Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

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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.

Senate Committee on Indian Affairs Hearing on Contract Health Services

Tribal testimony at the June 26, 2008 Senate Committee on Indian Affairs Contract Health Services Hearing. Second to the left is Linda Holt, NPAIHB Chair and Suquamish Tribal Council Member. *Article on page 4.*

In This Issue

This year will mark the tenth year that Tribal leaders, Area Health Boards, and national Tribal organizations have been working to complete reauthorization of the Indian Health Care Improvement Act (IHCIA). It was the fall of 1998 that Dr. Michael Trujillo, IHS Director, appointed the National Steering Committee (NSC) to oversee the reauthorization effort. The mantra for the NSC as it worked over the next two years to develop legislative priorities for the IHCIA was "Speaking with One Voice." The theme embodied the collective efforts of direct service, tribally operated, and urban Indian health programs in the reauthorization effort.

Unfortunately, the IHCIA (H.R. 1328) has stalled in the House over an issue whose politics are larger than the IHCIA bill and ignores the health care needs of American Indian and Alaska Native (AI/AN) people. The issue that has H.R. 1328 stalled is an amendment that would be offered by Representative Joseph Pitts (R-PA), which would prohibit IHS federal funding and facilities from being used to perform abortion services. The amendment would codify an annual appropriations measure, the Hyde Amendment (sometimes referred as the Hyde Restriction) that prohibits the use of federal funds to perform abortion services. The politics of this issue have House leadership concerned about how to move the bill during an election year and protect the pro-choice position. House leadership would prefer to avoid a vote on a controversial abortion issue going into the November elections, and prevent any legislation that would erode the pro-choice position, especially with a conservative Congress.

Most Indian health advocates believe a codification of Hyde is unnecessary as its restrictions already apply to the IHS. The irony of this situation is that most AI/AN people sympathize with Representative Pitts over this issue. Life is considered sacred in our spirituality and religion as AI/AN people and ending life is not to be taken lightly. Despite this position, debating a national abortion issue on a bill that authorizes health services to AI/AN people who suffer the worst health disparities of any group in the United States is inappropriate. Arguably, each year that the IHCIA is not reauthorized the lives of 1.9 million AI/ANs are put at risk—that often results in preventable deaths—and debating this national abortion issue on the Indian health bill is inconsistent with the policy position that is being put forth by Rep. Pitts. Sadly, the amendment injects an inflammatory, polarizing issue into a debate about comprehensive health care for AI/ANs and the obligations of the federal trust relationship.

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From the Executive Director:

Joe Finkbonner

Tribal communities are at varying levels of exposure to large scale emergencies, such as natural disasters or terrorist attacks, but the one threat that can affect all is that of a pandemic outbreak of disease such as influenza. While many tribal communities share many common values, the traditions and customs are rich and diverse. Creating one approach toward building awareness of both the threats and planned actions to reduce the distressing consequences of such an outbreak must therefore come from the community itself. It does take some work and commitment; however, our people know all too well the devastation our communities experienced as a result of infectious diseases. There is no one approach for all communities. Working to reduce the impact of infectious disease means that in some cases, we must understand how some of our most sacred practices can be either a protective factor, or a facilitating factor in the spread of disease. This is truly sensitive ground and one that can only truly be answered by the each tribal community.

While there is not a single approach or intervention, there are some steps that each tribe can take in the development of a plan that is reflective of its community's values, traditions, and practices; steps that results in the community coming together to build an understanding of the level of risk and the incorporation of its own unique cultural practices in addressing the threat of a pandemic outbreak. The first is to identify a lead person to become familiar with the various Emergency Preparedness guidelines and to receive training. This person should be aware of available resources held by the community and have a deep respect for the tribe's culture and practices. This person will be responsible for coordinating the local key players in the community who will gather to develop an action plan in case such an emergency should occur.

Key players should include tribal elders, spiritual and cultural leaders, practitioners, council members, community members, and health program staff. Tribal elders are a particularly important group as they are major opinion makers in tribal communities, particularly in the sensitive area where sacred and cultural practices may conflict with an intervention strategy. They can be key allies in the incorporation of Emergency Preparedness Plans. This list makes up a cultural and intervention advisory group.

This advisory group is charged with addressing such conflicts (both perceived and fundamental) in cultural practices and intervention strategies. It is also the group that will ultimately recommend to the tribal council the implementation and

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Contract Health Services

by Sonciray Bonnell, Health Resource Coordinator and Jim Roberts, Policy Analyst

The Indian health system is comprised of a network of programs operated directly by the Indian Health Service (IHS) or by Tribal health programs and urban clinics. The IHS, directly and through Tribal governments, carry out programs under the Indian Self-Determination and Education Assistance Act (P. L. 93-638). These programs provide health services to more than 2.3 million AI/AN people in the United States.[1] These services are provided to members of 562 federally-recognized tribes located in 35 different states.

The IHS and Tribal programs provide a wide variety of individual and public health services, including clinical, preventive, and environmental health services. Medical care services are purchased from outside the IHS system through the Contract Health Services (CHS) program when the care is not available at IHS and tribal facilities.

The CHS program originated under the Department of Interior, Bureau of Indian Affairs (BIA) when authority to enter into health services contracts for AI/ANs was provided under the Johnson O'Malley Act of 1934. The program was continued when responsibility for Indian health was transferred from the BIA to the Department of Health, Education, and Welfare in 1955 when IHS was established. The CHS program is administered through twelve IHS Area Offices that include 163 IHS and Tribal service units.

CHS funds are used to purchase health care services not available at IHS and tribally operated health care facilities. These services are critical for Tribes that do not have access to needed clinical services. The CHS budget supports essential healthcare services from non-IHS or Tribal facilities and include, but are not limited to, inpatient and outpatient care, routine and emergency ambulatory care, medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy. Some additional services include treatment and services for diabetes, cancer, heart disease, injuries, mental health, domestic violence, maternal and child health, elder care, refractions, ultrasound examinations, dental hygiene, orthopedic services, and transportation.

Purchasing health care services from non-IHS providers is essential to the overall IHS health care delivery system, as many IHS hospitals and clinics cannot provide these services. The CHS funds are used in situations where no IHS direct care facility exists, or cannot provide the required service, or the direct care facility has an overflow of medical care workload.

The agency has adopted the financial position that it is the Payer of Last Resort. This requires patients to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. The IHS also negotiates contracts with providers to ensure competitive pricing for the services provided; however, there may be only one or a limited number of providers or vendors available to the local community. The CHS authorizing official from each IHS or Tribal clinic either approves or denies payment for an episode of care. If payment is approved, a purchase order is issued and provided to the private sector hospital. In order to budget CHS resources so that as many services as possible can be provided, the agency applies stringent eligibility rules and uses a medical priority system.

CHS regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of care needed. Because of insufficient funding in the CHS program, most IHS and Tribal health programs often begin the year at a Priority One

1 Indian Registrants, Active Indian Registrants, and User Population data are all referenced in this testimony are from the "IHS Final User Population Estimates – FY 2007," accessed December 27, 2007, available at www.ihs.gov.

Program Challenges

level. If they do not begin the year at Priority One, they will move to this status by the second or third quarter of the fiscal year.

In FY 2008, the CHS program is funded at $579 million, with tribal programs managing $302.9 million and the federal programs managing $276.4 million. CHS programs are administered locally through 163 IHS and Tribal Programs. The funds are provided to the Area Offices which in turn provide resource distributing, program monitoring and evaluation activities, and technical support to health facilities providing care.

CHS Dependency

The use of contract care services varies considerably by IHS Areas. For example, in two areas California and Portland Areas all hospital-based services are purchased through the CHS program. In the other ten areas, some hospital-based services are provided at IHS-funded facilities, while others are purchased through CHS. Tribes have the option of operating their own direct care facilities and contract care programs. As of October 2001, tribes were operating 27 percent of the 49 hospitals and 70 percent of the 364 health centers and health stations. The remaining facilities were federally operated. For fiscal year 2005, approximately 50 percent of the IHS budget was allocated to Tribes to deliver services.

There are no IHS hospitals in the Portland Area, therefore inpatient care and specialty care services that are not available in health facilities must be purchased through CHS program. This important distinction makes Portland Area Tribes dependent on CHS funding for all specialty care services. Those Areas that do not have inpatient hospitals and must purchase all specialty care services under the CHS program are often referred to as "***CHS Dependent***" Areas.

"There is a dichotomy between Areas that have IHS hospitals and those that are CHS dependent. CHS expenses contributed to thirty percent of the budget for the Portland Area IHS office," Linda Holt, Chairwoman of Northwest Portland Area Indian Health Board and Suquamish Tribal Council Member.

CHS dependent Areas lack facilities infrastructure to deliver health services and have no choice but to purchase specialty care from the private sector. Nationally, the CHS program represents 19% of the total health services account. In the Northwest, the CHS program represents 30% of the Portland Area Office's budget making it the most important budget item for Northwest Tribes since there are no hospitals in the Portland Area.

Our estimates indicate that the CHS program has lost at least $778 million due to unfunded medical inflation and population growth since 1992.[2] This has resulted in rationing of health care services using the CHS medical priority system, in which most patients in the Portland Area cannot receive care unless they are in a Priority One status. In FY 2007, this under-funding resulted in a backlog of over 300,000 health services that were not provided because there simply was not enough funding. These services were not provided because they did not fall within the medical priorities, administrative processes were not followed, or a patient had moved outside of the Contract Health Service Delivery Area (CHSDA). What is most concerning is that the patients requiring these services do not go away. The patients are put onto a "denied/deferred" services list and when health programs receive funding for the new fiscal year, most health programs begin clearing this backlog of service. This process puts almost all Portland Area Tribes into a Priority One status at the beginning of each fiscal year. Postponing these services also results in higher cost of treatment once the patient is finally able to receive care.

2 "The FY 2009 IHS Budget: Analysis and Recommendations," p. 22, March 17, 2008, available at: www.npaihb.org.

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The IHS maintains a deferred and denied services report that is updated each year. The report is inclusive of CHS data from IHS direct operated health programs and may include limited data from Tribally-operated health programs. Unfortunately, the deferred/denied services report **understates** the true need of CHS resources due to the data limitations and the fact that many tribes no longer report deferred or denied services because of the expense involved in reporting. More disturbing is that many IHS users do not even visit health facilities because they know they will be denied services due to funding shortfalls. The result of this is that using the denied/deferral report to estimate funding shortfalls in the CHS program is not always appropriate because the report under represents the amount of funding required to address unmet need.

The denied/deferred service issue is a special concern for CHS Dependent Areas. When a patient is not provided care or does not report to a health clinics because they will be denied care, their patient visit may not be counted in the IHS User Population reports. This is an important issue because User Population data are used in many formulas to allocate IHS funds, including the CHS program. Those Areas with inpatient hospitals that can internalize costs associated with care that would normally be purchased by CHS Dependent Areas do not have this problem. This results in CHS Dependent Areas not receiving a fair share of resources when they cannot deliver the same level of services as those Areas that have inpatient care. This special concern should require an updated formula to allocate CHS funding.

There are at least two ways to calculate the amount of additional funding needed in the CHS program. The first would be take the IHS denied/deferred services reports and apply an average outpatient cost to the services. Last year, 300,779 unfunded services would have been approved had adequate funding been available. Applying an average outpatient rate of $1,107 to these services estimates that an additional $333 million was needed for the CHS program in FY 2007. Adding this amount to the FY 2008 CHS budget indicates that minimally, the CHS program needs at least $912 million per year. The second method of calculating additional funding needed in the CHS program, is to estimate the unfunded inflation and population growth over a period and apply that amount to the current funding level. Since 1992, we estimate that the CHS program has not received adequate funding for mandatory cost of inflation ($625.9 million) and population growth ($152.5) and that the CHS budget should be at least $1.3 million.[3]

The reason the CHS budget has eroded so badly is due to the fact that the Administration and Congress—or the IHS—have not adequately provided inflation increases. The CHS program is more vulnerable to inflation pressures than any other program in the Indian health system. CHS budget increases have averaged 4.5 percent over the last ten years, despite the fact that medical inflation has exceeded 10 percent in many of these years. Similar public health programs like Medicaid obtain budget increases that are based on actual medical inflation estimates. The Medicaid program has averaged an annual budget increase of 7.5 percent over the same period. The CHS program should

3 The FY 2008 CHS budget is $579.3 million, our estimates for unfunded inflation $625.9 million, and population growth $152.5 million equate to a CHS budget of $1.3 million in FY 2009.

Program Challenges

From the Chair:
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receive medical inflation adjustments equal to the Medicaid program since both provide similar services and purchase care from the private sector. Medicaid's enrollment in FY 2008 is expected to grow by 2.2 percent and is comparable to the growth rate of 2.1 percent for IHS, so population growth alone does not justify the higher inflation rate for Medicaid. Surely, the relatively small Indian Health Program is not able to secure better rates from providers than the Medicare and Medicaid programs. It is reasonable to expect that Medicaid program inflation rates will exceed 10 percent in FY 2009. It seems clear that CHS, while an efficient alternative to building hospitals and specialty clinics, is subject to higher rates of inflation than the rest of the IHS budget and should be provided with an appropriate increase annually.

Senate Committee on Indian Affairs Hearing

The CHS hearing before the Senate Committee on Indian Affairs was held Thursday June 26, 2008 and included the following tribal witnesses: Linda Holt, Chairwoman, Northwest Portland Area Indian Health board and Suquamish Tribal Council Member; H. Sally Smith, Chairperson, National Indian Health Board; Marlene Krein, President/ CEO, Mercy Hospital, Devils Lake, ND; Stacy Dixon, Chair, Susanville Indian Rancheria; Jefferson Keel, Lt. Governor, Chickasaw Nation, and; Brenda Shore, Tribal Health Program Director, United South and Easter Tribes. The Indian Health Service (IHS) was represented by Robert McSwain, Director; Dr. Charles North, Chief Medical Officer, and Carl Harper, Director of the Office of Resource, Access, and Partnerships.

All witnesses testified about how important the Contract Health Service (CHS) program is and how it is chronically under-funded. Tribal witnesses discussed the high number of denied and deferred services in the CHS program and how many patients have to go without receiving services and live in pain and discomfort. Chairwomen Holt testified about the level funding that is truly needed in the CHS program, challenges associated with CHS dependency, Tribal concerns about the existing CHS distribution formula, and the need to identify best practices for delivering care with CHS funding.

Both Chairwomen Smith and Holt invited the SCIA Chairman, Sen. Byron Dorgan, to hold field hearings on the CHS program at the NIHB Annual Conference later this fall in California and at the Direct Service Tribe's Annual Conference in September in Spokane, Washington.

It is times like this, that I am glad we have the Board and organizations like Affiliated Tribes of Northwest Indians, the National Indian Health Board, and the National Congress of American Indians. I believe that Indian health policy is at a crossroads and the decisions that we make in the next two years will have lasting effects on our programs. The fact that we have all been working so hard to get the IHCIA passed in the last ten years speaks to the challenges that we have before us. We are starting to see important Medicaid and SCHIP provisions relating to IHS programs being challenged by both the Administration and Congress. As states and the federal government continue to reform the health care system to control costs—all mean that Indian health policy is at a critical juncture.

I believe the work we do in the next two years will be some of, if not, the most important work we do on behalf of our People. Indian Country can look to our Board for leadership on many of these issues and I will look to you all for your expertise and support as we work to "Speak with One Voice."

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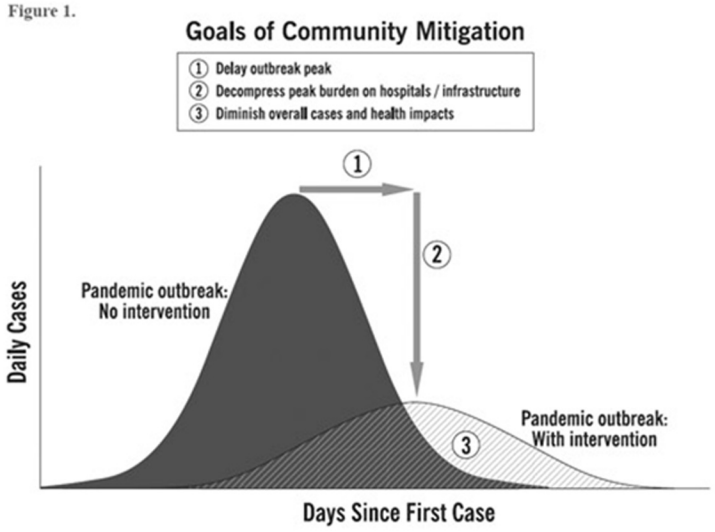
education plan to build community awareness of the action plan. This can be done in any number of ways: developing local public service announcements, developing/customizing curriculum for schools, working with faith-based or cultural programs, local businesses, as well as more familiar outlets for health education, such as clinics and tribal health centers.

There are a number of federal agencies that are putting a great deal of resources to planning to control or perhaps to prevent a full scale flu pandemic. Recently a collaborative group developed the publication, *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States—Early, Targeted, Layered Use of Nonpharmaceutical Interventions*, (herein after referred to as the guide) published and distributed by the Centers for Disease Control and Prevention (CDC). The purpose of the document is to provide recommendations to states, tribes, and local governments on interventions that can be utilized to reduce the spread of a pandemic and hopefully reduce the loss of life due to such an outbreak. While this document is a 109 page document, it is a fairly fast read. It is broken into fifteen sections, including detailed references and appendices. The goals are best illustrated in Figure 1 presented in the guide.

The fact that a well-matched pandemic strain vaccine will not

Figure 1.



be immediately available, non-pharmaceutical interventions are key to staving the spread and overall consequences related to a pandemic influenza outbreak. A review of the 1918 Pandemic Influenza outbreak provides evidence that early interventions can reduce the overall devastation and reduce the spread of the virus, and in many of the locations where such interventions were utilized there were fewer deaths. The key to effectively instituting such interventions is pre-planning because such outbreaks are unpredictable. Interventions presented in the guide include: voluntary isolation of ill persons, voluntary quarantine of household members of ill persons, child social distancing, and adult social distancing.

These interventions can only be implemented with a coordinated approach that includes input and planning from key players: tribal councils, county and state officials, businesses and other employers, childcare programs, elementary and secondary schools, colleges and universities, faith-based and community organizations, and community members to represent individuals and families.

As each tribe has its own set of beliefs and practices, the same is true of the tribes' relationships with the surrounding counties and local governments. Some tribes have a good working relationship with other local governments, and others have struggled with their relationships. However, a pandemic wave will cross neighboring jurisdictions without prejudice. Therefore these interventions will need to be a coordinated approach that includes partners from the tribal government, state and local governments, as well as community partners and representatives.

The guide outlines interventions and provides recommendations as

Pandemic Influenza Outbreak

to the how and when they should be applied per the level of impact and infection. The document identifies a severity index at which those various interventions are triggered. The severity is determined using a case fatality ratio. Drills and exercises are invaluable in testing responses at five discrete severity categories. Table A in the guide is a summary of the community mitigation strategy at the various severity levels:

At the various stages, the guide discusses issues of feasibility and cost associated with each intervention, while recognizing the overall cost cannot compare to the devastation of failing to take action.

The guide also identifies the need for research including the development of point-of-care rapid influenza diagnostics, antiviral medications, pre-pandemic vaccines, face mask and respirator use in community settings, and home-care infection control management strategies. Results from such research will better inform the communities and allow for more efficient utilization of resources and limit the need for isolation and quarantine.

There is much to be considered in planning and developing an appropriate strategy for each community. Amongst the interventions to be developed, so too is a public education outreach or campaign plan. If the community is properly informed of a plan, the greater the success and efficiency will be during a frightening experience. The Cultural advisory group will be invaluable in the development of such items as a public education plan. The goal is to communicate appropriately with community members. For example, a community member who is intrinsically knowledgeable on how to read or understand the water currents in order to successfully navigate the river to avoid bottoming out in his boat might respond to a statement such as, "this is our mitigation strategy by pandemic severity index," with an, "okay." Yet, no information was conveyed. Developing a proper outreach and education plan will yield the best opportunity for community member compliance.

More information on pandemic influenza preparation may be found on the web at www.pandemicflu.gov.

Table A. Summary of the Community Mitigation Strategy by Pandemic Severity

	Pandemic Severity Index		
Interventions* by Setting	**1**	**2 and 3**	**4 and 5**
Home **Voluntary isolation** of ill at home (adults and children); combine with use of antiviral treatment as available and indicated	Recommend†§	Recommend†§	Recommend†§
Voluntary quarantine of household members in homes with ill persons¶ (adults and children); consider combining with antiviral prophylaxis if effective, feasible, and quantities sufficient	Generally not recommended	Consider**	Recommend**
School **Child social distancing**			
-dismissal of students from schools and school based activities, and closure of child care programs	Generally not recommended	Consider: ≤4 weeks††	Recommend: ≤12 weeks§§
-reduce out-of-school social contacts and community mixing	Generally not recommended	Consider: ≤4 weeks††	Recommend: ≤12 weeks§§
Workplace / Community **Adult social distancing**			
-decrease number of social contacts (e.g., encourage teleconferences, alternatives to face-to-face meetings)	Generally not recommended	Consider	Recommend
-increase distance between persons (e.g., reduce density in public transit, workplace)	Generally not recommended	Consider	Recommend
-modify postpone, or cancel selected public gatherings to promote social distance (e.g., postpone indoor stadium events, theatre performances)	Generally not recommended	Consider	Recommend
-modify work place schedules and practices (e.g., telework, staggered shifts)	Generally not recommended	Consider	Recommend

SDPI Closer to Reauthorization

by Jim Roberts, Policy Analyst

The Special Diabetes Program for Indians (SDPI) was authorized in 1997, when Congress passed the Balanced Budget Act, to provide funds to the Indian Health Service to develop programs to prevent and treat diabetes in Tribal communities. The program was set to expire this year leaving many diabetes programs in a state of uncertainty despite the efforts of Tribal advocates to reauthorize the program. Fortunately, when Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (S. 2499) it included a provision that extended the SDPI programs through FY 2009. This means that SDPI programs are guaranteed funding through at least September 30, 2009. Current efforts are underway to reauthorize the program longer and increase the funding to $200 million a year.

After FY 2009, the SDPI program will have provided over $1 billion to support diabetes and prevention programs on reservations and in urban Indian communities. This is a significant contribution to fight the diabetes epidemic in Indian Country! Recent reports to Congress validate with data that there have been considerable improvements in American Indian and Alaska Native (AI/AN) diabetes care. These results include significant reductions in Hemoglobin A1C results, improvements in blood pressure control, prevention of kidney failure in people with diabetes, and reduction in lower extremity amputation rates. The SDPI has also allowed new prevention activities to be developed and implemented in Tribal communities. Some of these programs include physical activity programs in schools, wellness programs and fitness centers, nutrition education with improved menus in schools, community health fairs, and increased overall community awareness about the effects of diabetes and the importance of exercise.

Fiscal Year	Balanced Budget Act	Supplemental Funds	H.R. 5738 New Funding	S. 2499 SCHIP Extension	TOTAL
FY 1998	$ 30 million				$ 30 million
FY 1999	$ 30 million				$ 30 million
FY 2000	$ 30 million				$ 30 million
FY 2001	$ 30 million	$ 70 million			$ 100 million
FY 2002	$ 30 million	$ 70 million			$ 100 million
FY 2003		$ 100 million			$ 100 million
FY 2004			$ 150 million		$ 150 million
FY 2005			$ 150 million		$ 150 million
FY 2006			$ 150 million		$ 150 million
FY 2007			$ 150 million		$ 150 million
FY 2008			$ 150 million		$ 150 million
FY 2009				$150 million	$ 150 million
TOTAL	$ 150 million	$ 240 million	$ 750 million	$ 150 million	$ 1.29 billion

The ultimate goal for Tribes is to reduce the prevalence of diabetes and its complications, but these outcomes will take years to achieve given the enormous impact of the diabetes problem throughout Indian Country. The SDPI has made an enormous and substantial impact on the problem of diabetes in Indian communities and needs to be continued if this goal is ever to be realized. National diabetes organizations that include the American Diabetes Association and the Juvenile Diabetes Research Foundation have joined Tribal leaders to reauthorize this program. Reauthorization objectives include increasing funding from $150 to $200 million and extending the program over five years. Unfortunately, getting Indian health legislation passed in the remaining days of this Congress is proving extremely difficult.

Recent efforts to reauthorize the SDPI as part of the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331) were overturned in the Senate. The House passed the bill earlier which includes a provision at Section 303 to extend the SDPI at $150 million through FY 2011, in effect extending the program an additional three

years. The bill includes protections for Medicare physician payments and is a very important for many members of Congress. The SDPI provision is not controversial and will likely remain in the bill. Because of its significance, the bill is likely to pass out of the Senate and will eventually be sent to the President. The Administration has threatened to veto the bill because it would pay for the increase by trimming costs in the Medicare Advantage program, in which private insurers provide benefits for seniors in place of the government. Increasing federal contributions to the Medicare program is something that President Bush is not supportive and would likely veto the bill. This means that Tribes would have to work on other strategies to get the SDPI reauthorized in this Congress.

Methamphetamine Use Among American Indians in The Northwest

by Birdie Wermy, Data Into Action Project Specialist

Methamphetamine Use (and other drugs) Among American Indians in the Northwest (MOD) began in February, 2008 at the Northwest Portland Area Indian Health Board (NPAIHB), in conjunction with Oregon Health Science University (OHSU). Birdie Wermy from the Northwest Portland Area Indian Health Board will serve on this project as the Project Assistant and Liaison between tribes.

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

MOD will conduct focus groups (talking circles) at each site with twenty-five individuals seeking treatment, meth use, treatment services and health problems due to drug use. We will complete a survey with each individual in a reservation-based drug treatment center and in an urban health center.

This project is still very new and we've established the five Northwest tribes we would like to collaborate with and are currently in the process of setting up site visits. We feel that this project will bring hope, education, and knowledge to the Native Communities we are serving and look forward to working with the tribes selected for this project.

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

Organizations and Investigators

Oregon Hawaii Node of the National Drug Abuse Treatment Clinic Trials Network (CTN)
Dennis McCarty, Traci Rieckmann, and Kathyleen Tomlin
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William Lambert
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Native American Rehabilitation Association (NARA)
Steve Gilbert

Indian Health Service Externship Program

by Craig Carter (Haida & Inupiaq), IHS Extern

The Indian Health Service Scholarship Extern Program, which is a separate program from the main IHS scholarship, gives American Indian and Alaska Native students the opportunity to work for IHS in a health related field. The program is nationwide and information on the scholarship can be accessed at ww.ihs.gov or by contacting your Indian Health Service Area Coordinator.

I graduated in 2001 from Craig High School which is a small community located in southeast Alaska. I attended Western Washington University and graduated in the spring of 2006 with a Bachelors of Arts in political science. Currently, I am working towards a Masters Degree in Public Administration and Health Administration at Portland State University which I will complete in the summer of 2009.

For my externship I was placed at the Northwest Portland Area Indian Health Board where I am in the middle of my 120 days of service. The majority of my time is spent on health policy, and projects include a two-year mental health strategic plan with the State of Washington. Our focus is to identify barriers to adequate mental health care through in depth research and develop recommendations for improvement. In the State of Washington it is estimated that 12% of adults suffer from some type of mental illness. Although American Indians and Alaska Natives make up the smallest percentage of the state's population at 1.7%, they have the highest reported need of services at 5.9%.[1] My second project is a five year strategic plan between the Center for Medicare and Medicaid Services and American Indians and Alaska Natives. On this project I have assisted the Tribal Technical Advisory Group in addressing problem areas and drafting the revised 2010-2015 plan.

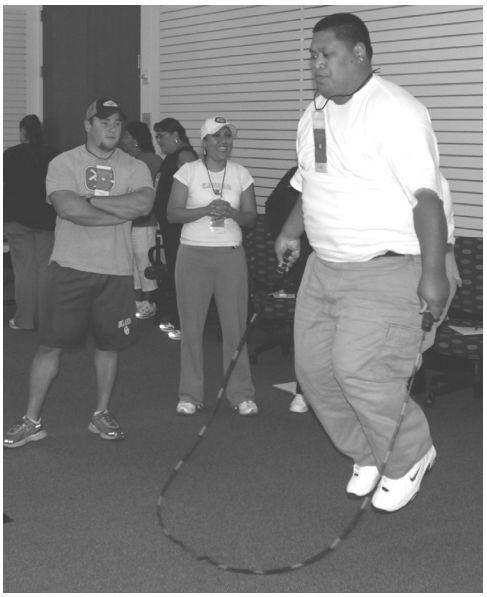
As you can see, the Indian Health Service Extern Scholarship Program provides invaluable, real-world experience. I highly recommend applying and know that I will be able to better serve the American Indian and Alaska Native community due to my experiences.

1"Partnerships for Recovery" Governor Christine Gregoire's Office. October, 2005.

Native Fitness V: Save the Date

September 29th, 30th, and October 1st 2008 – Native Fitness V

It is time to pull out your schedules and block out September 30 and October 1, 2008 for the Native Fitness V training, to be held at the Nike World Headquarters and Nike's Edo Field in Beaverton, OR. This is scheduled to be year five of the highly innovative and popular fitness training coordinated by the Western Tribal Diabetes Project, National Diabetes Prevention Program, Portland Area Indian Health Service, and Nike. This year we will partner with the Native American Fitness Council, providing sessions such as: functional fun training for adults and elders, tag "your fit," and chair aerobics native style. There will also be resource information on diabetes interventions, bringing your diabetes data to life, and innovative prevention programs. We are looking forward to seeing fresh new faces this year from Tribal Diabetes and Fitness Programs across the Northwest and beyond.



For more information, contact:

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Access to American Indian Recovery (AAIR)

by Erik Kakuska, AAIR Project Specialist

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

In the time that I have been working for the program, I find that there is a great need for a voucher funded program in the Northwest (AAIR vouchers work through a Voucher Management System to fund treatment). With the rise of Methamphetamine use in the Northwest and a constant stream of substance abuse, AAIR has been trying to find a way to help those in need. SAMHSA mandates that the AAIR program use at least 30% of their funding for methamphetamine users. I am pleased to announce that AAIR has currently enrolled more than 450 of our native people from California, Idaho, Oregon and Washington; 40% of these clients are meth users.

Since the collaboration between the California Rural Indian Health Board (CRIHB) and the Northwest Portland Area Indian Health Board (NPAIHB), we have been able to enroll more than sixty providers. Throughout the Northwest alone, we have been able to enroll eight, meeting SAMHSA's required goal for the first year; and this is only the beginning. Currently, we have another five NW providers awaiting approval. With your help the list continues to grow. For that reason, I'd like to say thank you for helping AAIR achieve these goals.

In order to help understand the AAIR Program, we are currently conducting training seminars throughout the Northwest, one of which was held July 11, in Portland, Oregon. This training and others offer enrolled providers a better understanding of the program and how to receive these funds. We are continually searching for providers and a host site for these trainings.

How to access the AAIR Program to become a provider

Please contact Erik Kakuska (ekakuska@npaihb.org) if your health center wishes to provide substance abuse treatment or recovery support services to AI/AN people in Idaho, Oregon, or Washington. You may also apply on the AAIR website (www.crihb.org/aair). All new applicants are required to complete and submit a Provider Enrollment Application. Once you submit the application with the required supporting documents, it will be reviewed by AAIR program staff and you will be notified of the decision within a few weeks.

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

Ruth L. Kirschstein National Research Service Award

Kelly Gonzales, a PhD student in Public Health at Oregon State University and former employee of the Northwest Portland Area Indian Health Board (NPAIHB), has been awarded a prestigious pre-doctoral Individual National Research Service Award, funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health to complete her doctoral dissertation research. The title of her doctoral study is," The Effect of Discrimination on the Use of Diabetes Medical Services and on Diabetes Management Among American Indian Women in the Northwest." The main objective is to examine self-reported discrimination in health care among adult American Indian women with diabetes who seek medical care at reservation-based Indian health care facilities located in the Northwest, and to estimate the association of discrimination and the use of medical services, diabetes health measures, and diabetes management. She is collecting data with Native American women in four Northwest tribes located in Oregon and Washington.

Kelly's professional goals are to direct health research in American Indian & Alaska Native populations, and to mentor Native youth interested in education and public health.

Award Information

The Ruth L. Kirschstein National Research Service Award for Individual Pre-doctoral Fellowships (F31) to Promote Diversity in Health-Related Research provides pre-doctoral training support for doctoral candidates who have successfully completed their comprehensive examinations by the time of award and will be performing dissertation research and training. This funding offers support for a tailored research training plan for the applicant, including training obtained through classes, seminars, and opportunities for interaction with other groups and scientists.

The primary objective of this funding is to help ensure that diverse pools of highly trained scientists will be available in appropriate research areas to carry out the Nation's biomedical, behavioral, health services, or clinical research agenda. This initiative seeks to improve the diversity of the health-related research workforce by supporting the training of pre-doctoral students from groups that have been shown to be underrepresented, including individuals from underrepresented racial and ethnic groups, individuals with disabilities, and individuals from disadvantaged backgrounds. The fellow must identify a primary sponsor, and will work together with his/her sponsor(s) and institution to plan, direct, and execute the project research. Through this funding opportunity, the NIH expects that efforts to diversify the workforce will lead to:the recruitment of the most talented researchers from all groups; an improvement in the quality of the educational and training environment; a balanced perspective in setting research priorities; an improved capacity to recruit subjects from diverse backgrounds into clinical research protocols; an improved capacity to address and eliminate health disparities.

For more information Ruth L. Kirschstein National Research Service Award go to http://grants.nih.gov/grants/guide/pa-files/PA-07-106.html

New NPAIHB Employee

Greetings! My name is Megan Hoopes and I am the new Director of the NW Tribal Registry Project. I recently finished my studies at Oregon Health & Science University, obtaining a Masters of Public Health degree in epidemiology and biostatistics, during which I was active in several research projects pertaining to Northwest Tribes. For my thesis project, I examined factors associated with methamphetamine use and non-medical use of prescription pain relievers among American Indians nationally. I have also worked in breast and cervical cancer outreach among minority women, and am committed to disease prevention and health promotion in varied communities. I am excited and honored for this opportunity to continue working to improve Tribal health in the Northwest.

I grew up in Bozeman, MT, and then spent five years in Flagstaff, AZ, where I obtained my bachelor's degree at Northern Arizona University and met my wonderful husband, Joe. We then spent about a year in Anchorage, AK before settling in Portland about five years ago. I am the oldest of three girls in my family; my parents and youngest sister still live in Bozeman, and my other sister lives in New Zealand with her husband and 1-year-old daughter. Some of my hobbies include traveling, hiking, camping, disc ("Frisbee") golf, and pretty much anything else outdoors.

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.

April 2008 NPAIHB Resolutions

RESOLUTION #08-03-01
Support for Application to CDC Funding for National Tribal Tobacco Prevention Network

RESOLUTION #08-03-02
Elimination of Health Disparities through Translation Research (R18) Alcohol and Substance Use During Pregnancy

RESOLUTION #08-03-03
Reducing Health Disparities among Minority and Underserved Children (R21) What Influences Breastfeeding Initiation and Continuation in AI women

RESOLUTION #08-03-04
Native American Research Centers for Health (NARCH)

RESOLUTION #08-03-05
Request for FEMA to Reconsider its Decision to Provide the Quileute Tribe with Disaster Relief Funding to Repair Health Clinic

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