Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

April, 2010

Our Mission is to assist Northwest tribes to improve the health status and quality of life of member tribes and Indian people in their delivery of culturally appropriate and holistic health care.

Congress Reauthorized and Made Permanent the Indian Health Care Improvement Act (IHCIA)

LtoR: Rachel Joseph Fox and Buford Roland, IHCIA National Steering Committee Co-Chairs

After eleven years of hard work by Tribes nationally, Congress reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). In the late hours of Sunday, March 21, the House of Representatives voted to approve a sweeping health reform bill entitled, the Patient Protection and Affordable Care Act (P.L. 111-148). This historic legislation included the reauthorization of the IHCIA, which was signed into law by President Barack Obama on March 23, 2010. Artilce on Page 2.

IHCIA Reauthorized & Made

by Jim Roberts, Policy Analyst

Finally, after eleven years of hard work by Tribes nationally, Congress has reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). In the late hours of Sunday, March 21, the House of Representatives voted to approve a sweeping health reform bill that the Senate had passed just before Christmas. The health reform bill entitled, the *Patient Protection and Affordable Care Act* (P.L. 111-148), is expected to provide health coverage to approximately 32 million Americans who currently do not have coverage. This historic legislation included the reauthorization of the IHCIA, which was signed into law by President Barack Obama on March 23, 2010.

The IHCIA is the cornerstone legislation that authorizes appropriations for Indian Health Service (IHS) programs and projects. It establishes the basic programmatic structure for delivery of health services to Indian people and authorizes the construction and maintenance of health care and sanitation facilities in Indian Country. Since its initial enactment in 1976 as P.L. 94-437, the IHCIA has been periodically reauthorized and amended, most notably in 1988, 1992, and extended for one year in 2001.

"Reauthorization" refers to the extension of the "life" of a law by Congress. Often Congress will enact laws, particularly major program laws, which carry a "sunset" date -- that is, the date through which Federal funding is authorized to be appropriated. This procedure enables Congress to take a fresh look at a law and determine what changes should be made and the amounts of Federal funds that should be authorized for particular programs. Under the U.S. Constitution, the expenditure of Federal funds for a particular purpose must be *authorized* by a law before funding can be *appropriated* in an appropriation Act. The bill passed by Congress includes a permanent reauthorization of the IHCIA with no sunset date and many new or amended provisions.

The IHCIA will improve the Indian health care system in several ways. The legislation sets to improve workforce development and recruitment of health professionals in Indian country. It also provides new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs. It will create opportunities to improve access and financing of health care services for Indians. For example, the law now allows IHS to carry out long term care related services and be reimbursed for them, such as home and community based services. The bill makes a marked improvement at modernizing the delivery of health services provided by IHS.

Some of the key changes included in the reauthorization bill include authority for IHS and tribes to carry long-term related care such as hospice

Permanent in Health Reform

care, assisted living, and home and community-based services. Included is the authorities is that IHS can now provide directly or enter into arrangements under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) to carry out delivery of long-term care services provided in IHS or tribal facilities. These arrangements can include sharing of staff or other services between IHS and a long-term care or related facility owned and operated by Tribes or between tribal health programs. The provisions also allow for construction and renovation of facilities that provide long-term care or expand a long-term care or other similar facility.

The new bill rewrites IHS related mental health services into a renamed title, *Behavioral Health* (current law reference is Substance Abuse Programs), to better reflect the objective of combining into one title all programs dealing with substance abuse, mental health, and social services programs, and to integrate these programs. Other key changes include Tribal access to the Federal Employee Health Benefit Plan, the same health benefit plan provided on behalf of federal employees. Another provision allows Tribes and tribal organizations authority to purchase health benefits coverage for tribal members.

Included in the behavioral health is a subtitle that includes authorities to establish Indian youth suicide prevention and substance abuse programs and services. This includes authority for IHS to include grant programs, with the goal of reducing the high rates of suicide among Indian youth. The grant authority includes providing suicide prevention activities with tele-mental health demonstration projects, which will make grants to tribes and tribal organizations to provide services to Indian youth. Also, a directive for the Secretary to facilitate greater efficiency to assist Tribes to access grants to fund mental health and suicide prevention activities.

There are many other important changes included in the Indian Health Care Improvement Act. Realizing the full benefit of these changes will be contingent on two things happening. First, Congress must provide adequate funding so that IHS and Tribes can implement the new programs and services authorized. Secondly, the IHS and Department of Health and Human Services must acknowledge the authorities and move quickly to work with Tribes to implement the new provisions. Several of the new authorities are *self-executing* and will not require promulgating regulations or developing administrative procedures to implement. In these instances, it's important that IHS move forward and work with Tribes to carry out the new authorities. In other instances, implementation will require developing rules and policies which will take longer to implement. The key is that IHS work with Tribes to develop a short and long term implementation plan on key provisions that will improve services and funding for Indian people.

Northwest Portland Area Indian Health Board

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Health Care

by Jim Roberts, Policy Analyst

Over the past year the Congress and Administration have been working to pass a health insurance reform bill that is intended to lowers costs, guarantees choices, and enhances quality health care for all Americans. Building on that year-long effort, the President signed into law this historic national health care legislation on March 23, 2010. The *Patient Protection and Affordable Care Act* (P.L. 111-148) is expected to provide health coverage to approximately 32 million Americans who currently do not have any. It aims to reform the health insurance system in a number of ways, including banning pre-existing condition exemptions, capping out-of-pocket expenses, increasing competition and providing increased government oversight.

The newly enacted health care legislation includes several important provisions pertaining to Indian health programs and the reauthorization of the Indian Health Care Improvement Act (IHCIA). The legislation reauthorized the IHCIA (S. 1790) with no sunset date thereby making the IHCIA permanent. The bill also included Indian specific provisions separate from those contained in the IHCIA section of the bill. The Indian specific provisions are intended to ensure that the Indian health system will be effectively integrated with many of the new health reform program and services.

Indian-Specific Provisions

The health reform legislation is organized into ten different titles that amongst other requirements, establishes a mandate for most residents of the United States to obtain health insurance. It will set up state insurance exchanges through which individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that health coverage. The legislation will expand Medicaid eligibility considerably, while also reducing the growth of Medicare's payment rates for most services. The new law will also impose an excise tax on insurance plans with high premiums and make various other changes to the federal tax code, Medicare, Medicaid, and other programs.

The key Indian provisions are contained in Titles I, II, IX, and X (IHCIA). The following is a short summary of the key Indian specific provisions in the health reform law.

Individual Mandate: The new law makes most Americans responsible to carry some form of health insurance coverage. Compliance with this requirement will be enforced through the use of tax penalties by the Internal Revenue Service. The law *exempts members of Indian Tribes* on the basis of the federal trust relationship.

Insurance Exchange: Individuals who do not have health coverage through their employer would be able to purchase coverage through state-based insurance exchanges by 2014. Three *Indian specific provisions will protect Indians from cost sharing requirements* at or below 300% of FPL, a second protects Indians from any cost sharing for service delivered through an IHS program, and Indians will be allowed to enroll in Exchange plans on a monthly basis.

Medicare Part B: Removes sunset date of December 31, 2009, to *allow IHS programs permanent authority to receive reimbursement of some Part B services*. Provision initially passed in Medicare Modernization Act of 2003 limited authority to a five-year period.

Medicare Part D "TrOOP fix: Effective January 1, 2011, the value of drugs *provided by IHS programs* will now count toward "true out of pocket" costs.

Tax Exemption on Tribal-provided Insurance: Effective March 23, 2010, the law *excludes from an individual Tribal member's gross income the value of health benefits*, care, or coverage provided by IHS programs, a Tribe, or tribal organization.

How Will Health Reform Work?

The underlying premise for health reform is that, beginning in 2014, an *individual mandate* will require all individuals to have health coverage. Those who do not have

Reform Snapshot

health insurance will have to pay $95 penalty in 2014. The penalty will increase to $750 or two-percent of income in 2016, and will incur a cost-of-living increase for each year thereafter. Compliance with the individual mandate will occur through tax penalties enforced by the Internal Revenue Service. While Indian people are not exempt from the individual mandate, they are exempt from having to pay the tax penalty if they are a member of a federally recognized Tribe, which achieves the same of objective of being exempt from mandate. Congress was unwilling to make any exemptions from individual mandate, but granted an exemption from the tax penalty on the basis of the federal trust relationship.

A new change will require employers that do not offer coverage and employ more than 50 employees to provide qualifying health coverage or pay a penalty ranging from $600 to $2,000 depending whether employees receive some form of assistance from state insurance exchanges. The reform bill also requires group health plans that cover dependent children to extend coverage to dependents until age 26. In addition, the legislation limits health care reimbursement account contributions to $2,500 per year and no longer allows over-the-counter drugs to be reimbursed through health reimbursement accounts or health savings accounts unless prescribed by a physician. Additionally, employers will now be required to report the value of health benefits on IRS Form W-2 effective for the first taxable year after December 31, 2010.

The bill would provide a sliding scale tax credit for qualified small employer contributions to purchase health insurance for its employees. A "qualified small employer" would be an employer with no more than 25 full-time-equivalent employees employed during the taxable year, and whose employees have annual wages that average no more than $50,000.

The new legislation will create State Insurance Exchanges where individuals who do not have health coverage can purchase coverage through state-based insurance exchanges by 2014. Federal subsidies would be provided to those who meet poverty level requirements. The subsidies will be funded by fines on employers who have 50 or more full-time workers and do not provide health coverage and individuals that do not comply with the individual mandate. Indian people would be eligible to purchase coverage from exchanges and could be eligible for subsidies in order to purchase care. Tax credits and subsidies will be available to assist individuals to purchase health coverage through the State Insurance Exchanges beginning in 2010. People with incomes between 100 percent and 400 percent of the federal poverty level (or $22,050 for a single person to $88,000 for a family of four) would be eligible. Most people who are offered coverage by their employer would not be eligible for tax credits.

There are also some very important changes that will extend Medicaid coverage at State option to cover non-elderly and non-pregnant individuals. It will create a new mandatory Medicaid eligibility category for individuals with income at or below 133 percent of the Federal Poverty Level (FPL) who are not on Medicare. It also changes the mandatory Medicaid income eligibility level for children ages six to nineteen changes from 100 percent FPL to 133 percent FPL. Newly-eligibles (described above) would receive benchmark or benchmark-equivalent coverage consistent with the requirements of section 1937 of the Social Security Act. Financing for these new expansions will come from the federal government who will provide states 100% of the cost of Medicaid expansion in 2014-2016, 95% of the cost in 2017, 94% of the cost in 2018, 93% of the cost in 2019, and 90% of the cost in 2020 and beyond. There are other requirements that will require states to maintain the same income eligibility levels through December 31, 2013 for all adults. This "maintenance of effort" (MOE) requirement would be extended through September 30, 2019 for all

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Community Dons PINK to Support Breast Cancer Awareness

by Eric Vinson (NTCCP Coordinator), Janine Dankovchik (Navigator Project Specialist), Megan Hoopes (NW Tribal Registry Director), Jasen Henderson (Grand Ronde Cancer Prevention Coordinator)

Breast Cancer Awareness Bingo was hosted March 24th by the Confederated Tribes of Grand Ronde Health and Wellness Clinic and Spirit Mountain Casino. Jasen Henderson, Cancer Prevention Coordinator working for Grand Ronde Health & Wellness and funded by the Northwest Portland Area Indian Health Board, worked on the event to increase awareness related to the importance of breast cancer screenings, resources available for screenings and how to get in touch with those resources. Proceeds from bingo were dedicated to two organizations that have supported tribal members receiving cancer screenings and support during cancer treatment. The event drew 800 people from the community, about 475 of who played breast cancer awareness bingo. The event raised $13,821 to support cancer survivors and screening through the Willamette Valley Cancer Foundation and the Oregon and Southwest Washington Affiliate of Susan G. Komen for the Cure. Based on a survey conducted at the event, 56 women requested follow-up screening and 15 are already scheduled for a mammogram.

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children currently covered in Medicaid or CHIP. Between January 1, 2011 and January 1, 2014, a State would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133 percent of FPL if the State certifies to the Secretary that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year.

The new law prohibits cost-sharing for Indians enrolled in a qualified health benefit plan in the individual market through a State Exchange. Also, facilities operated by the Indian Health Service (IHS) and Indian, Tribal, and Urban Indian facilities (I/T/Us) would be added to the list of agencies that could serve as an “Express Lane” agency able to determine Medicaid and CHIP eligibility. And finally, it removes the sunset provision, allowing IHS and Tribal provided services to continue to be reimbursed by Medicare Part B.

Implementation for the new health reform law will take several years. There will also be technical fixes that will need to be passed by Congress to deal in unintended consequences. The Board will monitor the implementation process and continue to stay involved in the development of any technical changes that might be required.

Cow Creek Diabetes Prevention Program

by Bob Dunas, Health Education Cow Creek Band of Umqua Tribe of Indians

The Cow Creek Health and Wellness Center , located in Southern Oregon, is offering a new program which can help individuals prevent diabetes. There are approximately 40 million Americans that are pre-diabetic. This means that their blood sugar levels are higher than normal, but not high enough to be considered diabetic. It also means that there is still time to do something to prevent the progression from pre-diabetes to Type 2 Diabetes. Once you are diagnosed with diabetes, you always have diabetes. The good news is that pre-diabetes screening is often the wake-up call for folks to make the changes necessary to prevent diabetes.

The Cow Creek Tribe has partnered with two other Southern Oregon tribes, the Coquille and Klamath Tribes to form the Southern Oregon Diabetes Prevention Consortium which provides pre-diabetes screening as part of their diabetes prevention program. The program is open to Native Americans over eighteen years of age who go through the screening and are eligible. Being eligible means you have taken any of several blood tests, the most common being the 2 hour OGTT (oral glucose tolerance test- which many women who have had children are familiar with as it is used during pregnancy to test for gestational diabetes). This is the basic test we use to determine whether or not someone is pre-diabetic and eligible for the program. The Diabetes Prevention Program consists of weekly and bi-weekly classes held at the Cow Creek Health and Wellness Center, spread out over a six month "intensive" time frame. Goals for the participants are moderate: a 7% weight loss (for example, 14 pounds for a 200 pound person) and 150 minutes of activity a week (30 minutes of walking 5 times a week). Reaching these goals has been proven effective in preventing Type 2 Diabetes 90% of the time. Another strong point of the program is that once the six month "intensive" part of the classes is finished, we continue with monthly "after core" classes to help people stay on track, continue to make progress towards new health related goals, and to provide ongoing education and support as they continue on their journey.

All three consortium tribes have found that not only has the program been very effective in preventing diabetes, but the lifestyle changes made by one person in a family effect the other family members as well. If a mother in the program starts shopping, cooking and eating differently herself, it will change how the rest of the family eats too. If a dad in the program begins exercising regularly, the children are positively influenced to do the same. In this way, the DPP has impacted many more people than just the participants; it reaches family members, friends and changes communities.

ChristieCare's

The Cedar Bough Program at Clackamas River

In 2007 ChristieCare opened the Cedar Bough Program at Clackamas River in Oregon City, Oregon, offering culturally responsive residential treatment for Native American youth. We work with youth and families in this culturally specific program to address emotional, spiritual, cultural, educational, and physical needs. Program staff work closely with their families and tribal communities. The program is guided by ChristieCare's Native American Advisory Council, facilitated by John Spence, PhD, a Gros Ventre tribal member and ChristieCare consultant. The Advisory Council is composed of community members and Native organizations, including representatives from all nine federally recognized tribes in Oregon, and Terry Cross, Seneca tribal member and Executive Director of the National Indian Child Welfare Association (NICWA) and ChristieCare Board member.

The Cedar Bough program is located on 35-acres of pristine land along the Clackamas River in Oregon City. The campus includes residential housing facilities, an on-site school providing specialized education services and equipped with technology, including SMART Boards. The facility also includes: an indoor gymnasium, outdoor sports court, garden area, therapeutic ropes course, and multiple family visitation rooms.

The program also offers a wide range of enrichment opportunities including participation in ChristieCare's Equine Assisted Psychotherapy Program at Butte Creek Ranch that has proved especially helpful for Cedar Bough youth who haven't responded to traditional talk-therapy. Horses serve as a living, breathing, therapeutic tool that naturally grabs a youth's attention and motivates even the most treatment-resistant child. Through guided activities centered on direct interaction with a horse, children learn responsibility, empathy, trust, and relational self-confidence. Additional cultural enrichment activities include: drumming and singing classes, talking circles, traditional arts and crafts, elder visits, sweat lodge visits, and culturally appropriate food.

Program Specifics

Children, youth, and families who are struggling with mental health problems are provided holistic care through curriculum that incorporates the physical environment and mind/body healing best practices; provided experiential opportunities for children, youth, and their families with a focus on skill and competency development; provided opportunities to develop partnerships with youth, families, and their communities to ensure a successful return to the community following treatment; and provided the opportunity to participate in cultural events and practices as part of the recovery and wellness process.

ChristieCare creates and delivers mental health solutions that promote enriched, full lives for children and families.

ChristieCare has made a concerted investment in culturally specific outreach programs connecting Cedar Bough to Native communities throughout Oregon, including: The Native American Youth Family Center (NAYA); The Native American Rehabilitation Association of the Northwest (NARA), including the NARA Indian Clinic; ChristieCare's Native American Advisory Council with representatives from Oregon's nine federally recognized tribes; The National Indian Child Welfare Association (NICWA); The Portland Indian Elder's Support Group; The Bow and Arrow Culture Club; The Nine Tribes Quarterly Prevention Meetings; and Longhouse leaders and other Native spiritual advisors from various urban and reservation

Cedar Bough Program

communities. Clackamas County Education Service District (ESD) provides the educational component of our program. The kids at Cedar Bough attend classes on a regular school schedule for credit. The first project each Cedar Bough child completes as part of their school experience is to present a fully researched history of the Native tribe they are affiliated with; this project serves to reinforce a sense of belonging and pride in the child's cultural identity.

Inspired by some Native traditions of giving a hawk feather in recognition of a great accomplishment, or the realization of a life's work; youth graduating from Cedar Bough are presented with a feather as an acknowledgement of their achievement.

The program relies on the best-practice treatment model of Trauma Informed Care, designed to serve children, youth, and families who have repeatedly experienced a variety of traumatic events. This program enables young people to reconnect with family, community, and tribal traditions, thus reducing the isolation that is a major factor in depression and emotional struggles.

Funding for Treatment Services
Cedar Bough is most commonly funded through:
Oregon Health Plan
Private health insurance
Indian Health Services
Other options are available

Tribes have helped to fund services when other options have not been available. Tribes are not billed for services unless we have a contract with them to provide services.

ChristieCare understands that navigating private insurance and public health systems can be overwhelming. Please contact us if you have any questions about funding, we are happy to assist you in identifying your options.

ChristieCare
ChristieCare is Oregon's oldest children's social service agency, having provided supports for children and families since 1859. Today we offer a range of services for children from across the state that suffer from severe emotional disorders and mental illnesses.

ChristieCare annually serves 800 children and young people from all thirty-six Oregon counties and nine federally recognized tribes. All programs are guided by our Re-Education (Re-ED™) treatment philosophy, a dynamic approach centered on helping troubled children build competence and achieve success, rather than focusing solely on their problems. Through Re-ED™ we build collaborative, supportive relationships with families and help create healthier, more stable environments.
ChristieCare services are developed and delivered by a highly trained and skilled team including educators, nurses, psychiatrists, Licensed Clinical Social Workers, therapists and teacher counselors. ChristieCare is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the Oregon Department of Human Services (DHS) – Addictions & Mental Health Division. ChristieCare is a member of the American Re-EDucation Association (AREA).

For access and referral information, please call 1-888-98ACCES (1-888-982-2237) or feel free to contact our Access Manager, Angela Leet, at 503-675-2246 or a.leet@christiecare.org

New NPAIHB Employee

Hello, my name is Eugene Mostofi and I am the new Fund Accounting Manager. I am excited to be working with you to further the mission of the Northwest Portland Area Indian Health Board. I have worked with non-profits in the past and most recently with a book publisher specializing in Northwest and Alaska photography, calendars, printing and binding. I am very interested in health issues and particularly in holistic health and preventative medicine. I grew up in Northern New Jersey, just a stone's throw from New York City where I was born. I attended the University of Texas at Austin where I obtained my marketing degree and the University of Houston where I obtained my accounting degree. I also have my CPA certification in the State of Texas. I enjoy the arts, travel, and sports.

Training Available

Risky Business

Tribal Health Educators, Program Managers, and Community Health Representatives often wear multiple hats within their healthcare system, and do not have the time or resources to attend multiple trainings. Because "Risky Behaviors" put individuals at risk for multiple health outcomes, integrated and holistic health messages are needed to provide effective outreach. Recognizing this need, the Northwest Portland Area Indian Health Board has collaboratively developed a training workshop that covers several health promotion/disease prevention topics, including: tobacco, diabetes, cancer, sexually transmitted diseases, injury prevention and obesity are among some of the topics covered. The trainings includes risk reduction strategies, AI/AN prevalence rates and community-based activities, and resources to increase tribal awareness.

For more information, contact Terresa White, NPAIHB Tobacco Program Coordinator: 503-416-3272 or twhite@npaihb.org

Risky Business
Tuesday, May 4, 2010
8:30 am to 4:30 pm
Northern Quest Resort and Casino
100 N. Hayford Rd., Airway Heights, WA 99001
Lunch provided

Second Wind Facilitators Training

Second Wind was designed specifically to help American Indian/Alaska Natives stop smoking and remain smoke-free. It provides basic information on smoking, practical counseling, problem solving, and social support. The Second Wind program focuses on making the stop-smoking experience positive and successful. The training will be provided by Cynthia Tainpeah, Director of the Muscogee (Creek) Nation Tobacco Prevention and Control Program, developer of "Second Wind" program curriculum.

Second Wind Tobacco Cessation Facilitators Training
Monday, May 24, 2010
9:00 am to 3:45 pm
Northwest Portland Area Indian Health Board
2121 SW Broadway, Ste. 300, Portland, OR 97217
Breakfast and lunch provided

HHS Announces $267 Million in Recovery Act Funds for New Health IT Regional Extension Centers

NEWS RELEASE
Tuesday April 6, 2010

Contact: HHS Press Office
(202) 690-6343

Grants to Provide Hands-On, Community-Based Support to Providers to Accelerate the Adoption of Health Information Technology

U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced today that more than $267 million has been awarded to 28 additional non-profit organizations to establish Health Information Technology Regional Extension Centers (RECs). This investment, funded by the American Recovery and Reinvestment Act of 2009, will help grow the emerging health information technology (health IT) industry which is expected to support tens of thousands of jobs ranging from nurses and pharmacy techs to IT technicians and trainers.

RECs enable health care practitioners to reach out to a local resource for technical assistance, guidance, and information on best practices. RECs are designed to address unique community requirements and to support and accelerate provider efforts to become meaningful users of electronic health records.
"Health care in our country is community-based. Today's awards represent our ongoing commitment to make sure that health providers have the necessary support within their communities to maximize the use of health IT to improve the care they provide to their patients," said Secretary Sebelius.
This round of awards, bringing the total number of REC's to 60, will provide nationwide outreach and technical support services to at least 100,000 primary care providers and hospitals within two years. The primary care provider is usually the first medical practitioner contacted by a patient. Studies have also found that primary care providers are at the forefront of practicing preventative medicine, a key to improving population health and reducing overall health costs. More than $375 million had been awarded earlier to RECs under this program.

Additionally, all REC awardees, those announced today and the 32 announced on Feb. 12, 2010, now have an opportunity to apply for a two-year expansion supplemental award. The supplemental awards would ensure that health IT support services are available to over 2,000 of the nation's critical access hospitals and rural hospitals, both defined as having 50 beds or less. Approximately $25 million is available through this supplemental expansion program.

"Regional extension centers will provide the needed hands-on, field support for all health care providers to advance the rapid adoption and use of health IT. RECs are a vital part of our overall efforts to improve the quality and efficiency of health care through the effective use of health IT," said Dr. David Blumenthal, national coordinator for health information technology.
Today's awards are part of the $2 billion effort by the American Recovery and Reinvestment Act of 2009 to achieve widespread meaningful use of health IT and provide use of an electronic health record by every person by the year 2014.

Learn More:
Today's Awardees
Complete listing of REC grant recipients and additional information about the Health Information Technology Regional Extension Centers, see http://HealthIT.hhs.gov/programs/REC/.
For information about other HHS Recovery Act programs, see http://www.hhs.gov/recovery/

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.

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Northwest Portland Area Indian Health Board
February 2010 Resolutions

RESOLUTION #10-02-02
Recommend to Create a Tribal Cabinet Post for the State of Idaho

RESOLUTION #10-02-03
Access to Recovery Grant

RESOLUTION 10-02-04
Empowering Native Youth to Engage in Policy Change Addressing Nutrition & Physical Fitness

RESOLUTION #10-02-05
Supporting a Plan to Address the IHS Backlog of Contract Support Cost Funding during the Obama Administration