Zephier et al, 2006; Denny et al, 2003; CDC, 2005.
3 Michel, 2004.
4 IHS, 2001.
5 Halpern, 2007.
6 Hillabrant et al, 2001.
7 Story et al, 2003.
8 Gray and Smith, 2003.
9 Mendlein et al, 1997; Sugarman, 1992.

From the Chair: Continued

continued from page 2

that included the Urban Institute, Kaiser Family Foundation, and the National Academy for State Health Policy Making. Through the support of Northwest Tribes, we continue to partner with the National Indian Health Board and National Congress of American Indians to advocate on important health issues with federal agencies. Five years ago, the Board was successful in partnership with other Area Health Boards, to get an exemption form the CMS outpatient prospective payment system, something that resulted in millions of dollars to our heath care system. Because of our quality of work and reputation on health care issues, we have access to members of the Administration and Congress. This access allows us to bring important health issues affecting our Tribes.

The Board has done an exceptional job of providing our Tribes with training and technical assistance on a variety of issues. We have also added several programs that include health promotion and disease prevention (HP/DP) activities benefiting Northwest Tribes. Many of these programs are housed in the EpiCenter and have research components associated with them. This facilitates our ability to conduct surveillance and develop research projects by collecting data and conducting analysis in a responsible manner so that it benefits Tribal communities. Likewise, our HP/DP projects also include training and technical assistance efforts for Tribes. Thus, the programs that we continue to build upon compliment one another in all of the priority areas of our strategic plan. From one of our first contracts in 1973 which evaluated special programs for prevention of accidental death and injury in tribal communities to our collaborative approaches with HIV/STD prevention, Tobacco Control, Comprehensive Cancer, Women's Health Promotion, Maternal and Child Health, and fitness promotion, we have developed with guidance of the tribes and the creativity of staff, innovative and effective approaches that are culturally relevant and reflective of a wholistic approach that is true to Indian community values and resource efficient.

It's hard to believe that we have been around for thirty-five years and have many Tribal leaders to thank, as we could not have done it without their support. The Board has grown from a staff of three to five people in 1972, to over forty people today. I look forward to our next five years and our 40th Anniversary. I know you all will continue to work hard to forge our course and welcome your ideas on how to improve the programs and services of the Board.

I compliment you all on your dedication and service on our 35th Anniversary!

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PRT meets in the spring to provide educational seminars for health care professionals; the board holds quarterly meetings and, on occasion, reserves an extra for coalition members to meet and learn from one another.

Anita Davis, a community health educator and member of the Confederated Tribes of Warm Springs in central Oregon, said utilizing the CRM theory has made a difference for her. She admitted that before Rushing came along, she was sour on the effectiveness of PRT in rural areas.

''For me, the surveys are like a light,'' she said. ''It was information that I needed and I am going to run with it. It really built my confidence.''

PRT is funded by the Centers for Disease Control and Prevention through a three-year grant, which began in September 2004. The Library of Medicine issued a grant in 2006 for PRT to develop culturally appropriate HIV media materials for Northwest tribes.

For more information on PRT, visit www.npaihb.org/epicenter/project/project_red_talon.

Oregon Health Fund Board (OHFB)

by Sonciray Bonnell, Health Resource Coordinator

Like many states around the country, Oregon is wrestling with the challenge of ensuring access to health care for all its citizens. To address the challenge, the Oregon Health Fund Board (OHFB or the Board) was created by Senate Bill 329 (The Healthy Oregon Act) on June 28, 2007. The purpose of the OHFB is to develop a comprehensive plan to achieve the Oregon Health Fund program goals as outlined in SB 329 which include providing health insurance coverage to uninsured Oregonians; reforming the health care delivery system; giving Oregonians timely access to a health benefit plan; financing coverage of essential health services; encouraging participation; promoting public and private health care partnerships; controling costs and overutilization; advocating for heath care management; improve end-of-life care; changing payment structure; establishing high quality, transparent health care delivery; making funding equitable and affordable; and trying to limit inflation to cost of living. OHFB will report to the Legislative Assembly by February 29, 2008, describing its progress toward developing a comprehensive plan.

The Oregon Health Fund Board is a seven member board appointed by the Governor and confirmed by the Oregon Senate. The Board and its committees are supported by the professional and administrative staff of the Office for Oregon Health Policy and Research (OHPR). OHFB staff are assigned to each committee to support and assist in their work. In their efforts to develop a comprehensive plan ensuring access to health care for all Oregonians, the Board will gather public input on key health reform concepts.

Six committees, consisting of citizens who have volunteered their time and resources, are accomplishing a significant portion of the work: Finance, Benefits, Eligibility and Enrollment, Federal Laws, Delivery System, and Health Equities. Members are appointed by the OHFB to sit on these committees. Committees are currently preparing recommendations on their respective health care reform topics. All committees are on the fast track to submit their recommendations to the OHFB with enough time for the board to make recommendations to the 2009 Legislature.

As you can imagine, the work of the committees is complex and compounded by a very short timeline. OHFB is using three approaches to coordinate the work of the six committees: 1) committees will receive summaries of the deliberations of other committees; 2) OHFB and OHPR staff meet weekly to discuss ongoing work and areas of policy development that potentially relate to multiple committees; 3) Board officers meet jointly with the chairs of those committees that have critical interdependencies.

Why health reform?

- Our current system doesn't spend enough money on prevention, and then spends too much when we are ill. The Healthy Oregon Act (SB 329) intends to propose ways to renew focus on health promotion and disease prevention.
- Too often, the uninsured or underinsured only get health care in the emergency room which is extremely expensive. Their care is being paid for, but only by a few. The uninsured health costs often include emergency room visits and unpaid medical bills, which leads insurance companies to raise rates for the rest of us. It is a hidden tax. The The Healthy Oregon Act, with input from the public, will attempt to make it more equitable.
- Limited health care dollars

The OHFB has an extraordinary opportunity to create an active exchange of ideas with consumers, advocates, industry representatives, tribes, and other stakeholders. Oregon tribal leadership has much to contribute to this health reform process. Four tribal representatives currently sit on committees: Cheryle Kennedy (Grand Ronde) sits on the Federal Laws Committee, Joe Finkbonner (Lummi) sits on the Health Equities Committee, Judy Mushchamp (Siletz) sits on the Finance Committee, and Eric Metcalf sits on the Eligibility and Enrollment Committee.

OHFB

The OHFB and its committees are interested in receiving public comment on their health care reform work and dedicated approximately thirty minutes at every meeting for public comment. Written comments may also be submitted. Please consider contributing to the process.

Oregon is well positioned to begin the process of state health reform to not only provide access to health care for all Oregonians, but to close the health disparities gaps that continue to impact our communities. Many of the detailed information on SB 326, committee member lists, meeting agendas, and supplemental documents can be found on the OHFB website. http://www.oregon.gov/OHPPR/HFB/index.shtml

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New NPAIHB Employee

Hi my name is Monika McGuire and I am the new Project Assistant for the Western Tribal Diabetes Project. I am very excited about being here and being a part of this great organization. I am an enrolled member of the Confederated Tribes of the Umatilla Indian Reservation in Pendleton, OR. I was born here in Portland and grew up in Fairview, Oregon. My parents are Brian and Violet McGuire both of Fairview. I have two brothers, one who lives here in Portland and one who lives in Pocatello, and a sister who lives in Washington, DC. I also have family in Pendleton, Portland, California, Idaho, Florida, Canada, and Ireland. I enjoy reading and watching sports mostly football and basketball. I love traveling, shopping, and spending time with family and friends. One of my favorite places is Las Vegas and of course the Pendleton Round – Up. I look forward to meeting and working with you all.

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.

Northwest Portland Area Indian Health Board

October, 2007 NPAIHB Resolutions

RESOLUTION #08-01-01
Support for the Establishment of a National Tribal Organization on Alcohol, Substance Abuse, and Behavioral Health

RESOLUTION #08-01-02
Support for Application to American Legacy Foundation Funding for National Tribal Tobacco Prevention Network

RESOLUTION #08-01-03
Support for Data Sharing Agreements for Collection and Analysis of State Tribal WIC Data

RESOLUTION #08-01-04
Support Continued Funding for Camp Chaparral to Provide AI/AN Veteran Services

RESOLUTION #08-01-05
Support for the NativeTruth Application to American Legacy Foundation Funding for the Western Tobacco Prevention Project

RESOLUTION #08 – 01-06
Support for Tribal Policy Development and Rejection of Commercial Tobacco Vendor Displays and Giveaways at Native Conference

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD