Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

July, 2005 Issue

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.

National Roundtable on The Indian Health System and Medicaid Reform

In light of proposed Medicaid changes, several organizations have worked to develop a national roundtable that will work to protect the vital interests of American Indian and Alaska Native people in the Medicaid program--especially families with children, disabled, and elderly individuals--who depend on Medicaid for basic health and long-term care services. The Northwest Portland Area Indian Health Board, in partnership with the National Indian Health Board, the Indian Health Service (IHS), and the Urban Institute will host "A National Roundtable on the Indian Health System and Medicaid Reform." The roundtable will be held in Washington, D.C. on August 31, 2005 and will be hosted by the Urban Institute. The Urban Institute is a nonpartisan economic and social policy research organization that has conducted a significant amount of work on Medicaid issues.

At more than $300 billion, the Medicaid program is now the nation's largest health care program that accounts for one of every five dollars spent on health care. The recent growth in Medicaid spending has been driven primarily by enrollment growth due to the economic downturn and an aging population, both of which have had a considerable impact on state budgets. The growth in Medicaid and state fiscal pressures coupled with the growing federal deficit has many scrutinizing the costs of the Medicaid program. The President's FY 2005 budget request called for "modernizing Medicaid and SCHIP" by providing states with additional flexibility in Medicaid in order to increase coverage among low income individuals and families without creating additional costs for the Federal government. The budget narrative indicated the Administration's plans for restructuring Medicaid, which proposed building upon SCHIP and the kinds of changes that states have adopted through Section 1115 Medicaid waivers. Shortly after Secretary Michael Leavitt's confirmation, he indicated his interest in Medicaid and SCHIP modernization by extending broad new flexibility to states with respect to "optional" Medicaid populations, posing the question: "Wouldn't it be better to provide health insurance to more people, rather than comprehensive care to a smaller group? Wouldn't it be better to give Chevies to everyone rather than Cadillacs to a few?" A Medicaid Commission has also been organized by the Administration to develop approaches that will address the raising costs in the Medicaid program.

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From the Chair:

Pearl Capoeman-Baller

This year marks the eighth annual joint meeting between the California Rural Indian Health Board (CRIHB) and the Northwest Portland Area Indian Health Board (NPAIHB). Our joint meeting with CRIHB is truly unique compared to other regional and national meetings and is perhaps the only meeting of its type in the country. It brings together representatives from 83 different tribal health programs and gives the Indian Health Service (IHS) and other federal agencies an opportunity to dialogue with tribal officials on Indian health care and policy issues. There are many similarities between our organizations and the joint meetings provide a forum for us to learn from one another. This year's agenda will provide each organization an opportunity to meet with Dr. Charles Grim, IHS Director, and to learn about our different programs, hear updates from CMS, learn about the Next-Gen electronic health record, receive an update on CRIHB's Access-to-Recovery project, and many more valuable sessions. I want to personally thank the Siletz Tribe for hosting this year's meeting and know they will do a fabulous job, so thank you!

Our last Quarterly Board Meeting was held at my home, the Quinault reservation, and it was great not to have to travel. We had a wonderful turnout and a very productive meeting. Shortly after our Board meeting, the Quinault Tribe also hosted the HHS Region X Tribal consultation meetings at the Ocean Shores Casino and Resort Hotel. Our tribe took the opportunity to host a salmon bake for principals from HHS that included Charles Currie, Administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA), Andy Knapp, Deputy Chief of Staff to the HHS Secretary, and others. The social event offered our tribal council members an opportunity to meet with HHS representatives in an informal setting to talk about issues affecting our tribe. Earlier in the day the HHS representatives received a tour of our health clinic and got to see first hand the lackluster facility and conditions that our health professionals have to deliver services in. They certainly contrast those state of the art facilities in which most Americans receive health care and I hope they came away with an understanding of the issues that we as Indian people have to endure when it comes to health care.

This National Congress of American Indians mid-year session was held in Green Bay, Wisconsin and hosted by the Oneida Nation. The mid-year agenda included an appearance by former HHS Secretary Tommy Thompson who provided a retrospect of his administration's work with Indian tribes. The National Indian Council on Aging (NICOA) also held a hearing at NCAI in order to prepare for the White House Conference on Aging. The White House Conference on Aging is scheduled for October 23-26, 2005 in Washington, DC. The purpose of the confer-

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From the Acting Director:
Verné Boerner

This quarter has seen some significant changes that began with the April Quarterly Board Meeting. It has been an adventure and challenge making adjustments to Ed Fox' leave of absence. I want to recognize Ed for the contributions that he has made towards realizing the Board's mission and serving Northwest tribes and American Indian and Alaska Native people nationwide. Any organization facing their director taking a leave of absence expects many questions from staff, partners, and stakeholders. Ed has provided updates and has kept the Executive Committee informed of his status. At this point, there is still much up in the air and hopefully we will know more next month.

On the operations side, we have kept very busy. This quarter the auditors completed their work on the audit and finalized their report. I am very happy to say that the audit was an efficient and successful process this year. The auditors had no findings or reportable conditions and were quite pleased with the presentation of work papers and the Finance Department's responsiveness. Great work Sue, Bobbi and Mike!

Also this quarter, we finalized our negotiations for our Indirect Rate. We now have an approved provisional rate of 40% for FY 2005 and FY 2006. This is up from 37.1% that we had been applying to programs this year. Projects and programs are making appropriate adjustments. The Finance Department is working hard to assist the programs in their spending plans and is currently reviewing our Indirect budget to seek cost savings as well.

Our programs continue to perform. Our project managers and staff are really top-notch folks. The big challenge that we see this year is that some of our mainstay programs are scheduled to sunset this year and the expected next generation funding announcements have yet to be announced. The two main programs are our Western Tobacco Prevention Project and our National Tribal Tobacco Prevention Network. Both of these projects have met their objectives and projected budgets year after year. The challenge that we see is that the delayed announcements have a domino effect that will likely delay any awards granted under these projects. We believe that both these programs would be very competitive, but that there may be a lag from when these programs are scheduled to sunset and when the new awards for the next generation of funding are granted.

The next challenge that we are experiencing is a significant drop in funding awards for two new generations of grants. Both our Native American Research Centers on Health (NARCH) grant, the source of funding for our Northwest Tribal Research Center, and the Dental Support Center awards are significantly reduced. The Board's proposal

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Northwest Portland Area Indian Health Board

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Nichole Hildebrandt, WTPP Project Director
Karen Schmidt, WTPP Project Specialist
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Eric Vinson, Survivor & Caregiver Coordinator

Project Red Talon
Stephanie Craig, Project Coordinator
Lisa Griggs, Project Assistant

FY 2006 IHS Budget Moving

By Jim Roberts, Policy Analyst

The full Senate and House have both taken action on the FY 2006 Interior, Environmental, and Related Agencies Appropriation bill, which provides funding for the Indian Health Service (IHS). The Senate has approved $26.3 billion in budget authority, while the House has approved $26.2 billion; the difference in spending amounts between the two houses is $107.5 million. The bill will now go to a Senate/House conference committee that will work to resolve the differences. It is anticipated that this could happen as early as July. Committee staff indicates that Congress is trying to push through the FY 2006 appropriations as swiftly as possible in order to allow more time to deal with other pressing matters.

The House has traditionally authorized more spending for the Interior bill, however this year the bill picked up responsibility and budget authority for the Environmental Protection Agency (EPA), due to committee restructuring. The higher amount for the Senate is primarily due to the EPA budget. If the EPA appropriation is removed from the Interior bill, the House continues to provide more funding for Interior and related agencies. This continues to be case for the IHS appropriation.

The Senate and House approved budgets are both greater than the President's recommended increase of $62.9 million for the IHS. The Senate amount of $3.0 billion is $82.9 million more than last year's spending level for the IHS, an increase of only 2.8%. The House approved amount of $3.1 billion is a $118 million increase--$35.1 million more than the Senate—over the President's request and is a 4% increase over the FY 2005 enacted level. Both amounts will again fall short of the amount needed to maintain current services

When compared to the overall discretionary spending picture, it might seem that the IHS budget will fare well compared to other federal agencies. This is certainly the picture that the President, the Office of Management and Budget, and representatives within Health and Human Services would like to present. However, even if the final approved budget ends up being a $118 million increase, it will continue to fall short of the estimated $371 million that is needed to maintain current services. Northwest Tribes estimate that it will take at least $183.4 million to cover Contract Health Service and medical inflation, $15.3 million for facilities costs, $112 million for Contract Support Costs, and $54.4 million for population growth. This chronic under funding, will only serve to exacerbate the health disparities of American Indian and Alaska Native people.

It is almost guaranteed that Congress will continue the use of rescissions to deal with spending caps in the appropriations process. Over the last four years, the rescissions as a percentage of the approved IHS budget have increased significantly. This year's Interior appropriations bill over the 302(b) allocation caps and it is almost certain that the final IHS budget will be the subjected to rescissions that will continue to erode the Agency's base budget. Notwithstanding the increases for the health services accounts, the FY 2006 Interior bill as currently presented by Congress will once again fail to fulfill the trust responsibility that the United States has to provide health services to American Indian and Alaska Natives. The Board will continue to advocate for the budget recommendations developed during the All Tribes meeting and presented in the FY 2006 Budget Analysis and Recommendations report.

The most significant difference between the House and Senate amounts are in the Facilities accounts. The President's FY 2006 budget request substantially cut the Health Facilities Construction account by over $85 million. However, the House restored this amount by $46.8 million, while the Senate restored a lesser amount of $17 million. The Senate Committee on Indian Affairs expressed their concern with the one-year moratorium on health facilities construction, and endorsed the savings to be used to provide increases to other line items of the IHS budget in order to limit the eroding effect of past year's appropriations. It is the cease in facilities construction funding that has resulted in at least a 5% increase for all of the health services accounts. Overall, the House approved $35.1 million more for the Facilities accounts with a breakdown as follows:

	Final Enacted FY 2005	FY 2006 President's Request	Change Over FY 2005	% Change versus FY 2005	House Approved H. Rpt. 109-80	Change Over FY 2005	% Change Versus FY 2005	Senate Approved S. Rpt. 109-80	Change Over FY 2005	% Change Versus FY 2005
Services:										
Hospitals & Health Clinics	$ 1,288,944	$ 1,359,541	$ 70,597	5.5%	$ 1,359,541	$ 70,597	5.5%	$ 1,359,541	$ 70,597	5.5%
Dental Health	$ 108,723	$ 119,489	$ 10,766	9.9%	$ 119,489	$ 10,766	9.9%	$ 119,489	$ 10,766	9.9%
Mental Health	$ 55,026	$ 59,328	$ 4,302	7.8%	$ 59,328	$ 4,302	7.8%	$ 59,328	$ 4,302	7.8%
Alcohol and Substance Abuse	$ 139,712	$ 145,336	$ 5,624	4.0%	$ 145,336	$ 5,624	4.0%	$ 145,336	$ 5,624	4.0%
Contract Health Services	$ 498,068	$ 525,021	$ 26,953	5.4%	$ 525,021	$ 26,953	5.4%	$ 525,021	$ 26,953	5.4%
Sub-total, Clinical Services	*$ 2,090,473*	*$ 2,208,715*	*$ 118,242*	*5.7%*	*$ 2,208,715*	*$ 118,242*	*5.7%*	*$ 2,208,715*	$ 118,242	5.7%
Preventive Health:			$ -							
Public Health Nursing	$ 44,943	$ 49,690	$ 4,747	10.6%	$ 49,690	$ 4,747	10.6%	$ 49,690	$ 4,747	10.6%
Health Education	$ 12,457	$ 13,787	$ 1,330	10.7%	$ 13,787	$ 1,330	10.7%	$ 13,787	$ 1,330	10.7%
Community Health Representatives	$ 51,655	$ 53,737	$ 2,082	4.0%	$ 53,737	$ 2,082	4.0%	$ 53,737	$ 2,082	4.0%
AK Immunization	$ 1,582	$ 1,645	$ 63	4.0%	$ 1,645	$ 63	4.0%	$ 1,645	$ 63	4.0%
Sub-total, Preventive Health	*$ 110,637*	*$ 118,859*	*$ 8,222*	*7.4%*	*$ 118,859*	*$ 8,222*	*7.4%*	$ 118,859	$ 8,222	7.4%
Urban Health	$ 31,960	$ 33,233	$ 1,273	4.0%	$ 33,233	$ 1,273	4.0%	$ 33,233	$ 1,273	4.0%
Indian Health Professions	$ 30,375	$ 31,503	$ 1,128	3.7%	$ 31,503	$ 1,128	3.7%	$ 31,528	$ 1,153	3.8%
Tribal Management	$ 2,343	$ 2,430	$ 87	3.7%	$ 2,430	$ 87	3.7%	$ 2,430	$ 87	3.7%
Direct Operations	$ 61,428	$ 63,123	$ 1,695	2.8%	$ 63,123	$ 1,695	2.8%	$ 63,123	$ 1,695	2.8%
Self Governance	$ 5,593	$ 5,752	$ 159	2.8%	$ 5,752	$ 159	2.8%	$ 5,752	$ 159	2.8%
Contract Support Costs	$ 263,683	$ 268,683	$ 5,000	1.9%	$ 268,683	$ 5,000	1.9%	$ 268,683	$ 5,000	1.9%
Total, Services:	*$ 2,596,492*	*$ 2,732,298*	*$ 135,806*	*5.2%*	*$ 2,732,298*	*$ 135,806*	*5.2%*	*$ 2,732,323*	*$ 135,831*	*5.2%*
Facilities:			$ -							
Maintenance and Improvement	$ 49,204	$ 49,904	$ 700	1.4%	$ 54,904	$ 5,700	11.6%	$ 50,879	$ 1,675	3.4%
Sanitation Facilities Construction	$ 91,864	$ 93,519	$ 1,655	1.8%	$ 93,519	$ 1,655	1.8%	$ 93,519	$ 1,655	1.8%
Health Care Facilities Construction	$ 88,597	$ 3,326	$ (85,271)	-96.2%	$ 50,132	$ (38,465)	-43.4%	$ 20,326	$ (68,271)	-77.1%
Facil and Env Hlth Support	$ 141,572	$ 150,959	$ 9,387	6.6%	$ 150,959	$ 9,387	6.6%	$ 152,959	$ 11,387	8.0%
Equipment	$ 17,337	$ 17,960	$ 623	3.6%	$ 21,260	$ 3,923	22.6%	$ 17,960	$ 623	3.6%
Total, Facilities:	*$ 388,574*	*$ 315,668*	*$ (72,906)*	*-18.8%*	*$ 370,774*	*$ (17,800)*	*-4.6%*	$ 335,643	$ (52,931)	-13.6%
TOTAL, IHS	**$ 2,985,066**	**$ 3,047,966**	**$ 62,900**	**2.1%**	**$ 3,103,072**	**$ 118,006**	**4.0%**	**$ 3,067,966**	**$ 82,900**	**2.8%**

Medicaid Roundtable

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The Medicaid program has become an essential funding source for the Indian health system and any changes in eligibility rules, benefits packages, cost-sharing requirements, provider payment rates, and financing will have profound consequences on the health and well being of American Indian and Alaska Native people. Any changes will have serious financial effects on the ability of Indian health programs to continue to provide essential health services to some of the poorest communities in the United States. The roundtable will work to ensure that Indian people continue to have access to Medicaid services while preserving Medicaid reimbursements for the Indian health system.

Another objective of the Medicaid roundtable will be to develop a plan to respond to reform issues that are currently being considered by the Medicaid Commission, the National Governor's Association, the Administration, and members of Congress. Several Indian health policy experts are in the process of developing policy papers on reform issues that will serve for developing consensus on reform issues. The policy papers will be provided to Tribal leaders, health directors, and Indian health advocates for feedback and comment prior to the roundtable. The papers will be updated based on the comments received and the authors will present the issues at the roundtable with an opportunity to dialogue with Tribal leaders, health directors, IHS, CMS, and other health policy experts. The findings of the roundtable will be summarized into a follow-up report that will include tribal recommendations on Medicaid reform. The report will be shared with key stakeholders responsible for Medicaid reform. The Medicaid reform policy papers along with the summary report will be available at www.npaihb.org.

Pearl's Report...*continued from page 2*

ence is to develop recommendations for the President and Congress on policy and research issues in the field of aging. This NICOA event provided attendees with an opportunity to discuss and present resolutions and issues critical to addressing the needs of our Indian elders. Participants from the White House Conference on Aging included Orcas R. Hardy, Chairman, Robert Blancato, Policy Committee Member, and Moya Thompson, Director for Outreach Coordination. The session was facilitated by our own James DeLaCruz, President, National Indian Council on Aging and Quinault Nation Tribal Council member.

Finally, at the last Board meeting I announced my plans to step down as the President of the Quinault Nation and take more time to enjoy my grandchildren. My plans are to continue as a tribal council member so I will continue to be involved in the Board, however it does mean the end of me serving as the Chair on the National Tribal Environmental Council (NTEC). I have served as the NTEC Chair for two terms and have truly enjoyed my work on Indian environmental issues—which are not removed from health issues affecting tribes. I have always said that we as Indian people can not be completely healthy unless the four elements of body, mind, spirit, and our environment are in harmony with one another. If there is a disturbance in any one of these elements, it will affect our health as Indian people. During my tenure at NTEC we worked to develop drinking water and air training programs that provide technical assistance and policy development for tribes across the nation. NTEC has been able to administer Cooperative Agreements with the EPA Office of Solid Waste and Emergency Response that work with tribes to promote hazardous substance remediation for contaminants that impact tribal resources and tribal health. Other initiatives include NTEC's Public Policy Initiative, Tribal Roads to Environmental Protection, and NTEC's Vision 2015 that will increase and enhance tribal governance, responsive services, and strategic partnerships. My work at NTEC allowed me to better understand health and environmental issues and allowed me an opportunity to better represent the health care issues affecting Northwest tribes. I will miss my work with NTEC and look forward to spending more time with my grandchildren--I hope you will have the opportunity to do the same one day.

Future NPAIHB QBMs

October 18 - 20, 2006
Confederated Tribes of Grand Ronde, Grand Ronde, OR

January 2006 – Portland

April 2006 – Idaho Tribe, Site To Be Announced

Northwest Tribal Dental Support Center

By Bonnie Bruerd, DrPH, NTDSC Consultant

The Northwest Tribal Dental Support Center (NTDSC), administered by the Northwest Portland Area Indian Board (NPAIHB), was funded in Fall 2000 and is currently in its fifth year of operation. NTDSC provides services to all 33 IHS and Tribal dental programs in Oregon, Washington, and Idaho.

The overall goal of the NTDSC is to improve the oral health of American Indian and Alaska Native (AI/AN) people in the Pacific Northwest. The NTDSC has focused on several outcome measures including increased overall dental access, increased use of sealants, and increased access for children from birth to two years of age Services provided by the NTDSC include preventive and clinical on-site dental program reviews at 8-12 dental clinics each year, including closeout presentations and follow-up with comprehensive written reports. The dental support center also assists dental programs in planning and evaluating Health Promotion/Disease Prevention (HP/DP) initiatives by assisting them with grant writing along with the collection, analysis, and interpretation of local oral health data. Finally, the dental support center identifies training needs and provides IHS Area-wide training opportunities. Past training topics have included fluoridation training for water operators, dental assistant training, and effective billing techniques. All of the activities of the dental support center are supported through ongoing communication with local dental programs via site visits, email groups, telephone consultation, and an annual Prevention Coordinators' meeting.

Evaluation data include RPMS data, program review data, site visit satisfaction surveys, and yearly survey of training needs. NTDSC is currently completing the first grant cycle and has met or exceeded all of its original objectives. The clinical consultant and prevention consultant each provided 68 site visits during the five-year period. Anonymous satisfaction surveys were administered following each site visit during the past three years. Overall satisfaction averaged 4.84 out of a possible score of 5.0 using a Likert Scale. Furthermore, the NTDSC increased the number of sealants placed, topical fluoride treatments provided, access to screening, topical fluoride application and a traumatic restorative treatment for infants from birth to two years of age as well as the number of sealants placed and topical fluoride treatments provided.

Products of the NTDSC include a Prevention Manual, program review forms, Xylitol packet for dental providers, "Xylitol 1st" key chains and magnets, and several original pamphlets and other oral health education materials. The "beneficiaries" products are the thousands of children who have received sealants and topical fluoride treatments, the HP/DP programs that have received national funding, the infants who have received preventive services, and the dental providers who have been trained to implement public health principles in their dental programs to increase efficiency and improve access.

This is the final year of the five-year grant and so it is a year of celebration and an opportunity to honor the dental providers who work in the Pacific Northwest who have worked us to achieve project objectives. The accomplishments of the NTDSC in meeting our HP/DP objectives can be attributed to the fierce commitment of those dental providers in the Northwest who have worked both independently and collaboratively to achieve these objectives, adopting them as their own, and putting in the time and effort required to improve the oral health of the people they serve.

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DHHS Region X Tribal Consultation

By Sonciray Bonnell, Health Resource Coordinator

On May 25-26, 2005, the Department of Health and Human Services (HHS) representatives and Northwest tribal representatives gathered for the Third Annual Tribal Consultation Meeting. HHS is divided into ten regions and Oregon, Washington, Idaho, and Alaska are in Region X. The purpose of this important meeting is to provide a venue for tribal and HHS officials to share emerging issues and discuss challenges faced in the past year. Naturally, it is also an opportunity to remind these federal agencies of treaty obligations and tribal sovereignty. Almost immediately the agenda was modified by tribal representatives to better meet the needs of our tribal delegates - the changes were logical and productive.

Some of the operating divisions of HHS include the Centers for Disease Control and Prevention, the National Institute of Health, and the Substance Abuse and Mental Health Services Administration, divisions that many of our tribes and the Northwest Portland Area Indian Health Board (NPAIHB) rely on for supplementing health programs.

One of the significant issues discussed were the challenges that tribes and tribal organizations face when applying for federal funds. Specifically, the common Request for Applications (RFA) requirement that funds serve high populations which is difficult for many NW tribes and Alaskan communities to meet because of the small size of many of our communities. Other RFA's stipulate that only states are eligible to apply or that applicants must apply through the state. Not surprising, most tribes prefer to apply directly to federal agencies for funds. The good news is that Charles Curie, SAMHSA Administrator, stated that tribes are eligible for all SAMHSA RFA's and that he will require specific evidence to prove why a tribe or tribal organization would not be eligible.

The Quinault Nation and Pearl Capoeman Baller, President of Quinault Nation and Chair of NPAIHB, were gracious and generous hosts. HHS representatives from Washington DC were invited to a dinner on May 24 at the Quinault reservation in Taholah, Washington where they enjoyed watching traditional dances and feasted on local salmon. Earlier in the day, Washington DC guests, including Charles Curie, Stacey Eccofey, Andy Knapp, and Mr. Flowers were honored with a canoe trip up the Quinault River and there were plenty of jokes about it being a choice time to ask important questions of the feds. Some of the accounts of the canoe trip were quite fascinating, including one story about the trip being a 50-mile canoe pull. All returned happy and thankful for this rare experience.

Ocean Shores, Washington was a wonderful place to have the consultation, not only for its beauty and excellent accommodations, but for the significant location of being on tribal lands. Thank you to the HHS representative, some who traveled across the country, and to tribal leaders for gathering with the intention of improving relationships and ultimately to improve services to Indian Country.

From the Acting Director:
Verné Boerner

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for the NARCH grant was submitted with a budget just under $800k, yet the award was only $117k. We submitted the Dental Support grant proposal at $250k and the award approved was at $180k. We are in the process of responding to the award notices. We will keep the tribes informed of our progress.

This quarter we welcomed several guests to utilize our new meeting space including: the Native Researchers Summer Institute, the Diabetes Summer Institute arranged by our partner program, The Center for Healthy Communities at the Oregon Health and Sciences University, headed by Dr. Tom Becker; and the Northwest Area Foundation and the Coalition of Community Health Centers, two organizations with missions similar to the Board's mission. The Indian Health Service's Health Literacy Workgroup is scheduled to meet in our office space next quarter. We are happy to be welcoming various groups and organizations to our facilities, however, we also realize that we do need to help cover costs when we do have such guests to our offices. We have developed a new fee schedule for the use of our facilities that will be posted on our website and can be found in the NPAIHB Delegates' Packets at the upcoming Joint-Meeting.

In closing, I have to recognize those that have stepped up to the plate during this transition. Sonciray Bonnell and Joe Finkbonner have been instrumental in managing the redistribution of responsibilities in this last quarter. Jim Roberts, Policy Analyst Extraordinaire, has been busier than ever and traveling to boot! I am thankful for all their work! I also really want to recognize our support staff, all of whom are new, Erin Moran, Chandra Wilson, Ticey Casey, Lisa Griggs, and Elaine Cleaver for helping the management team (Sonciray, Joe, and myself) and our Policy Analyst meet the challenging demands! Ed has remained available to assist where needed, but has been respectful of his new responsibilities and his transition from the Executive Director position. We are blessed with a talented staff!

CRIHB Access to Recovery

California Rural Indian Health Board Awarded $17.1 Million Federal Grant for Substance Abuse Treatment

Charles Curry, Administrator for the U.S Department of Health and Human Services' (IHS) Substance Abuse and Mental Health Services Administration (SAMHSA), today announced that the California Rural Indian Health Board (CRIHB) will receive $17.1 million over three years, as part of the President's Access to Recovery Program.

CRIHB was the only tribal organization in the U.S. to receive such a grant. The money will provide treatment and recovery services for California's 88,000 American Indians and Alaskan Natives in need of treatment services for substance abuse.

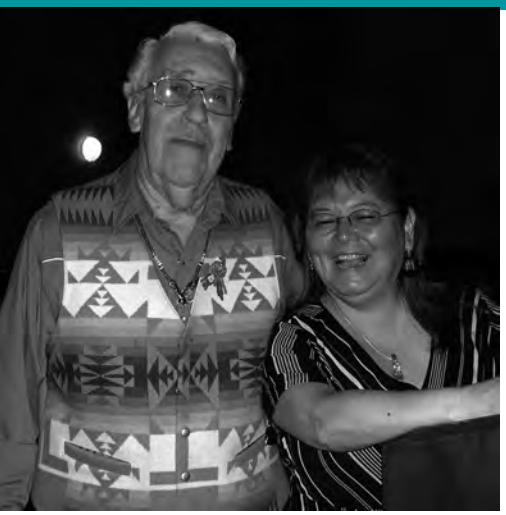
At a press conference in Sacramento, Mr. Curie said: "Access to Recovery is based on the knowledge that there are many pathways to recovery from addiction. The promise of this initiative — founded on a belief in individual choice — is that it ensures the availability of a full range of treatment options, including the transforming power of faith. That was the President's intent in creating this program in the first place, and requesting $600 million over three years in his 2003 State of the Union address."

"The California Rural Indian Health Board is honored to receive these funds," said CRIHB Executive Director James A. Crouch, M.P.H. "The money will allow our organization to play a vital role in improving access to health care services for American Indians and Alaskan natives."

"This is the largest grant the California Rural Indian Health Board has received in its 35 years of supporting and improving services and access to tribal health care in California," said Michael D. Weahkee, M.B.A., M.H.S.A., Director of Family and Community Health. "Our clinical information systems make it clear that resources are desperately needed in this area."

The Access to Recovery Program will expand treatment options by providing people seeking drug and alcohol treatment with vouchers for a range of appropriate community-based services. Earlier in the month, Curie announced that the California Department of Alcohol and Drug Programs would receive $22.8 million over three years for a program targeting youth between the ages of 12 and 20. California is one of 14 states that received the funding.

April 2005 QBM Pictures Hosted by the Quinault Nation



L to R: Harold Patterson (Mr. Pat) with Pearl Capoeman-Baller Quinault Tribal Members

L to R: Rod Smith, Cheryle Kennedy, Doni Wilder, Jim Sherril

Gene Kompkoff, IHS

Linda Milgram of University of Washington on Medline Plus

NPAIHB Delegates hard at work

Tom Becker, OHSU presenting Center for Healthy Communities Update

April 2005 QBM Dinner Pictures Hosted by the Quinault Nation

Quinault Welcome

Fawn Tadios

Quinault Dancers

Dinner guest Linda Holt enjoys the Quinault Buffet dinner

Delegates enjoying dinner and dancers

Western Trial Diabetes Project Update

By Don Head, WTDP Specialist

In April 2005, the Indian Health Service Division of Diabetes Treatment and Prevention (DDTP) and the Area Diabetes Consultants issued the "IHS Guidelines for Care of Adults with Prediabetes and/or the Metabolic Syndrome in Clinical Settings." Prediabetes (PD) and Metabolic Syndrome (MS) are good predictors for the development of diabetes. For instance, 29% of the control groups (those who received placebos and did not engage in intensive lifestyle changes) of the Diabetes Prevention Program (DPP) saw conversion from PD to diabetes. The American Diabetes Website (http://diabetes.org) states that most people with prediabetes develop diabetes within 10 years. The good news is that with prediabetes standards of care, we can prevent diabetes in our tribal communities.

The goals of the new guidelines are to a) prevent type-2 diabetes, and b) reduce the risk of cardiovascular disease. The guidelines include information about who should be tested for prediabetes, and which test is the most effective in diagnosing PD and MS. Information is also included about treatment plans, exercise guidelines and suggested lifestyle changes for the prevention of diabetes.

IHS guidelines also indicate that tracking and follow-up of patients is essential. NPAIHB Western Tribal Diabetes Project (WTDP) under the direction of the Northwest Tribal Epidemiology Center (EpiCenter) is available to assist Northwest tribal programs in developing prediabetes registers in their communities. Prediabetes registers are helpful in tracking patients who are at-risk for developing diabetes. They can then be contacted for prevention activities, or educated in the clinic about the risks and consequences of developing diabetes. Additionally, the WTDP conducts bi-annual Advanced Diabetes Management System trainings that include information on setting up and populating prediabetes registers. The WTDP offers the Diabetes Screening Toolkit, containing templates, instructions and guidelines for setting up screenings in tribal communities.

The guidelines can be viewed and downloaded from the DDTP website, http://www.ihs.gov/MedicalPrograms/Diabetes/index.asp.

To request assistance from WTDP to conduct screenings, site visits for trainings, and audit assistance, please call 1-800-862-5497.

Risky Business Training

By Cicelly Gabriel, Comprehensive Cancer Control Project Assistant

NPAIHB staff collaborated once again to present the "Risky Business" training for Northwest Tribes. It has been a great success. The goals of the trainings are to provide attendees with much needed updates on risk factors, implementing strategies for prevention and methods to promote overall good health and wellness; our aim was also to help build effective community programs that will reduce the health burden among tribal communities in the Northwest.

The first training took place in Ocean Shores; Washington at the Quinault Beach Resort and Casino with 15 lucky participants at this beautiful location the training had many interactive questions and contributions to the presentations. Participants went home revived and refreshed and with some valuable information to share with their community.

The second round was held at the Coeur d'Alene's Tribal Wellness Center with an audience of 32. What a great location, some even took part in wellness activities while at the Center. Participants were encouraged to use the provided Curriculum and PowerPoint presentations and supporting materials in other settings.

Last but not least, the final training was held at the Spirit Mountain Casino with sixteen attendees, with nearly half of the Oregon tribes and NARA staff participating. All trainings included information and educational materials on tobacco, sexually transmitted diseases, diabetes, cancer and maternal and child health for community ready education sessions. Working lunches provided an opportunity for participants to share their experiences with behavioral health programs, and helped promote collaboration between tribes.

Although cancer and other diseases cannot always be avoided, people can reduce their risk by practicing healthy behaviors. Some suggested guidelines for increasing healthy behaviors should include: maintain a healthy weight; exercise for thirty minutes each day; don't smoke; eat a healthy diet; limit alcohol consumption; protect yourself from the sun; and protect yourself and your partner from sexually transmitted diseases. We hope participants brought home some valuable information to share with the communities and promote healthy lifestyles. The staff members at the Board offer their appreciation to all the participants at the Risky Business Trainings. Thank you all for participating.

Please contact any of our staff members for specific information on cancer, tobacco, diabetes, HIV/AIDS/STDs, or maternal and child health. You can find us on the web at www.npaihb.org or by calling 503.228.4185.

A Federal Attempt to Bridge

By Kristyn Bigback, Intern for Project Red Talon

Viruses serve as fair, unbiased, and nondiscriminatory actors in the lives of humans. The horrifying speed and worldwide span of the HIV/AIDS pandemic has starkly substantiated the impartial nature of the causative HIV virus – those afflicted are of every age, race, religion, and from nearly every region of the globe. However, the way in which the infected are treated, both publicly and clinically, is not nearly as unbiased, nor are the societal avenues of transmission – one's position within society can have an enormous effect on his or her degree of exposure to the virus, access to antiretroviral (ARV) treatments, and social and other clinical support. The Department of Health and Human Services (DHHS) has made various attempts to bridge this disparity, one of which is the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

What Is The Ryan White CARE Act?

In its purest form, the Act is an effort to improve both the quality and accessibility of care for those living with HIV/AIDS, as well as their families. It was first passed in 1990, reauthorized in 1996, reauthorized a second time in 2000 for a five-year period, and is currently funded at $1.9 billion[1]. Funding is provided through cities, states, community health centers, and other avenues reaching approximately 500,000 individuals each year who have little or no health insurance[2]. The Health Resources and Services Administration (HRSA) within the DHHS administers the Act[3].

Under Title V of the Act exists the Special Projects of National Significance (SPNS) program[4]. SPNS grants are competitively awarded to support the development of innovative models of HIV/AIDS care with a particular emphasis on hard-to-reach populations, including American Indians and Alaska Natives (AI/AN) and other minorities[3]. SPNS is considered to be the research and development (R&D) arm of the Act, and provides mechanisms for assessing the effectiveness of particular models of care, supports innovative program design, and promotes replication of effective program designs[5].

SPNS targets areas such as managed care, infrastructure development, training, comprehensive primary care, and access[3]. With the 1996 revision of the Act, programs that provide critical care services and/or build organizational capacity in underserved communities, and programs that ensure the ongoing availability of HIV care to AI/AN communities, became eligible for SPNS grants. Today, the SPNS boasts a portfolio of 72 grants, funded either solely by the HIV/AIDS Bureau of HRSA or in partnership with other Federal agencies, including the Centers for Disease Control and Prevention (CDC)[5].

In October 2002 SPNS started a new initiative for AI/AN communities that will continue until September 2007. For this period of time, funds six grantees' demonstration projects, as well as an evaluation center to develop integrated mental health, substance abuse treatment, rehabilitation, and HIV ambulatory medical care models. Grantees have incorporated cultural, spiritual, and traditional medicine practices into their approaches[6]. The organizations that run each of the six demonstration projects include tribal organizations, which give the AI/AN tribal communities a chance to have more direct control over the application of funds. This initiative follows the Innovative HIV Service Delivery Models for Native American Communities

the Social Gap in HIV/AIDS

Initiative, which concluded in 2002[6]. Of the six grantees, two are located in Alaska, one in California, one in New Mexico, one in North Dakota, and one in Washington State. The Technical Assistance Center at the University of Oklahoma assists grantees with local program objectives[7] and serves as the SPNS evaluation center.

Has It Lived Up To Its Promises?

The equitability of the Ryan White CARE Act and its various divisions has not been perceived as flawless. AI/AN populations are eligible to apply for funds through the Act yet often face challenges in accessing these funds. In 2003, at the DHHS Region X Annual Tribal Consultation in Portland, Oregon, a NW tribal delegate voiced the concern that tribes are not able to access the Act's funds. The visiting HRSA representative was made aware of barriers experienced by tribes in applying for funds, and offered technical assistance to our NW delegates.

From 1999 to 2003, the AI/AN population has experienced a 20.1 percent increase in the reported AIDS incidence rate[6] (the actual incidence rate is probably higher if unreported cases are taken into account.) In 2003, the estimated AIDS prevalence rate (cases per 100,000) for AI/ANs was 8.1, which, although lower than African Americans (58.2) and Hispanics (20.0), was higher than for Caucasians (6.1) and Asians/Pacific Islanders (4.0)[6]. One social factor that severely affects the AI/AN population is poverty – from 1998 to 2000, an average of 25.9 percent of AI/ANs lived in poverty, more than any other racial group. An average of 26.8 percent lacked health insurance[6]. In addition, studies indicate that AI/ANs experience significantly higher rates of co-morbidities for HIV, including sexually transmitted diseases (STDs,) mental illness (particularly depression,) and chemical dependency (including alcoholism.) [8]

Eligibility

One upshot of the Act for the AI/AN population is that no cost sharing or matching is required for a grant applicant to be eligible[9], which is helpful for applicants who simply do not have a pool of money that could be used for this purpose. Eligible applicants must be public or private non-profit agencies and must be able to document Medicaid provider status, though the Medicaid requirement may be waived for free clinics that do not impose a charge for health services or accept Medicaid, Medicare, or private insurance reimbursement.[9]. Applicants must also document that they are fully licensed to provide clinical services as required by their state and/or local jurisdiction. All of these requirements must be in place prior to submitting a grant application[9].

Individuals can receive services through the Act even if they are eligible for care from other sources including IHS, tribal or urban health programs and services[6]. It is key that AI/ANs begin to access their fair share of funding from the U.S. government. One step toward this idea is to encourage more tribes to apply for these grants. At the end of 2003, an estimated 1,498 AI/ANs were estimated to be living with AIDS[6], and this number is unquestionably higher today. All of these people deserve the highest care for their disease possible as tribal members, as American citizens, and human beings.

Want To Apply For Funding?

The complete application kit includes the Program and Application Guidance and the DHHS Public Health Service Grant Application (Form 5161-1). The Program and Application Guidance is a thorough packet that addresses most, if not all concerns one might have about applying and can be found at: http://hab.hrsa.gov/grant.htm. The application form, Form 5161-1 (Grant Application for Non-Construction Projects) can be found at: http://www.hhs.gov/forms/publicuse.html. The application form for FY2006 is not yet available but should be released in September 2005.

Be prepared: The Program and Application Guidance packet, while useful, is also a hefty read – in sixty pages it provides each and every detail of the grant application requirements and process.

Attempt to...*Continued on page 19*

2005 Tribal Tobacco Policy Workbook Completion

By Nichole Hildebrandt, WTPP Project Director

Since 1995, the Tribal Tobacco Policy Workbook has remained among the most comprehensive guides for achieving tobacco policy change in Tribal communities. With step-by-step guidance, this workbook has served as a resource for tribes throughout North America to write, pass, and enforce tobacco-related policies.

The original Tobacco Policy Workbook focused specifically on policy change addressing Secondhand Smoke exposure in the workplace and in tribal buildings. Using the workbooks as a guide, many tribes implemented smoke-free policies in their community buildings. Tribal tobacco policy change marks an important step towards protecting the health and wellness of Native communities.

Unfortunately, with 40% of American Indian and Alaska Native deaths still linked to commercial tobacco use, this matter has not been put to rest. The tobacco industry spends over $11 billion dollars a year promoting and advertising commercial tobacco, targeting our children, fostering addiction, and using our sacred images to increase their profits. This fight is not over -- A great deal still remains to be done!

After extensive collaboration and sharing among Tribes, members of the National Tribal Tobacco Prevention Network, and numerous health-related partners the Western Tobacco Prevention Project, is excited to share with you the benefits of this labor, the revised and expanded Tribal Tobacco Policy Workbook.

Whether this is your first attempt at creating a tobacco-related policy for your tribe, or you are moving on to new opportunities for policy change, this workbook will provide you with approachable steps, usable templates, and concrete examples. Using the wisdom and experience gained by tribes across the U.S., this guidebook now shares practical lessons learned by those who have successfully passed tobacco-related policies in their tribes.

The workbook is divided into 3 Sections and 13 Chapters:

Chapter 1: Tobacco Use in American Indian and Alaska Native Communities
Chapter 2: General Steps for Developing A Tribal Tobacco Policy
Chapter 3: Drafting the Right Policy

Chapter 4: Secondhand Smoke Policies
Chapter 5: Youth Prevention Policies
Chapter 6: Tobacco Tax Policies

Chapter 7: Workplace Cessation Policies

Chapter 8: Clinic-based Policies
Chapter 9: Secondhand Smoke Policies in Casinos & Tribal Businesses
Chapter 10: Traditional Tobacco Policies

Chapter 11: Additional Resources

Tribal Tobacco Prevention Programs
Smoking Cessation Quit Lines Additional Tobacco Resources

Chapter 12: 1995 Tobacco Policy Workbook
Chapter 13: Citations and References

All of the NW Tribal Tobacco Coordinators will be provided a hard copy of the workbook. If you are interested in getting a copy of the workbook, please contact Nichole Hildebrandt at nhildebrandt@npaihb.org or by phone at 503-228-4188 ext. 282.

Funding for this project was provided by the Centers for Disease Control and Prevention (UIA – CCU019281-01) and the Washington State Department of Health's Tobacco Prevention and Education Program (Contract # N12228).

Attempt to Bridge the Gap.....

Continued from page 17

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8. “2002 Program Services Update.” 2002. Univ. of Oklahoma. 23 June 2005. <http://www.ou.edu/rec/pdf/IHS_DC10-03.pdf>.

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Upcoming Events

August 2005

AAIP Annual Meeting
August 1 - 6, 2005,
Renaissance Hotel, Washington, DC
For more information visit:
http://www.aaip.com/annualmeetings/AM05.html

CHR Basic Training
August 1 – 18, 2005
Spring Hill Suites by Marriott, Lawrence, KS
For more information visit:
http://www.ihs.gov/NonMedicalPrograms/chr/

5th Annual National Native Conference On Tobacco Use
August 21 - 24, 2005
DoubleTree Hotel Portland Lloyd Center, Portland, OR
For more information visit:
http://www.tobaccoprevention.net/

September 2005

CHR Basic Training
September 6 – 22
Great Wolf Lodge, Kansas City, KS
For more information visit:
http://www.ihs.gov/NonMedicalPrograms/chr/

Coordinating Center for SPDI Competitive Grants
September 12 - 16, 2005
Denver, CO
For more information visit: http://www.ihs.gov

Healthcare Safety Conference 2005: Safety, Compliance and Risk,
September 26 - 29, 2005
Kansas City, MO
For more information visit:
http://www.tfilearning.com

October 2005

Tribal Self-Governance Fall Conference
October 10 – 14, 2005
The Capitol Hilton Hotel Washington, DC
For more information visit:
http://www.tribalselfgov.org

2005 NIHB Consumer Conference,
October 16 - 19, 2005
Hyatt Regency Phoenix Hotel and Conference Center Phoenix, AZ
For more information visit:
http://www.nihb.org

NIHB 2005 Tribal Public Health Workshop
October 20, 2005
Immediately following NIHB's 2005 Consumer Conference
Hyatt Regency Phoenix Hotel and Conference Center Phoenix, AZ
For more information visit:
http://www.nihb.org

NCAI 62nd Annual Convention,
October 30 - 4, 2005
Tulsa, OK
For more information visit: www.ncai.org

November 2005

American Public Health Association (APHA) Annual Meeting
November 5 - 9, 2005
Ernest N. Morial Convention Center New Orleans, LA
For more information visit:
http://www.apha.org/meetings

Tribal Self-Governance Advisory Committee Quarterly Meeting
November 14 – 15, 2005
Phoenix, AZ
For more information visit: http://www.ihs.gov


NTTPN's 5th Annual
National Native Conference on Tobacco Use
Best and Promising Practices: Blending Native Traditions & Tobacco Prevention
August 21 - 24 Portland, OR
Double Tree Hotel Portland Lloyd Center
503/416.3265 or twhite@npaihb.org
www.tobaccoprevention.net

NIHB Summer Meeting

By Sonciray Bonnell, Health Resource Coordinator

The National Indian Health Board (NIHB) Summer 2005 meeting was devoted to their strategic planning and delegates worked hard on their task. The strategic planning started with a review of the history of NIHB which was informative and gave a clear description of how NIHB has progressed over the years. Deanna Bauman recounted how NPAIHB and CRIHB came to the aid of NIHB during the 1980s when they found themselves in turbulent times – a testament to our commitment and belief in NIHB. Strategic planning is always a time to reflect where we've come from and where we hope to be in the future. We will keep you posted on when a draft plan will be available for your reading. The highlight of the meeting was a day-long tour of the Pine Ridge Indian Reservation.

Watch out Northwest tribes, the Oglala Sioux tribe rivals (but doesn't beat) your hospitality. The tour left Rapid City, South Dakota around 10:30 AM and was led by Carole Anne Heart (Rosebud/Yankton Sioux, Aberdeen Area Tribal Chairman's Health Board Executive Director, and renowned two-stepper) and Mario Gonzalez (Oglala Sioux and Oglala tribal Attorney). We learned about Rapid City, the 1972 flood, local Indian organizations, and that American Indians comprise about ¼ of the city's population. On the way to the reservation on highway 79 we were able to see Mt Rushmore in the distance. We learned about the Black Hills and how the Lakota have refused to accept money for the Black Hills. At the inception of the land dispute the award was 104 million dollars in 1978 and now it is in escrow and has mushroomed to 888 million dollars. The Lakota are holding out for what is important – their sacred Black Hills. We were impressed with the unending educational presentation from our hosts.

Once we arrived on the reservation we were welcomed by Oglala Tribal Council Vice-Chair, Alex White Plume. We all felt so welcomed when tribal members thanked us for visiting to their community. We learned about the history of their health clinics and hospital, family structure, the Wounded Knee massacre where over 300 women and children were murdered and left in the snow for two days, the Wounded Knee memorial ride, the revival of their traditions, the American Indian Movement (AIM) and the Wounded Knee Takeover of 1972, but what was so wonderful about these stories is that they were peppered with recollections of how these events personally touched the lives of Mario, Alex, and Carole Anne. Thank you for a one-of-king and genuine tour.

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.

New NPAIHB Employees

Hello! My name is Brandy Moran and I am the new Project Specialist for the Western Tobacco Prevention Project. I have lived in the Portland and surrounding areas my entire life and I grew up on a small farm in North Plains (Northwest of Hillsboro). I've recently graduated from the University of Portland with a Bachelors' Degree in Social Work. I was an intern at Department Health Services and at the Native American Youth and Family Center (NAYA). Prior to this position I was employed at the Indian Health Services in the Personnel Department. In my spare time I love to play basketball and travel.

I am very passionate about assisting Native youth in becoming successful in life and I am devoted to upholding American Indian cultural values. I am very excited to be here and look forward to the challenges that this position will bring.

Greetings, my name is Alethea Boyer and I am currently a Project Specialist for the Northwest Tribal Recruitment Project. I have been here since late June 2004, first as an extern during the summer then a temporary employee as a Project Assistant. I was raised in the Bay Area of California and when I graduated from High School, I moved to Rochester, New York in order to attend Rochester Institute Technology (RIT). I graduated at RIT with BS in Information Technology with the concentrations in the website design implementation and databases. I just completed the MS degree program in Health System Administration via RIT's online distance learning program. Before coming to the Board, I interned at the National Science Foundation in Virginia as a Database analyst and at the Department of Commerce in Washington, DC as a Database Management Specialist. Most recently, I worked as the Public Relations Coordinator for the National Technical Institute for the Deaf's Center for Human Performance by promoting the RIT's Intercollegiate Athletic, Recreational, Wellness and Intramural programs and opportunities available to Deaf and Hard Of Hearing students.

It has been a tremendous experience working here, from learning about NPAIHB to American Indian/Alaska Native culture to the Deaf AI/AN culture itself. I attended Intertribal Deaf Council (IDC) conference in Spokane, WA last summer where I met many Deaf Indians and have made friends with several of them. Many Deaf Indians at IDC have shared their tremendous experiences with me. It is my hope that I can bring you more information about Deaf and American Indian/Alaska Native culture, which is a unique way of life. I bring one of a kind characteristic to my work being profoundly Deaf using American Sign Language as my primary language. While not working, I enjoy helping set up the Deaf Professional Happy Hour events, designing the website (www.dphhoregon.org), and voicing support to alert the public and state legislators of ways to help Oregon provide better services for Deaf and Hard Of Hearing individuals because many individuals leave the state out of frustration for disparaging lack of information, service and support.

Thank you for allowing me to be part of the NPAIHB and I look forward to getting to know each of you!

Resolutions

RESOLUTION # 05-03-02
Support for an AI/AN Cancer linkage project with CHS and State Medicaid Programs

RESOLUTION # 05-03-03
Support for the Northwest Portland Area Indian Health Board 2005 Legislative Plan

RESOLUTION # 05-03-04
Support for the Northwest Portland Area Indian FY 2006 Health Board Annual Budget Analysis

RESOLUTION # 05-03-05
Support for a Child Safety Seat Project in Northwest Tribal Communities

RESOLUTION # 05-03-06
Maternal, Infant, and Reproductive Health: National and State Coalition Capacity Building

RESOLUTION # 05-03-07
Support for the Northwest Tribal Dental Support Center

RESOLUTION # 05-03-08
Support for the Northwest Portland Area Indian Health Board to Conduct Medicaid Roundtable

RESOLUTION # 05-03-09
Supporting Self-Determination under Section 813(b)(1)(B) of the Indian Healthcare Improvement Act

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