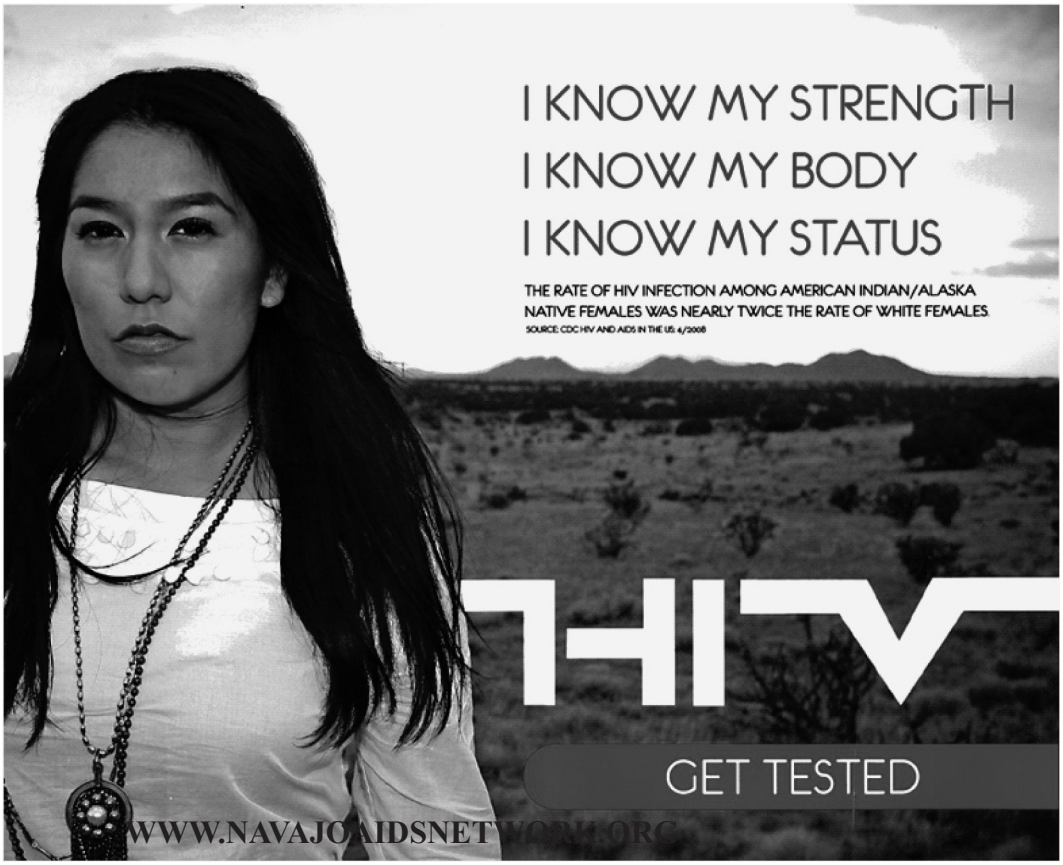
Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

October, 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.



Rapid HIV Testing. **Article on page 4.**

In This Issue

From the Chair:
Linda Holt

As I look back to the work that our Board has done over the last years, I'm impressed and hopeful, but know that it's not enough rest solely on our laurels. There is so much work that we must get done for our Indian people.

I want to acknowledge our Vice-Chair, Andy Joseph, for his important work. The Direct Service Tribes (DST) conference was held on August 6-7th and Andy was instrumental in the success of that event. The DST conference focused on the current state and future of Direct Service Tribes, the IHS budget, and Contract Health Services. Andy was also elected as the new DST Vice-Chairman, a continuing tribute to leadership from the Northwest.

The Board played an important role in three very important events. We held our NW Tribal Emergency Management Conference in Chehalis, and hosted this year's Native Health Research Conference in Portland. The Diabetes program hosted Native Fitness V at the NIKE World Headquarters in Beaverton this past month, and continues to provide important training opportunities for tribal diabetes staff. All the events were very well attended and I want to convey my kudos to our EpiCenter and staff for putting on these important events.

Finally, I want to say a word on our important work in Washington, D.C. By now, you have all heard the sad news that Tribes were not able to get the Indian Health Care Improvement Act (IHCIA) passed in this 110th Congress. As frustrating as this is, we did forge some important relationships with our Congressional delegation and other members outside of the Portland Area. Congress definitely knows who the Northwest Portland Area Indian Health Board is and understands we have made ten different trips to the hill calling on our members over seventy-five times in this legislative session. This does not include calling on members outside of Idaho, Oregon, and Washington or the times we have testified before committees. I applaud our Delegates for this work, as it would not be possible without your financial support and hard work on important health issues.

Of course, there are other things I would like to commend you on, but it's important we take sight of the work ahead too. We need to prepare for the new Administration and 111th Congress. Both will be making major changes to address health care issues, so we must continue to remind them that our programs continue to be under financed and our health disparities may be on the rise. Over the next quarter, we'll be working with you all to develop our legislative priorities for the 111th Congress and your needs are important. So I look forward to working with you all on our agenda and again, and as always, thanks for your support!

From the Executive Director:

Joe Finkbonner

National Indian Day Celebration
Portland's Pioneer Square

On September 26, 2008 the Northwest Portland Area Indian Health Board was the proud sponsor of an Indian day celebration event at Portland's Pioneer Square. This was the 2nd Annual celebration of National Indian Day, which is recognized on the fourth Friday in September. Although we didn't host the event in 2007 due to the National Indian Health Board Consumer Conference held in Portland, we are going to host the celebration of our cultures every year from this point forward. The event was a great success because of the people who attended and contributed. Our thanks to everyone involved, especially our veterans, emcee, whip man, dancers, and drums. We are also grateful to the many sponsors which are too numerous to list, so I refer you to our website for a specific list of sponsors: www.npaihb.org.

Our great nation chose Indian Day to honor indigenous Americans for the many contributions made toward the establishment of what has become the United States of America. It is not a federal holiday, state holiday, or even widely publicized in the greater population. Sadly, many with whom I spoke with didn't even know about National Indian Day, which prompted me to do a bit of research on the subject in order to provide a better understanding and hopefully get "the word" out so that we get the recognition deserved.

I decided to "Google search" Indian Day figuring I would get thousands of hits…nope. However, I found out that November 13th is National Indian Pudding day. The name "Indian pudding" is likely derived from the cornmeal, known as Indian meal way back when. Attached is the link to the recipe if you want to try it: http://www.elise.com/recipes/archives/000251indian_pudding.php.

One other interesting link took me to an article which discussed a proposal made to the Seattle Public Schools to have "Hug an Indian Day" in the

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I know my **Strength**, I know

by Stephanie Craig Rushing, Project Red Talon Director

In August 2008, the Centers for Disease Control and Prevention (CDC) released a new estimate of the number of new HIV infections in the United States, revealing that the HIV epidemic is much worse than previously known. They reported that approximately 56,300 people were newly infected with HIV in 2006 – suggesting that the annual infection rate is nearly 40% higher than previous estimates. The new reports also confirmed that American Indians and Alaska Native have the third highest AIDS rate of all racial and ethnic groups in the U.S.

- HIV Rates are on the rise. From 2001-2004, rates increased more than 12% among American Indians and Alaska Natives.

- Almost one-third of all HIV/AIDS cases among American Indians and Alaska Natives occur among women. Women most commonly report heterosexual contact as their primary cause of exposure to HIV.

- Despite what many now think, even young people are at risk for HIV. Half of new HIV infections occur among teens and young adults.

- Routine HIV screening is recommended for everyone age 13 to 64, regardless of risk, and yearly screening is recommended for individuals at higher risk.

Early testing is critical for care and survival. American Indians and Alaska Natives have the lowest AIDS survival rate of any group, with just 1 in 4 individuals living more than 3 years after their diagnosis. But effective treatments do exist. HIV counseling and testing enables people with HIV to take steps to protect their own health and that of their partners, and helps people who test negative get the information they need to stay uninfected. With early testing and appropriate treatment, HIV-positive individuals can now live long, healthy lives.

I know my Status. Altogether, more than 1.1 million people in the United States are now living with HIV, and more than 3,225 American Indians and Alaska Natives have been diagnosed with AIDS since the beginning of the epidemic. Unfortunately, the CDC estimates that about one-fifth of those who are HIV-positive are unaware of their status, and may spread the virus unknowingly. To address this distressing situation, Tribes and partnering organizations are now coming together to support a new nationwide Native HIV Testing initiative: I know my Strength, I know my Body, I know my Status.

The Native HIV Testing Initiative. To help support this collaborative effort, the Substance Abuse and Mental Health Services Administration (SAMHSA) has dedicated nearly $3 million to improving HIV/AIDS outreach, education, prevention, screening, and clinical capacity in Indian Country, through contracts with Tribes, Tribal organizations, and Urban Indian Health Clinics. One of the components of the initiative is to provide free Rapid HIV test kits to AI/AN healthcare providers and support testing activities at the community-level. Another component is to develop a nationwide AI/AN HIV media campaign that will encourage testing and reduce stigma.

The project addresses a number of Healthy People 2010 objectives, with the overarching goal of increasing the number of American Indians and Alaska Natives who know their HIV status and have access to appropriate counseling and informational materials. The first phase of the Native HIV Testing initiative will be ending in March 2009, so Tribes are encouraged to get involved soon.

my **Body**, I know my **Status**

Resources Available to Northwest Tribes associated with the Native HIV Testing Initiative

Clinical Training on How to conduct Rapid HIV Tests:
SPIPA – Tribal BEAR Project: Tribal BEAR project has provided four Rapid HIV Testing Trainings in the past year, and will conduct 1-2 more trainings in the coming months. Their interactive, hands-on training prepares attendees to conduct Rapid HIV Tests. Participants also discuss practical implementation issues and quality assurance. For more information contact: Jutta Riediger at (360) 462-3224 or riediger@spipa.org; Michael Maxwell at (360) 462-3225 or maxwell@spipa.org.

Free Rapid HIV Test Kits:
Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA will be providing 50,000 free Rapid HIV test kits and controls to AI/AN service providers. Questions about accessing the free test kits can be directed to: Andrea Israel at (970) 491-7872 or andrea.israel@colostate.edu; Love Foster-Horton at (249) 276-1653 or love.foster-horton@samhsa.hhs.gov; or to Deepa Chhatwal at dchhatwal@iqsolutions.com.

Community HIV Testing Event Grants:
Project Red Talon: Project Red Talon is providing up to $3,000 per site to support Tribal HIV screening events. Funds can be used to cover outreach materials, counselors/testers (wage compensation, travel, lodging), facility fees, print materials and advertisements, participant incentives, guest speakers (honoraria, travel and lodging), and any other relevant testing expense. Contact Stephanie Craig Rushing for more information at (503) 228-4185 or scraig@npaihb.org.

Media and Outreach Materials:
Project Red Talon: Project Red Talon is coordinating the National AI/AN HIV Media campaign. Campaign materials are now being designed and will be available by December 1, 2008. For more information or to contribute to the process, please contact Stephanie Craig Rushing at (503) 228-4185 or scraig@npaihb.org. Project Red Talon also has HIV brochures, fact sheets, and Tribal Advocacy Kits that are available year-round. Download materials at: www.npaihb.org/epicenter/project/prt_reports_publications_media_materials/

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Learn More
Find an STD/HIV testing site near you at: www.hivtest.org. Or visit your tribal health department. Visit Stop the Silence at: www.stopthesilence.org Call the CDC National AIDS Hotline at: 1-800-CDC-INFO (232-4636)

HIV Impacts Each of Us. What Can We Do?
Protect yourself against HIV infection. Know the risks associated with sex and drug use.

Get tested to better protect yourself and your partners. HIV screening is recommended for everyone age 13 to 64, regardless of risk, and yearly screening is recommended for individuals at higher risk.

Educate others about HIV/AIDS. Volunteer at your tribal HIV program.

Get medical care and support if you're living with HIV. Effective treatments exist.

Be a friend to someone living with HIV/AIDS. Help end stigma associated with HIV.

Please let us know if you have questions about any of these resources or opportunities! **Project Red Talon is here to support your work.**

Community Health Centers:

by Jim Roberts, Policy Analyst

To address the chronic underfunding of health programs and critical health disparities that their members face, many Tribes have looked to other funding sources to compliment their health care budgets. Community Health Centers (CHCs) can receive as much as $650,000 annually to provide health services to specific populations and targeted communities. Many tribal health programs have applied and become Community Health Centers to deal with funding and health disparity concerns. This article examines CHCs, how to apply, and considers some of the challenges that Tribal programs face when deciding to become a CHC program.

CHCs provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved areas (MUA) or for medically underserved populations (MUP). Community Health Centers exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population, and tailor services to the needs of the community. Many Indian reservations are already situated in MUAs and/or provide services in a locale that has been designated as a MUP area, and because of this, tribal health programs often apply to become designated as a CHC program. HRSA's Bureau of Health Professions designates MUAs and MUPs and they are published annually in the Federal Register.

The CHCs were first funded by the federal government in the mid-1960s under the Economic Opportunity Act. CHCs were established as part of the War on Poverty and designed to provide accessible personal health services to low income families residing in urban settings. In 1969, this authority was transferred to the Public Health Service (PHS) who began funding neighborhood health centers. Currently, the CHC program is authorized under Section 330 of the PHS Act and is operated by the Health Resources Service Administration (HRSA) within the Department of Health and Human Services. Thus, CHC programs are often referred to as 330 health clinics and are the same.

To apply to become a CHC, health programs must complete an application to HRSA's Bureau of Primary Health Care. Applicants must document need for primary care services in their area, complete a plan to address these needs, document the clinical capacity of their program, discuss the environment of the communities they serve, and substantiate its need with data. Because of these requirements, it is important that Tribes get an early start and begin collecting the required data. HRSA recommends that applicants start the process at least six months in advance of the application deadline.

Once designated as a CHC, tribal health programs receive a recurring grant that is capped at $650,000 per year. Not all CHCs receive the cap amount and many receive less. An amount up to $150,000 may be used in the first year for one time capital costs to cover equipment or alteration/renovation of a health facility. Section 330 funding is allocated within four categories described below:

1) New Access Points Grants provide funding to support new service delivery sites that will provide comprehensive primary health care and access to oral and mental health services. Applicants can be existing grantees or new organizations that do not currently receive Section 330 grant funds.

2) Expanded Medical Capacity Grants provide funding to expand access to primary health services in the health center's current service area (e.g. by adding new medical providers or medical services or expanding hours of operation). Only existing Section 330 grantees are eligible to apply.

3) Service Expansion Grants provide funding to add new or expand existing mental health/substance abuse and oral health services at existing health centers. Only existing 330 grantees are eligible to apply.

4) Service Area Competition Grants provide ongoing competing continuation funding for service areas currently served by health center grantees. Both currently funded section 330 grantees whose project periods have expired and

An Option for Tribes to Seek Additional Funding

new organizations proposing to serve the same areas or populations being served by existing Section 330 grantees may apply.

For tribal health programs, the opportunity to participate in the CHC program does not come without a price. The fact that CHCs must be willing to provide primary and related care to all community members being served in the MUA or MUP has been a barrier for Tribes. Many Tribes may not be willing to open the doors of their health facility to provide services to the non-Indian community. The CHC funding may not cover the costs of the additional demand for services that results when a Tribe opens its facility to the overall community. Granted, there might be additional revenue generated by providing services to Medicare and Medicaid eligibles, but these cost/benefit factors must be carefully evaluated. Indian health programs are already underfunded and Tribes must be careful not to diminish services for its members. This analysis will vary by Tribe and has geographic considerations. The chances of non-Indian patients walking into a Tribal health facilities are much different in the Aberdeen or Billings Area than they are for Tribal programs located in the Portland or California Area. Aberdeen and Billings Tribes tend to be geographically isolated from non-Indian populations, compared to California and Portland Area Tribes that are situated in more urban locations. Tribal programs have also been reluctant to pursue 330 funding due to concerns of losing their identity as an Indian health provider. It's important that Tribal members develop rapport with their health providers. They want to receive care from someone who understands their needs and provides care in a culturally competent manner. Health programs providing care to the general population run the risk of losing this quality of care issue that is important to Indian people.

Another barrier for Tribal participation is that CHCs must implement a sliding fee schedule or payments for the provision of health services. This sliding fee must be accessed to all individuals served by the facility—whether Indian or the general community. This often stops Tribes from pursing the CHC funding, but should not be such a concern and can be managed with good accounting controls. Another concern related to the schedule of fees is that it must be based on actual facility costs. Thus, you must know your costs and not all Tribes complete cost reports. Most Tribes that administer a CHC fee schedule pay the costs of copayments for Tribal beneficiaries out of their Contract Health Service (CHS) budgets. In effect, the Tribe charges everybody being served, and since a Tribal beneficiary is being covered out of the CHS program, the Tribe is paying itself for the service while satisfying the requirement that fees be assessed on all patients. Of course, copayments for general community members (non-Tribal members) would be covered with the CHC funding, and Tribal members never need to see a bill. Appropriate fiscal controls are required to track these administrative requirements.

Tribes are often concerned that if they receive Indian Health Service (IHS) funds to provide additional levels of service to Indian people, that they will have to provide those same services to everyone. However this isn't entirely true. When specific non-section 330 funds (i.e. IHS funds) are available to support additional services to specific patient groups, the terms under which those funds are made available must be honored. Beyond the required services, a CHC is expected to make a reasonable, good faith effort to arrange for necessary services for those not covered by special funds but is not required to provide the additional services to population groups not covered by the special funds. This means that tribal health programs can provide different levels of care to its members, but when practical, make them available to others served with CHC funds. In most instances, Tribal CHCs do make the same services available to all community members and are often reimbursed for providing them under the Medicaid program.

Other unique characteristics of tribal health providers have been addressed by HRSA in managing the CHC program, but more needs to be done if Tribes are to participate in this opportunity. For example, HRSA

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Community Health Centers: An Option for Tribes to Seek Additional Funding (continued)

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expects that any CHC must establish a mechanism for local input (often referred to as governing boards) into the health center operations. This is often accomplished with a board of directors or advisory board that includes representatives from the general community. In a tribal setting, this would mean that non-Indians would have input into managing the tribal health program. HRSA recognized that this would never happen in Indian Country and exempts tribal programs managing a clinic under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) from this requirement. HRSA could do more along these lines to encourage tribal participation in its programs.

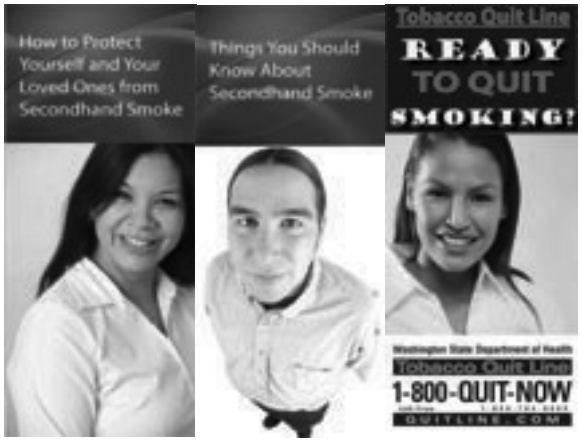
There are also payment scenarios that must be considered when Tribes set up a 330 program. Tribes can set up a CHC as a separate program operating in a separate facility than the tribal health program. These programs are established as Federally Qualified Health Centers (FQHCs). This is an important consideration, as the application of 100% Federal Medical Assistance Percentage (FMAP) will have an impact. States receive 100% FMAP for qualified Medicaid services provided to Indian beneficiaries at tribal health facilities. If Tribes set up a CHC as a separate FQHC, the State may not be able to claim 100% FMAP and will reimburse the Tribe at an FQHC rate and not the Indian Health Service (IHS) encounter rate. Some Tribes operating P.L. 93-638 health program may rent space to a 330 program it has established, which will also affect Medicaid reimbursements. Whether the two programs are located in the same building does not matter for Medicaid reimbursement. States (on behalf of the Tribe) are only able to claim 100% FMAP for expenditures to Indian beneficiaries served by the 638 program. In this instance, the CHC is never considered part of the IHS program and is reimbursed at the FQHC rate regardless of who is served.

While the Community Health Center program does provide financial benefits for tribal health programs there are trade-offs that must be carefully evaluated by each Tribe. Those circumstances will not always be the same for all Tribes either. Tribes must carefully consider the impact this will have on their beneficiaries. In some cases it can expand services, and in other cases in may diminish care provided to Tribal beneficiaries. Once a program becomes a CHC, there are additional funding opportunities to expand medical capacity and develop/expand behavioral health services. In order to be eligible for the additional funding, you must be a designated 330 program. Additional information on the 330 program can be obtained at: http://bphc.hrsa.gov.

How to Protect Yourself and Your Loved Ones

The Western Tobacco Prevention Project has developed three new Native-specific brochures for use in your communities:

1. How to Protect Yourself and Your Loved Ones from Secondhand Smoke
2. Things You Should Know About Secondhand Smoke
3. Ready to Quit Smoking?



While these were developed specifically for Tribes in Washington State, the brochure content is appropriate for Tribes in the Northwest and beyond. Files are available for download from the NPAIHB Western Tobacco Prevention Project Washington State Tribal Contractors Webpage: www.npaihb.org/programs/project/washington_state_tobacco_coordinators. For more information, contact NPAIHB Tobacco Programs Coordinator, Terresa White: twhite@npaihb.org, 503.416.3272.

Meet the new NPAIHB Administrative Officer

The Northwest has long been a "second homeland" to me, and I am now honored and very pleased to be serving the Northwest tribes again as the Administrative Officer of the NPAIHB! I've just said goodbye to the dear friends and relatives on my own reservation - the Sicangu Oyate of the Rosebud Reservation - and in Rapid City and the Black Hills communities. Now I am starting yet another exciting chapter of my life.

Jacqueline Left Hand Bull

To give a very brief overview, my grandparents are Left Hand Bull, Bordeaux, Standing Bear and either Lone Dog or Giroux (it's a mystery). I was born on the Rosebud Reservation and spent the early years in the Grass Mountain district, where only Lakota was spoken. Then my mother moved us to the Black Hills, where I graduated high school, and started exploring the big world outside of South Dakota, first in Colorado, then California, and then the Northwest. I actually did attend Portland State College (now University) for over a year, and so coming to an office on that campus a lifetime later makes me smile.

I've always worked in Indian Country - in Indian Education, serving on Boards relative to Indian peoples, and in indigenous programs and places both in the US and around the world. Some of those years, for example, were at Wa-He-Lute Indian School at Frank's Landing. My B.A. degree is from The Evergreen State College, with a focus on community development in the Indian Studies coordinated program. I picked up an interest in Indian art there and so also served on the Washington State Arts Commission. For years while we lived in Olympia I was involved in the efforts to get treaty rights to fish acknowledged, and was adopted by a dear Squaxin woman, Joyce Cheek - who married into the Makah Nation.

I've lived at home in the Black Hills for the past sixteen years, and of course there is no end to Indian community events and causes, and I've worked hard and loved it. Some weeks go by when I forget that there is a non-Indian population in the city, and I know I'll miss seeing friends everywhere. My most recent employment was with the Aberdeen Area Tribal Chairmen's Health Board, also as Administrative Officer there. But things change, and my sons, now grown and one married, are rooted in the Northwest and I recently realized that Rosebud and South Dakota are where their mother is rooted, and not where they consider home. So I decided that if I wanted to have more regular time with them, I'd need to come back west. The mild climate and fragrant forest beauty will not be hard to take. And I am so pleased and honored - and excited - to be working with and serving the Northwest Tribes in my second homeland. Mitaku Oyasin! We are all related!

National Indian Day Celebration

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Linda Holt, NPAIHB Chair and Suquamish Tribal Council Member Welcoming the crowd.

week prior to Thanksgiving in recognition of the implications that this holiday has had on Native American populations. I applaud them for their sensitivity in recognizing that Thanksgiving is not a "happy time" for all cultures and for acknowledging the fact that the first Americans traded friendship and generosity for 500 years of betrayal, land theft, disease, extermination, and forced assimilation. Although a "hug" seems like putting a band aid on a severed artery, I give them an "A" for effort.

California adopted the fourth Friday in September as "Indian Day," as passed by resolution and signed by then Governor Reagan in 1968 making it an official State holiday. The State of South Dakota, in 1990 changed the second Monday in October to be Native American Day. The significance of that change is that the South Dakota legislature replaced Columbus Day with Native American Day. That would be quite the milestone if we could accomplish the switch on a national level.

The meaning of National Indian Day is not defined so much by what is on the internet, in links to articles, Wikipedia definitions, or recipes, but instead what we make of it. We chose this day to celebrate who we are, share our cultures, and educate the public of the greater Portland metropolitan area about our values, health status, and some of the programs and organizations that serve our people. We look forward to the day when Indian Day celebrations are a big event in every urban area with an Indian population.

National Indian Day Celebration

MC: Gilbert Brown
Whipman: Ed Goodall
Drums: Four Directions, NARA, Little River

A Special Thank You to our Sponsors:

Corporations/Organizations

NW Portland Area Indian Health Board
Hobbs, Straus, Dean & Walker, LLC
NPAIHB EpiCenter
NAYA Family Center
Yee Haw! Western Wear
Bonneville Power Administration
Kah-Nee-Ta High Desert Resort & Casino
Confederated Tribes of Warm Springs
Chinook Winds Casino Resort
Confederated Tribes of Umatilla
Cow Creek Band of Umpqua Tribes of Indians

Individuals

Tiny Tots sponsored by the Hildebrandt Family

Joe Finkbonner, NPAIHB Executive Director, being interviewed.

FY 2009 Continuing Resolution

by Jim Roberts, Policy Analyst

On September 30, 2008 the President signed H.R. 2638 into law as the Consolidated Appropriations Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-181). The bill cleared the House on September 24th, and three days later was approved in the Senate. The bill includes continuing appropriations for all agencies and activities that would be covered by the regular fiscal year 2009 appropriations bills, until enactment of the applicable regular appropriations bill, or until March 6, 2009. The bill also provides annual appropriations for Homeland Security, Military Construction and Veterans Affairs, and Defense.

This means that the continuing resolution (CR) will only fund government operations for five months and when Congress returns next year, they will have to take up action to fund programs for an additional seven months. Funding for domestic programs and the Indian Health Service (IHS) will be at the FY 2008 funding levels. This is unfortunate for the IHS budget and other Indian health programs. The FY 2009 appropriations for the IHS were likely to see some of the best budget increases in the last ten years. Earlier this year, the House Interior Appropriations Subcommittee moved to recommend a $250 million increase for the IHS budget, which represents a 7.5% increase over last year's level. The recommendation was $275 million more than the President's request. The Senate mark for the IHS budget may have been better than the House due to the advocacy efforts of Indian Affairs Committee Chairman, Byron Dorgan (ND), who was successful in getting a $1 billion increase to the Senate's budget resolution to be applied to the IHS budget. The budget resolution is non-binding and it's not known if the IHS final appropriation would have seen the full $1 billion increase, but many held high hopes for the Senate's budget mark. Speculation was that it would be higher and worse case, would be at least the same amount as the House, so a $250 million increase would have been the floor for the IHS budget increase.

Congress may take action prior to next year's March 6th deadline to approve any of the appropriation bills, but this is highly unlikely given everything else the Congress has to deal with right now. Congress is working on passing another economic stimulus package and dealing with the Wall Street bailout, so it's unlikely any other appropriations measures or Indian legislation will be passed. The fact that the CR runs through March 6, 2009, could also mean there may be a lame duck session following the November elections. The Board will provide updates on the FY 2009 IHS appropriation as it becomes available.

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CA7AE: HIV/AIDS Prevention Project: CA7AE has developed a variety of free outreach materials with the slogan: "Protect Our People, Take the Test" (including buttons, stick on tattoos, fans, etc). To view materials visit: http://www.happ.colostate.edu/brochure.html and send requests to (970) 491-7872 or andrea.israel@colostate.edu.

Other Resources – The National Native Capacity Building Assistance (CBA) Network:
The **National Native American AIDS Prevention Center** focuses on strengthening organizational infrastructure and on adapting & training people on use of interventions for HIV prevention. Visit: www.nnaapc.org

CA7AE: HIV/AIDS Prevention Project: Focuses on strengthening community access to and utilization of HIV prevention services through support of local mobilization efforts. Visit: www.happ.colostate.edu

The **Intertribal Council of Arizona, Inc**. focuses on strengthening community planning for HIV prevention by increasing Parity, Inclusion, and Representation (PIR) of Native people in HIV planning groups. Visit: www.itcaonline.com

New Childhood

by Thomas Weiser, MD, MPH, Portland Area Medical Epidemiologist

A new initiative has been launched that will focus on improving immunization coverage for children throughout the Portland Area. Building on the success of last year's Late Season Influenza Immunization Initiative (See NAPIHB Quarterly Newsletter, April, 2008, p.8), this year-long initiative will focus on improving immunization rates at each IHS/Tribal/Urban location within the Portland Area. The effort has received dedicated funding from the Area Director's office and will be one of the Area Improvement Projects for 2008-09. The Area Improvement Support Team, the group of individuals charged with developing the improvement infrastructure necessary for the spread of the IHS Director's Health Initiative to improve chronic and planned care, will be using this as a springboard for learning and developing their approach to supporting real change that makes a real difference.

What will the Childhood Immunization Initiative do? Our goal is to improve immunization coverage for the Portland Area for children of all ages. But it is not enough do improve the Area rate, we want to see improvement at *every* site that is currently providing immunization services. The specific goals for improvement have not been finalized as of press time but at the very least, we want to attain the Healthy People 2010 goal of 80% of all two year-olds in the Portland Area being fully immunized.

How will this initiative improve immunization coverage? We will focus on direct communication with Immunization Coordinators, Public Health Nurses, Clinic Directors, Chief Executive Officers and State partners to identify barriers to immunizing children and accurately reporting those immunizations. This is being done through live presentations and conference calls ultimately culminating in a three day **Portland Area Indian Health Service Immunization Conference** to be held in Portland, December 3 – 5, 2008. The conference will bring us all together, along with staff from the IHS National Immunization Program and the Area Office for three days of learning, information sharing, and brainstorming how to accomplish our goals to improve childhood immunization coverage. The final day of the conference will be held

Portland Area Indian Health Service Immunization Conference

December 3-5, 2008

Portland State University, Native American Student Center

Wednesday December 3

- Successful immunization programs
- Breakout sessions

Thursday December 4

- Breakout session with state partners
- Clinical updates and changes for 2008-2009

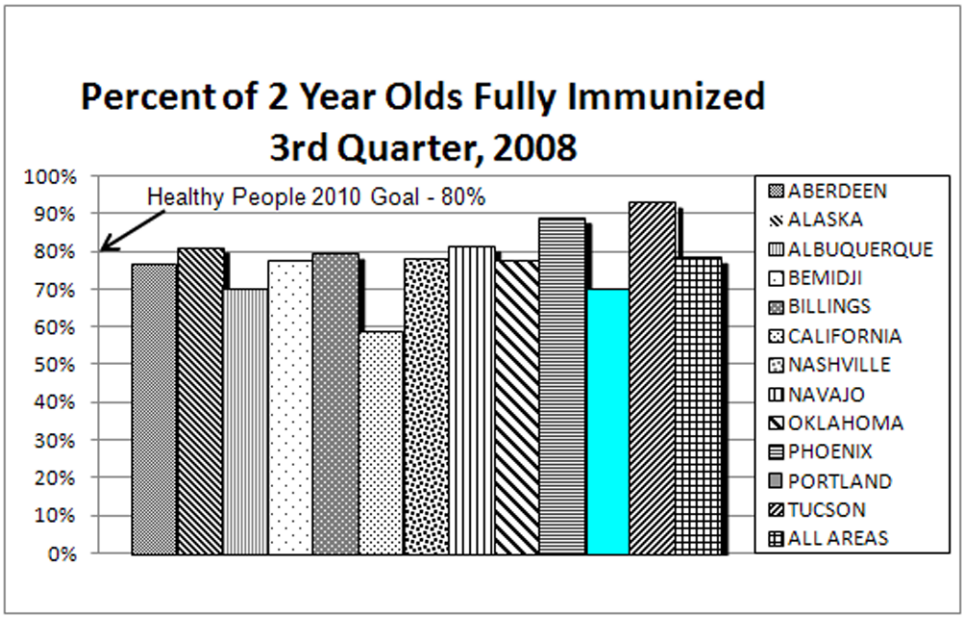
Friday December 5
NPAIHB

- Information technology training including RPMS Immunization Program, National Immunization Reporting System (NIRS), CPHAD, iCARE

For more information contact Clarice Charging (503) 228-4185 ext. 256 or charging@npaihb.org

Immunization Initiative

in the computer lab at the Northwest Portland Area Indian Health Board where participants can get hands-on training in using the latest version of the Resource Patient Management System (RPMS) immunization package, learn how to report using the new, web-based National Immunization Reporting Systems (NIRS), and learn how to use other tools that were introduced in the last two initiatives (CPHAD and iCare) to help carry out and document the efforts we are making.



Why is this being done? Currently, Portland Area is tied for second to last place for full immunization coverage of two-year olds (See Figure 1), with only 70% of our children aged two years or less having documented coverage of all required vaccines per age. We *believe* that many of these children have been vaccinated but we can't *prove* it, partly because our systems for accurately monitoring who has been vaccinated need to be used more effectively. If there are large numbers of our children who are not fully immunized, then we can target resources to get them up to date and protect them from serious, vaccine-preventable illness such as meningitis, pneumonia, measles, and influenza. Also, there are many new immunization recommendations that providers and parents may not be aware of. For example, we want to make sure that all children receive an influenza immunization this year and that all adolescent visits to the clinic for an adolescent exam and immunizations include human papilloma virus (HPV) vaccine for girls, meningococcal (MCV4), tetanus, diphtheria, and acellular pertussis (TDaP), and the second dose of varicella and measles, mumps and rubella (MMR) vaccine if they haven't had these already.

In the past year, the Pacific Northwest region has seen measles, mumps, pertussis, and influenza cases. These diseases can be easily spread from just one person to many in communities with low immunization rates. We must maintain vigilance in keeping our children safe from theses disease that, in the past, have caused so much unnecessary suffering for American Indian children. Please join us and lend your support as we tackle this important public health problem. Together, we can reach the Healthy People 2010 goal of fully protecting our children ahead of schedule and begin to reach beyond.

2008 Native Health Research Conference

by Luella Azule and Vanessa Short Bull

On August 25-28, 2008, the Native Research Network Inc. (NRN) and Northwest Portland Area Indian Health Board (NPAIHB) joined together to co-host 20th anniversary of the former IHS Research Conference. This year's conference had the highest attendance ever with 427 attendees. Among them, 125 were from tribal organizations, 66 students, 101 Universities, 46 from IHS and other Federal Agencies. Teshia Solomon, NRN co-chair and Victoria Warren-Mears, EpiCenter director, recruited several staff members from NRN, the EpiCenter, and NPAIHB to make this years conference a huge success!

Highlights included:
Two Pre-Conference Workshops:
Process Development and Content of Indigenous and Aboriginal Research Guidelines presented by Leslie Randall, RN, MPH, PhD Candidate from Nez Perce.

Health Communications for Your Community presented by Larry Wallack, DrPH

Point, Counter Point Plenary Sessions
Ethics in Native Health Research:
Point: Integrity in Native health research requires that investigators retain some degree of academic freedom in the analysis and reporting of their findings by Jace Weaver, PhD, JD Cherokee.

Counter Point: Accountability in Native health research requires that tribal governments retain sweeping control over the analysis and reporting of research findings from their communities by Grayson Noley, PhD Choctaw

Practice Issues in Native Health Issues:
Point: Traditional healing should remain segregated from institutionalized health care presented by Jeff Henderson, MD, MPH Cheyenne River Sioux

Counter Point: Traditional healing should be incorporated within institutionalized health care by Donald Warne, MD, MPH, Oglala Lakota

Epistemology of Native Health Research
Point: Scientific and traditional explanations depend on largely incompatible ways of knowing, and one should be accorded primacy over the other in Native health research by Clara Sue Kidwell, PhD, White Earth Chippewa

Counter Point: Scientific and traditional explanations have always co-existed in indigenous communities, and conflicts between them are rare or trivial in Native health research by Keith James, PhD Onandaga

"Overall I thought the conference was extremely good, very professional and culturally congruent. It was very informative…I was very pleased that an entire symposium was reserved for Native Hawaiian issues. Being a marginalized group as it is, I am hopeful that next year's conference will also be inclusive of this group." Conference Participant

Introducing the NPAIHB Child Safety Seat Study

by Tam Lutz, PTOTS Project Director

A new study aimed at preventing childhood motor vehicle injuries and deaths has been funded by National Centers on Minority Health and Health Disparities (NCMHHD).

This study is a collaboration among NPAIHB, University of Washington, and six Northwest tribes that will design and evaluate interventions to improve child safety seat use in tribal communities. Six Northwest tribes that participated in the Northwest Tribal Safety Seat Project (under Dr. Francine Romero, Principal Investigator) in 2003 will participate. From that observational survey, we learned that many American Indian children age eight and under were riding either unrestrained or improperly restrained in vehicles.

This study is a four-year project. We are currently working on the project start-up, developing our protocol, and preparing for implementation. During this four-year project we specifically aim to:

1. Determine the knowledge of AI community members about child passenger restraint systems, and determine barriers and facilitators that effect consistent and appropriate use in six tribes in the Northwestern US.

2. Work with members of six Northwest tribes to determine effective methods to increase child safety seat use, developing tailored community intervention programs that work with tribal communities to address unique needs.

3. Implement and evaluate the programs in the Northwest tribal communities, comparing improvement in child passenger restraint use to three comparison tribes in the Northwest through a controlled community trial.

In this study all six participating tribes will receive an intervention. Three will receive the intervention in phase 1, and three will receive the intervention in phase 2. We will collaborate with the tribal communities to develop interventions that will be meaningful to each community. We will evaluate child safety seat use in the community both before and after the intervention phase to see if the intervention had an impact on motor vehicle restraint use in the community.

This study is lead by Principal Investigator, Dr. Jodi Lapidus who has been partnering with the board for nine years. Also joining the study from the NPAIHB is Tam Lutz, Project Director, Nicole Smith, Biostatistician, Kristyn Bigback, Research Assistant, and from University of Washington, Dr. Beth Ebel.

For more information contact Kbigback@npaihb.org

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.

July 2008 NPAIHB Resolutions

RESOLUTION #08-04-01
Support for Application of Smoking Cessation for Patients with Diabetes

RESOLUTION #08-04-02
Recommendation for CMS and IHS to Develop a LTC Initiative to Assist Tribes to Provide Elder Care Services

Resolution #08-04-03
Injury Control Research Center

Resolution #08-04-04
Resolution to Appoint Health Research Advisory Council Member

RESOLUTION #08-04-05
Declaring a "State of Emergency" for Indian Health Care

Resolution #08-04-06
Comprehensive Center of Excellence

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

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