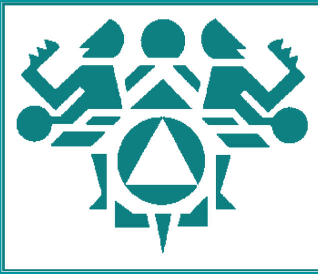

Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

July, 2009

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.

Health Reform will Impact Indian Country

Northwest Roundtable on Health Care Reform Policy Options for the Indian Health System on June 2-3, 2009 in Portland, Oregon. Hosted by the Northwest Portland Area Indian Health Board and Affiliated Tribes of Northwest Indians.
LtoR: Woody Patawa (Umatilla), Mike Clements (Warm Springs), Joe Kirk (Klamath), and Leroy Jackson (Klamath)

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Andy Joseph, Jr.

Northwest Portland Area Indian Health Board

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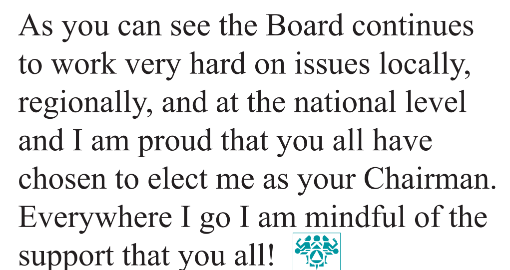
This has been a very busy quarter for me at the Board Chairman. I have been before Congress three times, testifying before the Senate Indian Affairs, House Appropriations, and most recently the House Natural Resources Committee. The Resources Committee testimony was to provide our comments on the new reauthorization bill for the Indian Health Care Improvement Act (H.R. 2708). I did take some time during the months of May and June to keep close to home so I could attend to my election at Colville. I am pleased to report that I was re-elected and proud to know that the people I serve continue to support me as a Tribal leader.

Some of the important meetings that I attended as the Chairman of the Board included the NIHB Quarterly Board meeting held in Washington, D.C. on April 26-28th. I also joined many of you at this year's HHS Department-wide Annual Budget Consultation session, where I presented testimony on CDC and SAMHSA issues affecting our Tribes. These issues haven't changed much and I believe the agencies can and should continue to do more to assist our Indian people. On May 11-14th, I attend the Contract Health Service training in Denver, CO to learn more about our CHS programs and the requirements that they operate under. As tribal leaders, we need to all learn more about the programs we are asked to represent and this training was very valuable for me. Of course, I attended the ATNI meeting held in Reno on May 18-21.

One of the most important items we are working on right now is health reform. I am very proud of the role that the Northwest has played in developing recommendations that have been used by national organizations to develop recommendations for all of Indian Country. The health reform roundtable that jointly sponsored by ATNI and the Board on June 2-3 was very well attended and received national recognition. It was good to see that key Congressional committees took the time to meet with Northwest Tribes to discuss health reform proposals that they were working on. Following the roundtable, the Board and ATNI submitted recommendations to all Congressional committees working on health reform. The recommendations have since be used nationally by NIHB, NCAI, the National Council on Urban Indian Health and many others.

As you can see the Board continues to work very hard on issues locally, regionally, and at the national level and I am proud that you all have chosen to elect me as your Chairman. Everywhere I go I am mindful of the support that you all!



From the Executive Director:
Joe Finkbonner

Contract Support Costs – Revisited

On June 10th and 11th the IHS Office of Tribal Programs (OTP) convened a meeting of the Contract Support Cost (CSC) Workgroup in Phoenix, Arizona. The purpose of the meeting was to review the current CSC policy and discuss CSC resource allocation issues, the FY 2009 and FY 2010 appropriation, impacts of National Business Center indirect cost rate negotiation changes, and CSC issues associated with American Recovery and Reinvestment Act (ARRA) funds.

Before I get started in the details of the discussion of this meeting and the issues, let me first refresh everyone's understanding of CSC as simply as I can, without using the legal, complicated, and confusing definition. Contract Support Costs are defined under the Indian Self Determination and Education Assistance Act (ISDEA), Public Law 93-638 as *an amount for the activities that must be conducted by a tribal contractor to ensure compliance with the terms of the contract and prudent management. They (CSC) include costs that either the Secretary never incurred in direct operation of the program, or are normally provided by the Secretary in support of the program from resources other than those under contract.* It is important to understand that, by definition, funding for CSC is NOT already included in the program amounts contracted by tribes. Contract Support Costs can be either Indirect, Direct, recurring, or one time.

Over the past ten years the annual increase to CSC averaged about 1.8%, which accounted for the decline in the level of need funded for CSC decline from 86.1% in 1998 to 69.4% in 2008. The decline in the level of need funded was not entirely due to the rate of increase of CSC appropriations, but also because tribes were continuing to exercise their right to either contract or compact the health programs, as well as expand programs previously operated by the tribe. The dilemma faced by the IHS, in a time when all of the CSC need was not fully appropriated, how to fairly allocate the funds received from Congress. Should any NEW funds received go to address the past year's funding CSC shortfall of currently operated programs, or to new or expanded programs?

Now on with the show…the impetus for the meeting in Phoenix was the President's request for an IHS Budget. In the 2010 budget, President Obama requested an additional $107 million over the 2009 amount, and the House increased the request by another $9 million for a total of $398.5 million available for CSC in FY 2010. This does not fully address the shortfall, but it does precipitate the age old question of where to allocate the funding…shortfall versus new/expanded. I want to add that the Northwest Portland Area Indian Health Board does not have

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Northwest Portland Area Indian Health Board

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Health Reform will

by Jim Roberts, Policy Analyst

Five Congressional committees are involved in developing health reform options to address rising health care costs, quality of care issues, and the growing number of uninsured and under-insured in this country. They include the Senate Committees on Finance and Health, Education, Labor, and Pensions (HELP); and the House Committees on Energy and Commerce, Ways and Means, and Education and Labor. Achieving comprehensive health reform is a high priority for President Obama and the Congress. In response to the movement to reform the country's health care system, the Board in partnership with Affiliated Tribes of Northwest Indians (ATNI) convened the "Northwest Roundtable on Health Care Reform Policy Options for the Indian Health System" on June 2-3, 2009 in Portland, Oregon.

The roundtable served as a forum for Northwest Tribes to develop policy recommendations on a series of papers released by the Finance Committee, which provided a broad framework of options for health reform. At the time, the Finance Committee papers were the only details available from any of the Congressional committees outlining health reform options. The Board's recommendations have since served as the basis for developing recommendations provided to Congress by the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), and the National Council on Urban Indian Health. As Tribal health reform issues have come up, Northwest Tribes have been at the center of the health reform debate.

Since the Northwest roundtable, health reform packages have been released by the Finance and HELP committees. The House has issued a discussion draft bill and is currently working on finalizing the comprehensive bill (called the "House Tri-Committee Health Reform" bill) that was scheduled to be released Friday, July 10th, however, was postponed due to concerns from conservative Democrats and Republican members who are threatening to withhold their support due to the high costs of the bill and until other concerns are addressed. Some of the concerns include the need for more cost containment measures, protections for small businesses, and a focus on rural health care.

Health Reform Proposals

The overall approach by the various committees to expand access and health care coverage to the country's uninsured and under-insured are very similar with different requirements. The Finance Committee legislation is not available yet, although details of the proposal indicate that it would provide a range of options to achieve health reform goals. The Finance package would require all individuals to have health insurance. It would create a health Insurance Exchange for individuals and businesses to purchase health insurance coverage. Insurance subsidies would be available to individuals and families with incomes between 100 – 400% of the federal poverty level. The Finance options would expand Medicaid and CHIP and offer a temporary Medicare buy-in for the pre-Medicare population. Finally, new regulations would reform the non-group and small group insurance markets.

The HELP Committee legislation is available and the title of the bill is the Affordable Health Choices Act. Like the Finance Committee, the HELP bill would require all individuals to have health insurance. It would establish state operated health insurance exchanges (called "gateways") through which individuals and small businesses could purchase health coverage. The gateways would set certain minimum requirements regarding the availability, pricing, and actuarial value of insurance policies and provide federal subsidies to substantially reduce the cost of coverage for eligible enrollees. The subsidies would be available to individuals and families with incomes up to 400% of the federal poverty level. Like the Finance Committee, the HELP bill also includes new regulations on the individual and small group insurance markets and expands Medicaid to all individuals with incomes up to 150% of the poverty level. The HELP proposal also includes provisions to establish a reinsurance program for

early retirees and improve access to and availability of community assisted living (long-term care and home and community based services).

The House Tri-Committee health reform discussion bill would also all require individuals to have health insurance. The House bill creates a Health Insurance Exchange similar to the Senate proposals that allow individuals and employers to purchase health insurance coverage. The House proposal also creates a public health insurance option as a qualified health benefit plan to be offered through the insurance exchange. Many involved in the health reform debate feel that the public plan is a necessary component of health reform. The public plan will include a basic, enhanced, and premium level of services for enrollees that have a defined set of benefits. Many feel that this will provide incentive for the private insurance markets to lower administrative costs, allow health purchasers to negotiate lower prices for health care and drugs, and lower overall costs and premiums for insurance. The Tri-Committee bill will offer premium and cost-sharing credits available to individuals and families with incomes up to 400% of the federal poverty level. The bill will require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage and impose new regulations on plans participating in the exchange and in the small group insurance market. The House plan would also expand Medicaid to 133% of the poverty level.

Tribal Recommendations

All of the congressional proposals will have an impact on the Indian health care system. The requirements and penalties concerning reform proposals like the individual mandate, employer requirements, expansion of public programs, premium subsidies for individuals, families, and employers, and the tax changes related to health insurance will have a profound impact on Indian people and the system for which they rely on health care.

The HELP Committee's Affordable Choices Act exempts Indians from financial penalties if they do not prove they have health insurance, but does not do much else to protect individuals and the IHS system from reform changes. The House Tri-Caucus bill has very few Indian provisions other than a requirement for the Health Choices Commissioner, who will oversee the health insurance exchange, to consult with Indian Tribes and tribal organizations; allowing costs paid by the IHS to count toward the annual out-of-pocket threshold in the Medicare Part D program; and allowing IHS and Tribal programs to be eligible for funding to conduct home health visits. The details of the Finance Committee package are not available, but discussions with committee staff indicate that some protections for the Indian health system will be included, such as exemptions from the individual mandate, tax penalties for Tribes providing care to Indian people, and Indians being eligible for subsidies who do not receive care from the Indian health system. These details are still preliminary and the final bill language could change these requirements.

The recommendations developed at the joint ATNI-NPAIHB health reform roundtable are summarized below. These recommendations have been provided to all five congressional committees and staff working on health reform legislation. The format of the original recommendations has been changed for the purposes of this article, and the full roundtable recommendations report can be accessed at www.npaihb.org:

1. Include Tribes on key commissions and boards created by health reform legislation and direct HHS Secretary to consult with Tribes on a government-to-government basis on any health reform policies and regulations so they are developed in a way that will create positive changes in the diverse Indian communities.

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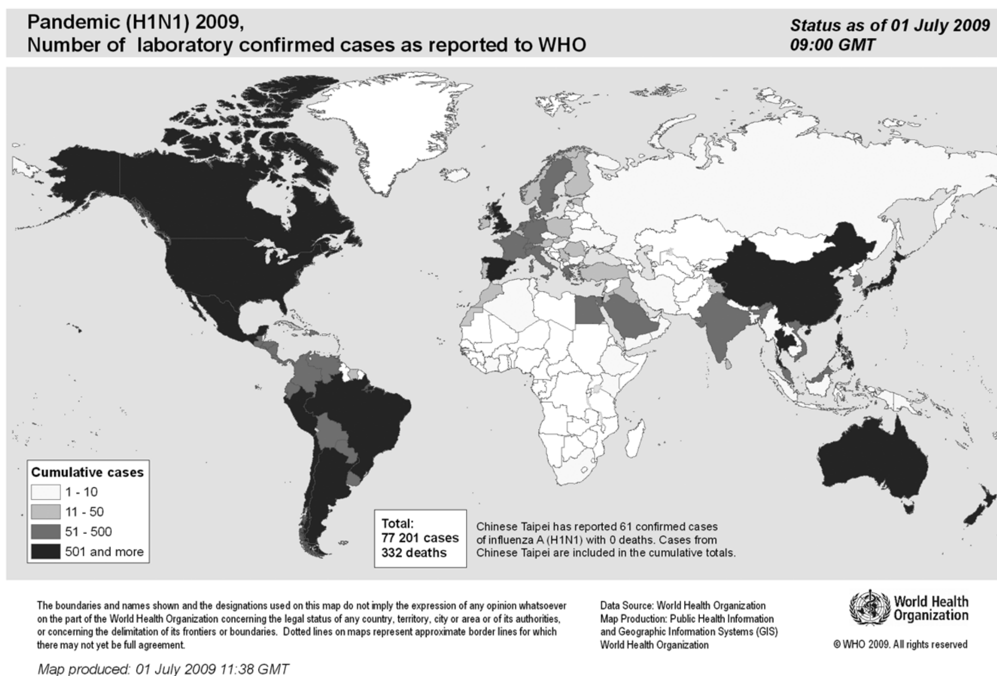
by Thomas Weiser, MD, MPH Portland Area Medical Epidemiologist and DJ Brumby, DVM, IHS Summer Extern

The first cases of confirmed infection with a new strain of influenza were identified in California and Texas and reported by the Centers for Disease Control and Prevention (CDC) on April 24, 2009. Severe respiratory illness in Mexico was confirmed to be from the same virus. Cases of infection with the new virus were soon reported from New York, the upper Midwest and eventually throughout the US. On June 11th, the World Health Organization (WHO) declared a global pandemic based on evidence of ongoing transmission in communities in multiple countries in at least two different WHO regions. As of 7/2/2009, there are 33,902 confirmed cases in the US with 170 deaths. Worldwide, the total stands at 77,201 cases with 332 deaths in 120 countries and dependent territories as of July 1, 2009.

Figure 1. World-wide distribution of Pandemic H1N1 infection, WHO, July 1, 2009



Northwest H1N1 Experience and Response

In Idaho, Oregon and Washington, there have been 1046 cases (ID: 92; OR: 366; and WA: 588) with eight deaths (four each in OR and WA). Washington State Epidemiologist, Antonio Marfin, advises there is on-going community transmission in many parts of the state, including at least one cluster of severe illness in which four patients required ICU admission for respiratory distress. Oregon and Idaho also continue to have on-going community transmission.

At the beginning of the outbreak, all three states initially activated their emergency operations centers, developed state-specific messages for distribution on their Health Alert Network systems, and prepared to receive and distribute antiviral medications and other supplies from the Strategic National Stockpile (SNS). In the first weeks of the epidemic, the CDC issued 25% of the total SNS to States which in turn took the responsibility for storage and distribution to local health jurisdictions, hospitals and Tribes according to previously developed pandemic flu plans.

During the first two weeks of the epidemic, CDC requested detailed investigations on each new case. With the increase in cases, investigation and reporting of individual cases was stopped and more emphasis was placed on community mitigation measures, testing, and treatment of hospitalized and high risk patients.

Preparing for the future

Multiple Waves

Like the stock market, there are no guarantees that past performance is indicative of the future, but one characteristic of previous epidemics that might be helpful as we prepare for the upcoming influenza season is that previous pandemics were observed to present in a series of waves rather than just once. In the 1918 influenza pandemic, the first

Influenza Pandemic

wave was relatively mild. The second and third waves were more *virulent*, resulting in more serious disease and a higher number of deaths (Figure 2). The virus can also become more *infectious*, meaning it can be more easily passed from person to person. The new pandemic strain of H1N1 is now circulating in the southern hemisphere where large numbers of cases are being reported from Australia, New Zealand, Argentina and Brazil. It is too early in the southern hemisphere flu season to tell if the virus has acquired new properties affecting its virulence or infectiousness.

Figure 2.

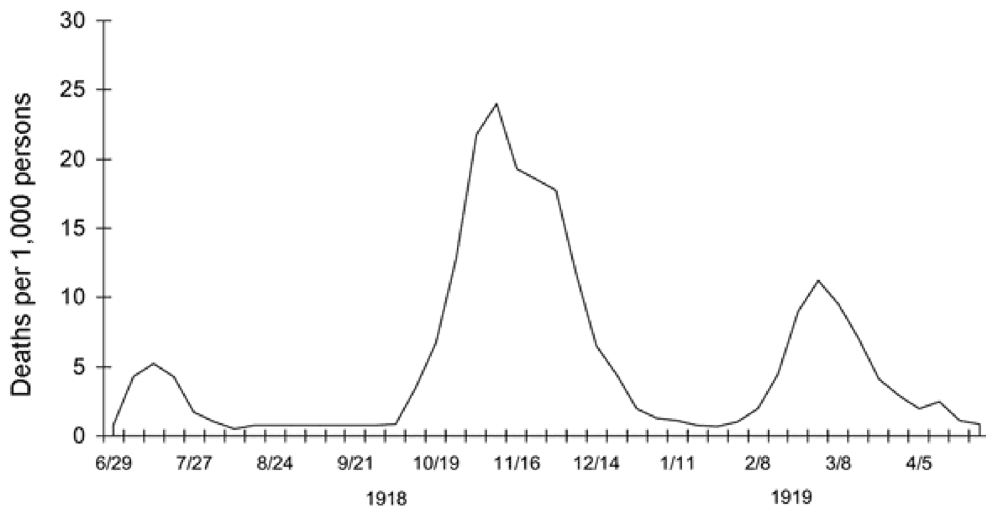


Figure 2. Three pandemic waves: weekly combined influenza and pneumonia mortality, United Kingdom, 1918–1919 (Jordan E. Epidemic influenza: a survey. Chicago: American Medical Association, 1927.)

Vaccine Planning

Several vaccine manufacturers throughout the world are working to produce a safe, reliable vaccine. Early indications are that an immunization to protect against the novel H1N1 influenza strain will require two doses to offer full protection. Novartis, a leading vaccine manufacturer, expects to have vaccine available after September. Immunization against the pandemic H1N1 strain, once available, will be in addition to the "seasonal" flu vaccine that is already in production. It will be important to plan for the additional effort that will be required to provide not one, but three doses of flu vaccine (one dose of "seasonal" vaccine and two doses of "pandemic" vaccine). Mass vaccination clinics, "drive-by" vaccinations, and vaccinations at alternative sites, such as work place settings, community centers and schools will have to be considered.

Antiviral Medications

CDC and State health departments are continuing to plan for the use of oseltamivir and zanamivir as a primary means of treating patients with pandemic H1N1 infection as well as prophylaxis to prevent infection in certain high risk groups. The 11 million doses of antiviral medications dispensed from the SNS have been replaced and an additional 2 million doses have been purchased by the US Department of Health and Human Services. Local health jurisdictions including Tribal health departments have an opportunity now to review written plans for receiving and distributing antiviral medications from the SNS and to use the past three months' experience to determine whether their systems functioned as planned and to address any unmet needs. There is potential for the virus to acquire resistance. Two reports have been made of one person in the Netherlands and one in Japan with documented resistance to the antiviral drug oseltamivir (Tamiflu®) but there is no evidence that resistance to oseltamivir has been spread from person to person with the pandemic H1N1 strain. However, since the recent 2008-2009 seasonal strain of influenza was resistant to oseltamivir, it is important to maintain vigilance to detect resistance if it occurs.

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Summer Institute 2009

by Nichole Hildebrandt, Program Manager

Data Linkages Class

LtoR Standing: Lisa Dirks, Erika Wolter, Elverna Bennet, Melissa Jim (instructor) and David Epsey (instructor)
LtoR Sitting: Eugene Tsinjinnie, Megan Hoopes, Bridget Canniff

Cost Benefit Analysis Class

LtoR: Paneen Petersen, Ashley Tuomi, amanda Fretts, John McConnel (instructor), Jenine Dankovchik

The 2009 Summer Research Training Institute was held June 15- July 7. This intensive three-week research training is designed for American Indian and Alaska Native (AI/AN) health professionals. The overall goal of the training is to develop a cadre of well-trained AI/AN investigators who will be able to increase their research skills as a result of the Summer Institute, and work to take more central roles in health-related studies as a result of their participation in the training. The curriculum is designed to meet the needs of professionals who work in diverse areas of American Indian and Alaska Native health, from administrators to community health workers, physicians, nurses, researchers and program managers. Each week, trainees are able to choose various courses designed to improve research skills, program development, implementation, and evaluation. In addition to the training, students are provided long-term support for research projects, manuscripts, and grant applications if they request assistance. In total, 98 students participated in the 2009 Summer Institute including 12 Indian Health Service injury prevention Fellows and students from the Northwest Indian College students enrolled in a special course titled, Encounters in Science.

Under a contract from Indian Health Service, Native American Research Centers for Health (NARCH) initiative, the NPAIHB provides a series of research-related short courses to interested AI/AN trainees from across the country free of charge to AI/AN students. Summer Institute trainees selected courses or modules that they needed or desired for professional advancement. Summer Institute students included; post-doctoral, graduate, and undergraduate AI/AN students and AI/AN health researchers and professionals interested in building new research skills and advancing their careers. In addition, three AI/AN summer interns were required to take a core set of Summer Institute courses and complete a capstone research project under the mentorship of one NPAIHB staff. Courses are taught by Native and non-Native experts in the field and include the following.

- Epidemiology
- Community-Based Participatory Research
- Data Into Action: Outbreak Response Epidemiology
- Data Management and Analysis Using STATA
- Questionnaire Design and Data Management
- Conducting Focus Groups
- Cost-Benefit Analysis
- Tribal Health Policy
- Media Advocacy in Public Health
- Research Design and Grant Development
- Program Evaluation
- Data Linkages
- Data Analysis with SAS
- Human Subjects Protection

The evaluation of the Summer Institute is focused on the development and delivery of the training curriculum and related post-course activities, course evaluations, and utility of the training program over time. We are pleased to report that preliminary evaluation data indicate that we have had another successful Summer Institute and we hope to continue to offer the Institute for many years to come.

Methamphetamine Use Among American Indians in The Northwest

by Birdie Wermy, MOD Project Assistant

Methamphetamine Use (and other drugs) Among American Indians in the Northwest is a project at the Northwest Portland Area Indian Health Board (NPAIHB) in conjunction with Oregon Health Science University (OHSU) in February 2008. Birdie Wermy from the NPAIHB has served as the Project Assistant and Liaison between tribes for the past year.

American Indians and Alaska Natives may be at higher risk than other populations for medical complications due to meth use. Addressing these disparities in Native Communities requires participatory research and will include education, learning and action. Since there is limited data available on methamphetamine use in American Indians exploratory and pilot studies will define treatment needs and assess health impacts on individuals and families.

We are currently working with the Native American Rehabilitation Association (NARA) in Portland and two rural sites, one from Oregon and Washington. We have met and discussed the details of the project with both sites and will be collecting a total of 150 Addiction Severity Index (ASI's) Assessments. Once these ASI's are completed we will conduct focus groups (talking circles) at each site with 25 individuals seeking treatment, meth use, treatment services and health problems due to drug use. We will complete a survey with each individual in a reservation-based drug treatment center and in an urban health center.

If you have any questions about this project please feel free to contact me, Birdie Wermy at bwermy@npaihb.org or 503-416-3252

Organizations and Investigators

Oregon Hawaii Node of the National Drug Abuse Treatment Clinic Trials Network (CTN)
Dennis McCarty, Traci Rieckmann and Kathyleen Tomlin
Oregon Health and Science University (OHSU) Prevention Research center
William Lambert
Northwest Portland Area Indian Health Board (NPAIHB)
Victoria Warren-Mears & Birdie Wermy
Native American Rehabilitation Association (NARA)
Steve Gilbert

H1N1 Continued

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Resources

The 2009 H1N1 influenza pandemic will be an important topic for discussion at the upcoming Emergency Preparedness Conference in Tulalip, WA July 28–29, sponsored by the Northwest Portland Area Indian Health Board and the Northwest Center for Public Health Practice. For more information, go to:
http://www.npaihb.org/.

Newest developments can be obtained from the following websites:

World Health Organization (WHO):
http://www.who.int/csr/disease/swineflu/en/index.html

Centers for Disease Control and Prevention (CDC):
General information: http://www.cdc.gov/h1n1flu/update.htm
Frequently Asked Questions: http://www.pandemicflu.gov/faq/swineflu/01.html

State Health Departments:
Idaho: http://healthandwelfare.idaho.gov/Health/DiseasesConditions/H1N1Influenzaswineflu/tabid/328/Default.aspx
Oregon: http://www.flu.oregon.gov/
Washington: http://www.doh.wa.gov/swineflu/
Frequently Asked Questions: http://www.doh.wa.gov/swineflu/faq.htm#Current_Status

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2. Confer with representatives of urban Indian organizations to determine the impact of reform proposals on the Indian people served by those programs.

3. Indian tribes perform several roles in a health care context: They are governments, employers, health care providers, patient advocates, and beneficiaries of the U.S. trust responsibility for health. All of these roles must be respected, together with the recognition that Indian people are a unique and distinct political group, not merely a minority classification.

4. Exempt AI/ANs from mandates and penalties. AI/ANs have already paid for their health care coverage. Failure to acknowledge that Indian people are different from other groups needing health care coverage will result in an abrogation of the federal trust responsibility or denial of their right to fully participate in health reform. It is not appropriate to subject AI/ANs to the individual mandate, especially the penalty for failing to acquire or purchase health insurance.

5. Tribal government exemption from employer penalties. The employer mandate provisions must also exempt Indian tribes, as employers, from penalties. Indian tribes are sovereign nations and should not be subject to federal penalties in their roles as employers.

6. AI/ANs should be eligible for insurance subsidies. Permit AI/AN to participate in subsidized insurance and explicitly permit tribes to pay premiums and cost sharing on their behalf.

7. Portability of health care is essential. In order to guarantee portability between health insurance and the Indian health system, include explicit language which allows AI/ANs to enroll in an insurance plan at any time without assessment of late enrollment penalties or other negative consequences. Without this protection Indian people may be denied options to which they are entitled as United States citizens. Indians should not be forced to choose between the Indian health system and other options; both should be available to them.

8. Indian tribes must retain the authority to decide whether or not to serve non-Indians at their health facilities and extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians.

9. Health care reform should require Tribal collaboration across all HHS agencies and other federal health programs to coordinate health care resources in order to ensure health related funding is more effectively available to tribes.

10. The IHS budget must be protected from offsets and must be enhanced to assure that Indian programs can attract and retain health care personnel needed to fulfill the Federal government's trust obligation to "permit the health status of Indians to be raised to the highest possible level".

11. Health reform should provide opportunities and incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.

12. Health care reform in Indian Country it will create a short term financial burden on the already seriously under-funded Indian health system and financing must be provided to assist in policy analysis and rule making and at the tribal level staff to build the local systems that are needed to effectively educate, enroll, and coordinate patient participation in a reformed system.

13. If the IHS is provided additional resources consistent with what would be provided in a publicly-funded health plan or other programs under health reform, the IHS shall distribute funds equitably to tribal and urban health programs under the terms and conditions of Indian Self-Determination and Education Assistance Act (ISDEAA) and the Indian Health Care Improve-

Impact Indian Country - continued

ment Act (IHICA) on the same allocation basis IHS makes funds available to directly operated service units.

Tribes Must Weigh-in Fast

NIHB and NCAI, in collaboration with Area Health Boards, have been working diligently to track health reform legislation. NPAIHB's recommendations have been instrumental to assist Indian Country to prepare responses to the hill. Because congressional proposals do not adequately address health reform objectives for Indian County, NIHB and NCAI (along with other health advocates) have sent to the hill technical and substantive amendments, as well as recommendations from the Indian Health Care Improvement Act that should be included in the health reform legislation.

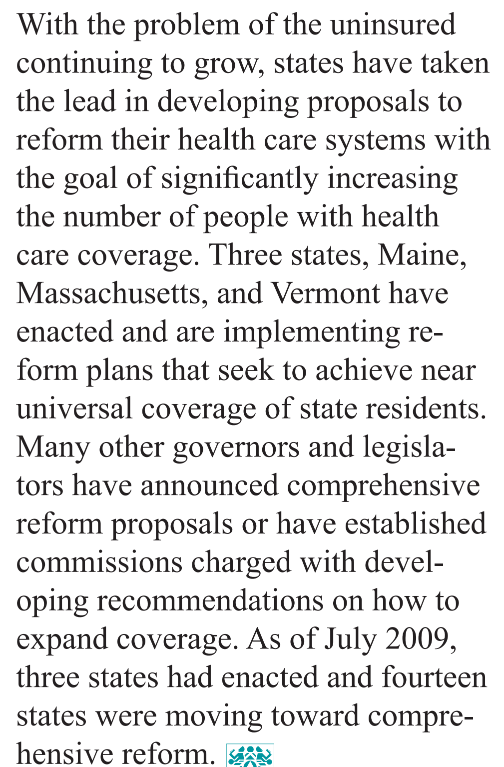
The House is scheduled to adjourn for a summer recess by July 31 and the Senate by August 7, though there have been suggestions the Senate deadline could slip to allow floor time for the health care overhaul. The aggressive time line to complete the health reform bills leaves Tribes little time to weigh in with Congressional members and it is imperative that they do so in order to protect AI/AN participation in health reform options and protect the vital role that the Indian health system plays in providing care. Tribes need to send forward their support for the NIHB and NCAI amendments (described below), which were provided to Congress on July 2nd. It is expected that the HELP committee will resume its mark-up sometime next week, while the House leadership and staff will hash out their concerns next week in order to begin mark-up very soon.

The substantive amendments include adding a definitions section to the bills to include Indian health programs as providers; requiring that health plans offered through the insurance exchange guarantee access to Indian health providers and prohibit discrimination in accessing health care for Indian beneficiaries; assure that components of the Indian health delivery system can participate in provider networks established by an entity which offers health benefits through a insurance exchange; exempt IHS and Tribal health facilities from state licensing requirements when participating in the public plan option; exempt Indian tribes as employers as well as sovereign governments from penalties, taxes, or contribution requirements imposed by its trustee and the Federal Government when a tribe acts in its role as an employer; exempt Indians from the tax assessed against an individual who does not meet the acceptable coverage requirement; waiver of the Medicare Part B late enrollment penalty, and; provisions that improve communication and promote access to health reform programs.

Substantive amendments for Medicare and Medicaid include making permanent the billing authority for all Medicare Part B services (set to expire on December 31, 2009); and a provision that clarifies that the value of "health services," "health benefits" or "health coverage" received by Indians, whether provided or purchased by the IHS or an Indian tribe or tribal organization is excluded from gross income when determining eligibility for subsidies or other benefits. This last provision is very important to protect Indian people from tax penalties and preserve their ability to qualify for subsidies that might be offered under health reform.

The Board will continue to weigh in with Congress on health reform proposals and continue to update Northwest Tribes. The full details of the Tribal amendments described above as well as additional details on health reform are available at: www.npaihb.org.

With the problem of the uninsured continuing to grow, states have taken the lead in developing proposals to reform their health care systems with the goal of significantly increasing the number of people with health care coverage. Three states, Maine, Massachusetts, and Vermont have enacted and are implementing reform plans that seek to achieve near universal coverage of state residents. Many other governors and legislators have announced comprehensive reform proposals or have established commissions charged with developing recommendations on how to expand coverage. As of July 2009, three states had enacted and fourteen states were moving toward comprehensive reform.



Centennial Accord between Washington Tribes

by Sonciray Bonnell, Health Resource Coordinator

Washington, Oregon, and Idaho Tribes realize the worth of a working relationship with their perspective state departments of health. The relationship between Indian Tribes and their state governments date back to territorial times and has been evolving for more than 200 years. In the earliest days, Indian Tribes dealt primarily with the federal government, under treaties that codified their relationship. This lasted more than a century and tribes have continued to strengthen their relationships with the federal government. Over the past few decades, however, Northwest tribes have actively developed a much greater connection between state government and Indian governments.

A driving force behind the development of a working relationship with state governments has been the shift in Tribes administering and operating their own programs using federal funds that are funneled through state government. To ensure that Tribes be an integral part of decision making that affects tribes, including access state benefits, tribes sought a better working relationship with their state.

Washington State Centennial Accord

On August 4, 1989, the Washington State Centennial Accord was executed between the federally recognized Indian tribes of Washington and the State of Washington, through its governor, in order to better achieve mutual goals through an improved relationship between their sovereign governments. This Accord provides a framework for that government-to-government relationship and implementation procedures to assure execution of that relationship.

Each Party to this Accord respects the sovereignty of the other. The respective sovereignty of the state and each federally recognized tribe provide paramount authority for that party to exist and to govern.

This Accord enhances and improves communications between the parties, facilitates the resolution of issue by building confidence among the parties, and outlines the process for implementing the policy. This Accord it is intended to institutionalize it within the organizations represented by the parties.

The parties recognize that implementation of this Accord will require a comprehensive educational effort to promote understanding of the government-to-government relationship within their own governmental organizations and with the public.

While this Accord addresses the relationship between the parties, its ultimate purpose is to improve the services delivered to people by the parties. Immediately and periodically, the parties shall establish goals for improved services and identify the obstacles to the achievement of those goals. At an annual meeting, the parties will develop joint strategies and specific agreements to outline tasks, overcome obstacles and achieve specific goals. The parties recognize that a key principle of their relationship is a requirement that individuals working to resolve issues of mutual concern are accountable to act in a manner consistent with this Accord.

The chief of staff of the governor of the state of Washington is accountable to the governor for implementation of this Accord. State agency directors are accountable to the governor through the chief of staff for the related activities of their agencies. Each director will initiate a procedure within his/her agency by which the government-to-government policy will be implemented. Each agency will establish a documented plan of accountability and may establish more detailed implementation procedures in subsequent agreements between tribes and the particular agency.

The parties recognize that their relationship will successfully address issues of mutual concern when communication is clear, direct, and between persons responsible for addressing the concern. The parties recognize that in state government, accountability is best achieved when this responsibility rests solely within each state agency. Each agency will facilitate this objective by identifying individuals directly responsible for issues of mutual concern.

Each tribe also recognizes that a system of accountability within its organization is critical to successful implementation of the relationship.

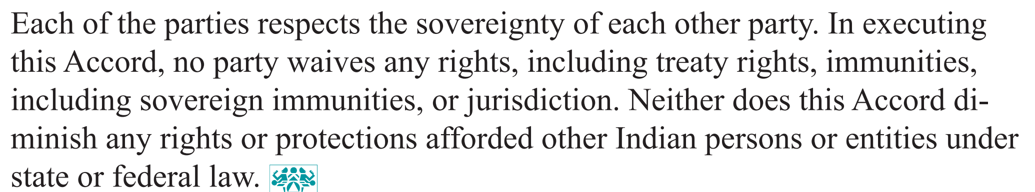
and the State of Washington

Therefore, tribal officials will direct their staff to communicate within the spirit of this Accord with the particular agency which, under the organization of state government, has the authority and responsibility to deal with the particular issue of concern to the tribe.

In order to accomplish these objectives, each tribe must ensure that its current tribal organization, decision-making process and relevant tribal personnel is known to each state agency with which the tribe is addressing an issue of mutual concern. Further, each tribe may establish a more detailed organizational structure, decision-making process, system of accountability, and other procedures for implementing the government-to-government relationship in subsequent agreements with various state agencies. Finally, each tribe will establish a documented system of accountability.

As a component of the system of accountability within state and tribal governments, the parties will review and evaluate at the annual meeting the implementation of the government-to- government relationship. A management report will be issued summarizing this evaluation and will include joint strategies and specific agreements to outline tasks, overcome obstacles, and achieve specific goals.

The chief of staff will use his/her organizational discretion to help implement the government-to-government relationship. The office of Indian Affairs will assist the chief of staff in implementing the government-to-government relationship by providing state agency directors information with which to educate employees and constituent groups as defined in the accountability plan about the requirement of the government-to- government relationship. The Office of Indian Affairs shall also perform other duties as defined by the chief of staff.

Each of the parties respects the sovereignty of each other party. In executing this Accord, no party waives any rights, including treaty rights, immunities, including sovereign immunities, or jurisdiction. Neither does this Accord diminish any rights or protections afforded other Indian persons or entities under state or federal law. 

For more information visit:
http://www.goia.wa.gov/Government-to-Government/Data/CentennialAccord.htm

LEAVENWORTH (11/4/99)--Governor Gary Locke and Attorney General Christine Gregoire joined tribal chairs from throughout the state Wednesday in signing an "Agreement To Institutionalize The Government-to-Government Relationship In Preparation For The New Millennium." This agreement, between the State of Washington and the Tribal Nations, is an affirmation of the 1989 Centennial Accord, as well as a compact to implement the terms of the Accord on a day-to-day basis.

NISQUALLY (4/28/05)--Governor Gregoire signed a Proclamation reaffirming the government to government relationship between the State and Federally-recognized Indian Tribes. The Proclamation signing took place during a meeting of the Association of Washington Tribes (AWT) held at the Red Wind Casino Conference Room on the Nisqually Indian Reservation.

FY 2010 IHS Budget Moves Effortlessly

by Jim Roberts, Policy Analyst

The Indian Health Service (IHS) FY 2010 appropriation seems to be moving effortlessly through this session of Congress. This is a striking from the previous Administration. While the Administration does not recommend and approve spending bills, it does weigh in about budget caps and can make veto threats if Congressional fiscal policies are not consistent with the Administration's budget. This has been common the last two years as the Democratic controlled Congress has often established different funding priorities than President Bush. The new Obama Administration has ushered in a welcome change for Indian health programs.

On June 26th, the full House approved by a 254-173 roll call vote, $471.3 million for IHS and Tribal health programs for FY 2010. In May, the Administration submitted to Congress a budget request that included a $453.5 million increase over FY 2009 for the IHS and Tribes. The House approved amount provides a $17.6 million increase over the President's request. Tribes were very pleased with the President's increase of almost one-half billion dollars, and see it as a starting point to restore years of neglect and chronic underfunding of the IHS budget by the previous Administration.

On June 25th, the Senate Interior Appropriations Committee recommended to match the President's requested increase for the IHS by approving a $453.5 million increase. The full Senate has yet to act on the Committee's recommendation. The House recommended additional funding over President Obama's request for Hospital and Clinics ($2.5 million), Dental Services ($1.25 million), Urban Health ($5 million), and Contract Support Costs ($9 million). The Senate Appropriations Committee recommended the same funding levels as requested by the Administration. The additional funding for the Hospital/Clinics line item will fund a domestic violence prevention initiative. This makes the House mark a 13.2% increase over FY 2009, while the Senate recommendation is 12.7% more than last year's enacted level.

Both the House and Senate bills provide $166.7 million to fund current services consisting of: $34.9 million for federal and Tribal pay cost increases, $44.6 million to fund population growth, $60.3 million for inflation (medical inflation at 3% and 1% for non-medical inflation), and $26.9 million for phasing in staff at new facilities. The Administration and Senate recommendations are the same for program increases, while the House bill provides slightly more funding.

Detail of Changes	President Requst	House Appoved	Senate Recomm.
Current Services			
Pay Costs	$ 34,927	$ 34,927	$ 34,927
Population Growth	44,632	44,632	44,632
Inflation	60,307	60,307	60,307
Staffing New Facilities	26,865	26,865	26,865
Total, Current Services	*$ 166,731*	*$ 166,731*	*$ 166,731*
Program Increases/Decreases			
Domestic Violence Init.	$ -	$ 2,500	$ -
Dental Services		$ 1,250	
Contract Health Services	117,000	117,000	117,000
Urban Health		5,000	
Direct Operations	2,000	2,000	2,000
Contract Support Costs	104,418	113,418	104,418
New Tribes	5,595	5,595	5,595
IHC Improvement Fund	45,543	45,543	45,543
Chronic Care Initiative	2,500	2,500	2,500
HP/DP Initiative	800	800	800
Health Professions	2,854	2,854	2,854
Hlth. Information Technology	16,251	16,251	16,251
Health Facilities Const.	-10,766	-10,766	-10,766
Facil. & Env. Hlth Suppt.	575	575	575
Total, Program Inc/Dec.	*$ 286,770*	*$ 304,520*	*$ 286,770*
Total Increase	**$ 453,501**	**$ 471,251**	**$ 453,501**

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President's FY 2010 Request for the IHS Budget

Compares FY 2009 to President's FY 2010

(Dollars in Thousands)

Sub Sub Activity	Final Budget FY 2009	President's FY 2010 Budget			House Approved Budget - H. Rpt. 111-180					Senate Appropriations Recommendation				
		President's FY 2010 Budget	Change Over FY 2009	Percent Change	House Approved	Change Over Request	Percent Change	Change Over FY 2009	Percent Change	Committee Mark	Change Over Request	Percent Change	Change Over FY 2009	Percent Change
SERVICES:														
Hospitals & Health Clinics	$ 1,597,777	$ 1,751,883	$ 154,106	9.6%	$ 1,754,383	$ 2,500	0.1%	$ 156,606	9.8%	1,751,883	$ -	0%	$ 154,106	9.6%
Dental Services	$ 141,936	$ 151,384	$ 9,448	6.7%	$ 152,634	$ 1,250	0.8%	$ 10,698	7.5%	151,384	$ -	0%	$ 9,448	6.7%
Mental Health	$ 67,748	$ 72,786	$ 5,038	7.4%	$ 72,786	$ -	0.0%	$ 5,038	7.4%	72,786	$ -	0%	$ 5,038	7.4%
Alcohol & Substance Abuse	$ 183,769	$ 194,409	$ 10,640	5.8%	$ 194,409	$ -	0.0%	$ 10,640	5.8%	194,409	$ -	0%	$ 10,640	5.8%
Contract Health Services	$ 634,477	$ 779,347	$ 144,870	22.8%	$ 779,347	$ -	0.0%	$ 144,870	22.8%	779,347	$ -	0%	$ 144,870	22.8%
Total, Clinical Services	*$ 2,625,707*	*$ 2,949,809*	*$ 324,102*	*12.3%*	*$ 2,953,559*	*$ 3,750*	*0.1%*	*$ 327,852*	*12.5%*	*$ 2,949,809*	*$ -*	0%	*$ 324,102*	12.3%
PREVENTIVE HEALTH:														
Public Health Nursing	$ 59,885	$ 64,071	$ 4,186	7.0%	$ 64,071	$ -	0.0%	$ 4,186	7.0%	64,071	$ -	0%	$ 4,186	7.0%
Health Education	$ 15,723	$ 16,682	$ 959	6.1%	$ 16,682	$ -	0.0%	$ 959	6.1%	16,682	$ -	0%	$ 959	6.1%
Comm. Health Reps	$ 57,796	$ 61,628	$ 3,832	6.6%	$ 61,628	$ -	0.0%	$ 3,832	6.6%	61,628	$ -	0%	$ 3,832	6.6%
Immunization AK	$ 1,823	$ 1,934	$ 111	6.1%	$ 1,934	$ -	0.0%	$ 111	6.1%	1,934	$ -	0%	$ 111	6.1%
Total, Preventive Health	$ 135,227	$ 144,315	$ 9,088	6.7%	$ 144,315	$ -	0.0%	$ 9,088	6.7%	$ 144,315	$ -	0%	$ 9,088	6.7%
OTHER SERVICES:														
Urban Health	$ 36,189	$ 38,139	$ 1,950	5.4%	$ 43,139	$ 5,000	13.1%	$ 6,950	19.2%	38,139	$ -	0%	$ 1,950	5.4%
Indian Health Professions	37,500	$ 40,743	$ 3,243	8.6%	$ 40,743	$ -	0.0%	$ 3,243	8.6%	40,743	$ -	0%	$ 3,243	8.6%
Tribal Management	2,586	$ 2,586	$ -	0.0%	$ 2,586	$ -	0.0%	$ -	0.0%	2,586	$ -	0%	$ -	0.0%
Direct Operation	65,345	$ 68,720	$ 3,375	5.2%	$ 68,720	$ -	0.0%	$ 3,375	5.2%	68,720	$ -	0%	$ 3,375	5.2%
Self Governance	6,004	$ 6,066	$ 62	1.0%	$ 6,066	$ -	0.0%	$ 62	1.0%	6,066	$ -	0%	$ 62	1.0%
Contract Support Costs	282,398	$ 389,490	$ 107,092	37.9%	$ 398,490	$ 9,000	2.3%	$ 116,092	41.1%	389,490	$ -	0%	$ 107,092	37.9%
Total, Other Services	*$ 430,022*	*$ 545,744*	*$ 115,722*	*26.9%*	*$ 559,744*	*$ 14,000*	*2.6%*	*$ 129,722*	*30.2%*	*$ 545,744*	*$ -*	0%	*$ 115,722*	26.9%
TOTAL, SERVICES	*$ 3,190,956*	*$ 3,639,868*	*$ 448,912*	*14.1%*	*$ 3,657,618*	*$ 17,750*	*0.5%*	*$ 466,662*	*14.6%*	*$ 3,639,868*	*$ -*	0%	*$ 448,912*	14.1%
FACILITIES:														
Maintenance & Improvement	$ 53,915	$ 53,915	$ -	0.0%	$ 53,915	$ -	0.0%	$ -	0.0%	53,915	$ -	0%	$ -	0.0%
Sanitation Facilities Construction	95,857	$ 95,857	$ -	0.0%	$ 95,857	$ -	0.0%	$ -	0.0%	95,857	$ -	0%	$ -	0.0%
Hlth Care Facilities Construction	40,000	$ 29,234	$ (10,766)	-26.9%	$ 29,234	$ -	0.0%	$ (10,766)	-26.9%	29,234	$ -	0%	$ (10,766)	-26.9%
Facil. & Envir. Hlth Supp	178,329	$ 193,087	$ 14,758	8.3%	$ 193,087	$ -	0.0%	$ 14,758	8.3%	193,087	$ -	0%	$ 14,758	8.3%
Equipment	22,067	$ 22,664	$ 597	2.7%	$ 22,664	$ -	0.0%	$ 597	2.7%	22,664	$ -	0%	$ 597	2.7%
Total, Facilities	*$ 390,168*	*$ 394,757*	*$ 4,589*	1.2%	*$ 394,757*	*$ -*	0.0%	*$ 4,589*	1.2%	*$ 394,757*	*$ -*	0%	*$ 4,589*	1.2%
TOTAL, IHS	***$ 3,581,124***	***$ 4,034,625***	***$ 453,501***	*12.7%*	***$ 4,052,375***	***$ 17,750***	*0.4%*	***$ 471,251***	*13.2%*	***$ 4,034,625***	*$ -*	0%	***$ 453,501***	12.7%

FY 2010 IHS Budget - continued

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The House bill provides an additional $2.5 million (currently funded at $7.5 million) for a total of $10 million to continue the initiative to address domestic violence and sexual assault in Indian Country. Currently, the IHS Behavioral Health Tribal leaders committee is in the process of developing recommendations for how to allocate the FY 2009 funding. The House Committee report stresses that Congress continues to be concerned about the problem of domestic violence, and in particular, abuse against women and children. Congress acknowledges that these issues cannot be addressed by IHS alone and expects IHS to work the Departments of Interior and Justice to provide needed services and support. The House also expects the IHS to implement a nationally coordinated Sexual Assault Forensic Examiner/Sexual Assault Response Team (SAFE/SART) Program to be used to fund IHS and Tribal hospitals through competitive grants. IHS is also directed to expand its national domestic violence grant program to address the growing need to increase Federal, Tribal, and Urban Domestic Violence program services.

The House report questions the Department's policy on witness subpoenas and is concerned that it hinders the IHS mission. Congress indicates that it has received reports that bureaucratic obstacles imposed by the Department prevent IHS personnel from presenting testimony in cases of rape or sexual assault. Congress is concerned that this policy has caused cases to be dropped and alleged perpetrators to walk free. The Committee finds this unacceptable and directs IHS and the Department to evaluate and revise this policy to ensure that IHS personnel are able to testify and present evidence in these cases and to report to the Committee on their efforts within 90 days of enactment.

The House and Senate bills both provide a sizeable increase of $117 million for the Contract Health Service program, which also provides a $17 million increase for the Catastrophic Health Emergency Fund (CHEF). Currently, the CHEF is funded at $31 million, and will now increase to $48 million. This increase in combined with the savings from Medicare-like rates and should preserve the CHEF well into the fiscal year. Historically, the CHEF ran out of funds sometime between January to March, and with the implementation of Medicare-like rates has lasted into June and July the last two fiscal years. This increase will hopefully allow the CHEF to last into August or September.

The House and Senate bills also increase the Indian Health Care Improvement Fund (IHCIF) by $30.5 million, providing a total of $45.5 million for the IHCIF. The increased funding will be provided to those operating units funded at less than 45% of their level of need. The IHS FY 2010 Congressional Justification included language that indicates the IHS will "conduct a thorough evaluation of the methodology and data sources utilized to distribute the IHCIF and will take action to improve and refine the formula if necessary." Unfortunately, Congress did not include this language in their appropriation reports. Northwest Tribes have always had concerns about the methodology to allocate the IHCIF and that it might not include all resources when establishing the federal disparity index of Tribes. Portland Area Tribes support a comprehensive evaluation of the IHCIF methodology and will request that when the appropriation bills go to conference that Congress direct the IHS to complete this evaluation.

A notable change for the FY 2010 appropriation is the sizable increase for the Contract Support Cost (CSC) line item. This year's CSC increases signal an end to a sad chapter of neglect for Self-Determination. Contracting and compacting were seriously undermined from 2002 through 2008, by the failure to pass adequate funding increases to not only support existing contractors, but those who wanted to participate in Self-Determination and Self-Governance opportunities. The lack of CSC funding has halted the federal policy of Indian Self-Determination. New contractors found themselves unfairly set up to fail when the IHS was unable to provide the level of contact support that was justified by the amount of activity taken over by Tribes. The House bill provides $9 million more than the President's and Senate recommendations of $107 million. The House bill provides $116 million

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Contract Support Costs – continued

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an official position (resolution) on this matter and anticipates that discussion would be spirited, given that we have programs on both sides of the issue. This is an opportunity for you to make your opinions and issues known to the OTP, and your congressional delegates.

ARRA was another item discussed during the two day meeting, with fewer diverging opinions on the matter. Given that ARRA funded only two major facilities outside of the NW and the Health IT funding is staying in IHS Headquarters, equipment dollars are limited, as well as maintenance and improvement funding, tribal representatives from the NW were not eager to include ARRA into the shortfall request.
The IHS is due to have another shortfall report out in November to provide to Congress. The current reported shortfall is identified at $158 million with a large variation in the level of need percentage across the nation. Several ideas were discussed about the methodologies that could be implemented to provide equity across the nation, with the following principles in tact…"do no harm to existing programs, and bring everyone up to the same level."

One other item that generated some angst among tribal representatives in the audience was the National Business Center Indirect cost rate negotiations. The decision made by the National Business Center to exclude the 50% of Tribal Council activities from indirect CSC was not met pleasantly; needless to say Tribes will continue to work to identify ALL the costs associated with fulfilling the contracts for operating their health programs, including Business Council activities along with the appropriate justification for inclusion of these expenses.

With a new Administration, comes the need to re-examine existing policies and to identify the need for new policies and the IHS chose to gather additional feedback on its existing CSC policy and brainstorm possibilities for improvement. To date, the Obama Administration is following through with statements made on the campaign trail in Indian Country to address the disparities of our people through the aggressive (by recent standards) request for funding for the IHS. I would encourage everyone to quickly comment on issues related to CSC, and to follow our policy updates on other matters related to Indian Health.

IHS Budget

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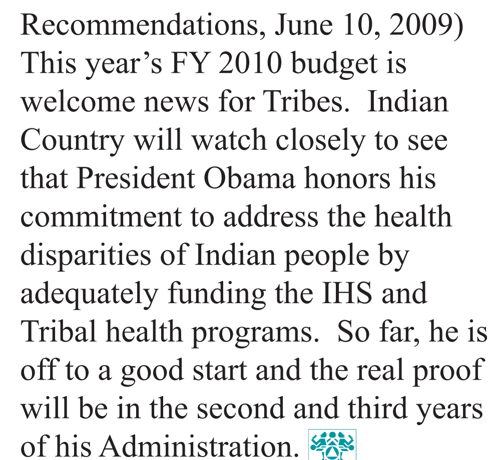
for CSC, and if the recommendation becomes final, will provide Portland Area Tribes with approximately $10 million in new CSC funds. It is expected that the IHS will direct all of the increase to past year's CSC shortfalls.

The NPAIHB's FY 2010 Budget Analysis and Recommendations report estimates that it will take at least $469 million to maintain current services. This year's House approved budget is adequate to fund current services; however the Senate's will fall short by $15 million. The House budget provides adequate funding, however, the allocations should be adjusted to fund current services by increasing funding for Dental Services by $1.6 million, Mental Health by $1.5 million and Public Health Nursing by $1.2 million. (See NPAIHB FY 2010 Budget Analysis and Recommendations, June 10, 2009)
This year's FY 2010 budget is welcome news for Tribes. Indian Country will watch closely to see that President Obama honors his commitment to address the health disparities of Indian people by adequately funding the IHS and Tribal health programs. So far, he is off to a good start and the real proof will be in the second and third years of his Administration. 

Methamphetamine Initiative

by Dr. Linda Bane Frizzell, Ph.D., Nak NuWit P.I.

The Northwest Portland Area Indian Health Board (NPAIHB), is collaborating with the Assistant Secretary for Health, Office of Public Health - Office of Minority Health, on a project to reduce American Indian and Alaska Natives (AI/AN) health disparities. The emphasis of this collaboration will be reducing methamphetamine use and the related effects.

This collaboration will address the following objectives:

- Increase knowledge and understanding of health conditions, methamphetamine use, and other health risk factors disproportionately affecting AI/ANs. Data will be gathered from accessible sources to define objective data elements, barriers, and availability of services, referrals, and prevalence of use.
- Develop strategies to improve service delivery and access to quality and culturally competent health services, public safety programs, and other local community driven services. Information will be developed for access electronically and/or by hard copy. Information from other Collaborators from this Initiative will also be compiled.
- Develop the infrastructure capacity to conduct formative research, evaluations, and testing of new and innovative health care service delivery and health promotion models and interventions for AI/ANs.

The specific objectives of the NPAIHB are to define objective data elements, including exploration of data quality and availability within current systems, to coordinate with other tribal epidemiology centers on survey development and implementation, to identify current treatment service availability, referral and use by AI/AN, and to assist with review of the methamphetamine tool kit.

Background

Methamphetamine use and production have approached epidemic proportions in many tribal communities across the country. According to a recent study, treatment admission of persons with primary methamphetamine use problems increased from 21,000 to 117,000 in 2003. In 2004, 1.4 million persons aged 12 or older had used methamphetamine in the past year and 600,000 had used methamphetamine in the past month.

In 1997, the Indian Health Service (IHS) began collecting methamphetamine patient encounter data. During the first reporting year, the Agency reported 31 patient visits that were methamphetamine related. In 1998, methamphetamine related visits increased by 1,877% to 613 in a single year. While this increase may be a result of better patient encounter data and availability, the longitudinal trend shows increased methamphetamine related visits. Within the IHS system, the actual methamphetamine encounters are unknown due to a lack of primary diagnostic coding. Within the IHS system, there is a mechanism for secondary coding. However, preliminary investigation indicates that this mechanism is used sporadically within the reporting system.

This Initiative is designed to establish data bases and an information repository about the effects of methamphetamine for the tribes in the Northwest. Currently no such data exists, therefore, access to existing knowledge about AI/AN issues regarding the impact of methamphetamine in tribal communities and AI/AN populations is severely limited.

Access to American Indian Recovery

by Erik Kakuska, AAIR Project Specialist

Welcome to the Access to American Indian Recovery (AAIR) program! AAIR is a substance abuse treatment and recovery support program that provides services to those looking to end their addiction(s). The AAIR program, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is administered by the California Rural Indian Health Board, Inc. (CRIHB) and the Northwest Portland Area Indian Health Board (NPAIHB) is a grant partner. Our mission is to help our clients overcome the barriers that make accessing treatment difficult and recovery sometimes impossible to achieve.

In the time that I have been working for the program, I have found that, more than ever, there is a greater need for a voucher funded program. With the rise of Methamphetamine use in the Northwest and a constant stream of substance abuse, AAIR has been trying to find a way to help those in need. At the start of the program, SAMHSA mandated the AAIR program to use 30% of their funding for methamphetamine users. I am pleased to announce that AAIR has, so far, enrolled more than 2308 of our native people from California, Idaho, Oregon and Washington; 45% of these clients are Meth. users, surpassing SAMSHA's mandate by 15%.

As a result of the collaboration between CRIHB and NPAIHB, more than 102 providers are enrolled into the AAIR provider network. Throughout the Northwest alone, we have been able to enroll 24, meeting SAMHSA's required goal for all three years; and we still have another year and a half left. We also have another five providers awaiting approval. With your help, the list continues to grow. For that reason, I would like to say thank you for helping AAIR achieve these goals.

Currently, CRIHB and the NPAIHB have formed a training team to visit the NW tribes in order to better understand the program and the Voucher Manage System (VMS). We are continually searching for providers and a host for these trainings. If your organization is interested in hosting, please contact me.

How to access the AAIR Program to become a provider

Please contact me (ekakuska@npaihb.org) if your health center wishes to provide AAIR services to AI/AN people in Idaho, Oregon, or Washington. All new provider applicants are required to complete and submit a Provider Enrollment Application to apply for enrollment. Once you submit the application with the required supporting documents, it will be reviewed by AAIR and you will be notified of the decision within 30 days.

- Access to American Indian Recovery (AAIR): www.crihb.org/aair
- Access to American Indian Recovery call center: (866) 350-8772 (toll free)
- Substance Abuse and Mental Health Service Administration (SAMHSA): www.atr.samhsa.gov

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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.

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Northwest Portland Area Indian Health Board April 2009 Resolutions

RESOLUTION #09-03-01
Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (State and Tribal Youth Suicide Prevention Grants)

RESOLUTION #09-03-02
Support for NPAIHB EpiCenter Data Linkage with Comprehensive Hospital Abstract Reporting System of Washington

RESOLUTION #09-03-03
Support for NPAIHB EpiCenter Data Linkages with Vital Statistics Records of Idaho, Oregon, and Washington

RESOLUTION #09-03-04
Support for NPAIHB EpiCenter Data Linkages with State Trauma Registries of Idaho, Oregon, and Washington

RESOLUTION #09-03-04
Methamphetamine and Suicide Prevention Imitative for American Indians and Alaska Native Communities