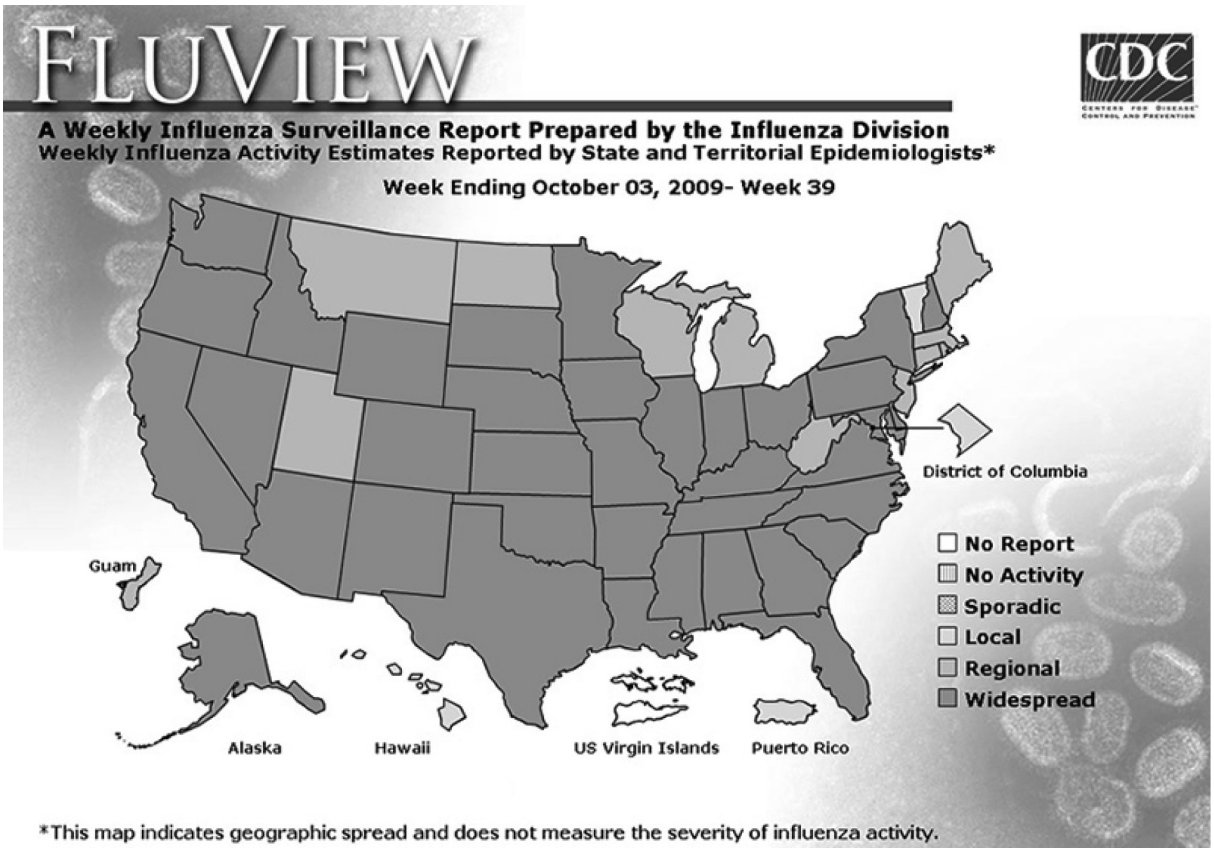
Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

October, 2009

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



Portland Area Office Indian Health Service and Northwest Portland Area Indian Health Board Joint H1N1 Pandemic Influenza Response - article on page 4

In This Issue

From the Chair:

I thought I was busy before, but the national health reform activity has thrown us all into a work frenzy. Once again NPAIHB staff have met the challenge of tracking health reform activities, distributing timely information to our delegates, providing analysis of how the national health reform might potentially affect Indian Country, and responding to individual tribes' request for technical assistance during this complicated yet far reaching national reform.

Many of the meetings I attended this past quarter addressed national health reform. In July I attended the National Indian Health Summit/ Health Reform in Denver, Colorado. The IHS provided three opportunities for tribal consultation during the Summit which attracted leaders from across Indian Country. As usual, Northwest tribal leaders were well represented and many spoke their concerns. I was also able to attend the Affiliated Tribes of Northwest Health Commission Chair meeting with Larry Echohawk. Some of the key meetings I attended in August include the Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Justice and Safety in Indian Country, National IHS Direct Service Tribes Meeting, White House Meeting on Health Care Reform, National Indian Health Board Consumer Conference, and Affiliated Tribes of Northwest Indians. During the August NIHB conference I testified at the Senate Committee on Indian Affairs oversight hearing to examine

LtoR: Reno Franklin (CRIHB Chair) and Andy Joseph Jr. (NPAIHB Chair)

Andy Joseph, Jr.

the federal tax treatment of health care benefits provided by tribal governments to their citizens. The Senate Committee on Indian Affairs often provides webcasts of their hearing if you are interested in following a particular issue.

I would like to end with some highlights from the 10th Annual Joint Quarterly Board Meeting with the California Rural Indian Health Board (CRIHB), which took place in July at the Tulalip Tribe. CRIHB and NPAIHB long ago recognized the value of collaboration on issues that affect our health programs and the strength in providing a united front when taking those issues to Congress. Our Boards have enough similarities that we often share the same concerns. What we've done differently than other IHS areas, is to use those mutual concerns as an opportunity to collaborate. The saying, "two heads are better than one," certainly fits our situation and I am thankful to the leaders who established our joint meetings. A special thanks to the Tulalip tribe for their hospitality – the food was incredible, the tours of your facilities made many of us envious of such beautiful settings yet glad for the Tulalips using those facilities, and the welcome from your tribal leadership. We look forward to working together well into the future.

Mel Sheldon, Tulalip Chair

Northwest Portland Area Indian Health Board

Projects & Staff

Administration
Joe Finkbonner, Executive Director
Jacqueline Left Hand Bull, Administrative Officer
Marcella Dennison, Fund Accounting Manager
Mike Feroglia, Business Manager
Debi Creech, Accounts Payable/Payroll
James Fry, Information Technology Director
Chris Sanford, Network Administrator
Chandra Wilson, Human Resource Coordinator
Elaine Dado, Executive Administrative Assistant
Tanya Firemoon, Office Manage

Program Operations
Jim Roberts, Policy Analyst
Sonciray Bonnell, Health Resource Coordinator

Northwest Tribal Epidemiology Center
Victoria Warren-Mears, Director
Tom Becker, Medical Epidemiologist
Tom Weiser, Medical Epidemiologist
Ticey Casey, EpiCenter Project Coordinator
Tam Lutz, PTOTS & Native CARS Director
Carol Grimes, PTOTS Research Project Coordinator
Nicole Smith, Biostatistician
Kerri Lopez, Western Tribal Diabetes Director
Cassandra Frutos, WTD Project Assistant
Don Head, WTD Project Specialist
Katrina Ramsey, WTD & Epi Project Specialist
Stephanie Craig Rushing, Project Director
Lisa Griggs, Suicide Prevention Coordinator & Program Operations Project Assistant
Megan Hoopes, NW Tribal Registry Director
Matthew Town, Navigator Project Director
Jenine Dankovchik, Navigator Project Specialist
Bridget Canniff, TECC, TEC Project Director
Birdie Wermy, TEC Project Specialist & MOD Project Assistant
Jaci McCormack, TECC Project Specialist
Linda Frizzell, Nak NuWit P.I.
Vanessa Short Bull, Outreach & Training Coordinator
Michelle Edwards, Grants Administrator
Clarice Charging, IRB & Immunization Project Coordinator
Erik Kakuska, AAIR Project Specialist
Jodi Lapidus, Native CARS P.I.
Kristyn Bigback,Research Assistant Native CARS

Western Tobacco Prevention Project
Terresa White, WTPP Project Coordinator

Northwest Tribal Cancer Control Project
Kerri Lopez, NTCCP Project Director
Eric Vinson, Project Coordinator

Northwest H1N1

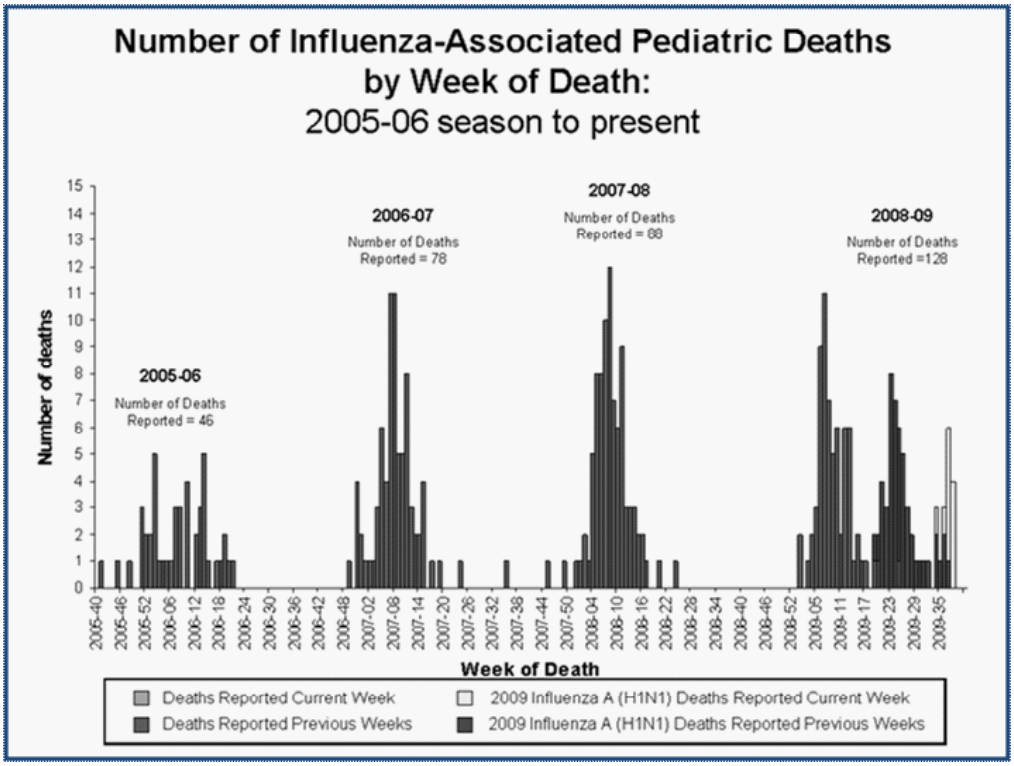
by Tom Weiser, PAO Epidemiologist

The Portland Area Office Indian Health Service (PAO IHS) and the Northwest Portland Area Indian Health Board (NPAIHB) are working together in response to the 2009 H1N1 Influenza Pandemic concentrating on four key areas: Surveillance, Mitigation, Immunization, and Communication. Together we are also engaging the IHS Division of Epidemiology (Albuquerque); the Centers for Disease Control and Prevention (CDC); and the state health departments of Idaho, Oregon and Washington.

Surveillance

Most surveillance data are collected by state health departments from providers, laboratories, and hospitals then communicated to CDC where it is aggregated into national level reports. These reports are updated each Friday and can be seen at: http://www.cdc.gov/flu/weekly/. Figure 1 shows the number of influenza-associated pediatric deaths for the past four influenza seasons. Those deaths from the Pandemic H1N1 influenza strain are shown in the far right of the graph for the most recent weeks. What is striking about this data is the tremendous impact this new strain of influenza has had, essentially doubling the number of influenza-associated deaths over what would have been expected; it has been like having two and now a third influenza season back to back without the usual time between.

Figure 1.



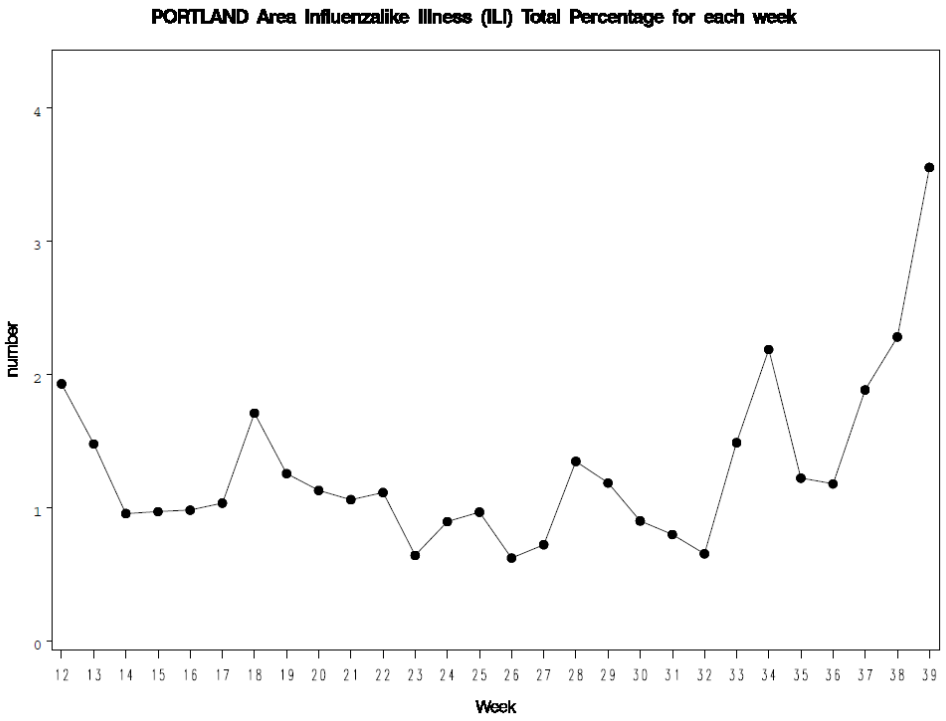
The IHS Division of Epidemiology has also been collecting influenza-like illness (ILI) surveillance data from those sites using RPMS and have installed the patch to report this data electronically. Access to these reports is controlled by the Division of Epidemiology through the Area offices. To obtain access to your site's reports, contact Tom Weiser at tweiser@npaihb.org. An example of the most recent ILI surveillance data is shown in Figure 2. Over the past four weeks there has been a steady increase in the percent of patient visits each week that are for ILI, from 1.2% to 3.5%. During the same period in Oregon, ILI rose from about 1% to just over 7%. Nationally, 4.2% of visits were for ILI as of week 38 which ended September 26th.

Mitigation

The CDC and State and local health departments have made numerous recommendations to help mitigate the severity of the pandemic by limiting opportunities for the spread of the disease. These recommendations range from following simple instructions such as wash your hands often with soap and water or use alcohol-based hand sanitizer, to more detailed recommendations on the use of personal protective equipment for healthcare workers or exclusion guidelines for schools and daycare facilities. These recommendations change rapidly as more information is learned about the

Pandemic Influenza Response

Figure 2.



severity of infection, how the virus spreads, and who is most susceptible to infection. It is best to become familiar with national, state, and local sources of information to develop an accurate understanding of the situation. The website at www.npaihb.org is one place where tribes and IHS staff can find links to the latest information. One example is "10 Steps for Clinicians" (Box 1).

Immunization

Immunization is by far our most effective weapon to prevent the spread of novel H1N1 influenza. Not only can immunization prevent infection for many, it also helps prevent hospitalization and death in others. Seasonal influenza immunization of those under 65 years is 70-90% effective at preventing influenza infection. For those who are frail or elderly, immunization is less effective at preventing infection (30-40%), but still very effective at reducing hospitalizations (50-60%) and reduces fatalities by up to 80%. Even though seasonal immunization is very effective, the Portland Area influenza vaccination rates for adults (Figure 3) show that many go unimmunized every year. Every effort must be made to ensure that those for whom influenza vaccination is indicated, whether *seasonal* influenza vaccination, *novel H1N1* vaccination or both, receive appropriate vaccination this Fall.

continued on page 6

Box 1.

10 Steps for Clinicians

1. Develop a Business Continuity Plan
2. Inform employees about your plan for coping with additional surge during pandemic
3. Plan to operate your facility if there is significant staff absenteeism
4. Protect your workplace by asking sick employees to stay home
5. Plan for a surge of patients and increased demands for your services
6. Care for patients with novel H1N1 flu in your facility
7. Take steps to protect the health of your workforce during an outbreak of novel H1N1 influenza
8. Provide immunization against seasonal flu at no cost to your staff
9. Make sure you know about the pandemic planning and response activities of the hospitals, outpatient facilities and local public health in your community
10. Plan now so you will know where to turn to for reliable, up-to-date information in your local community

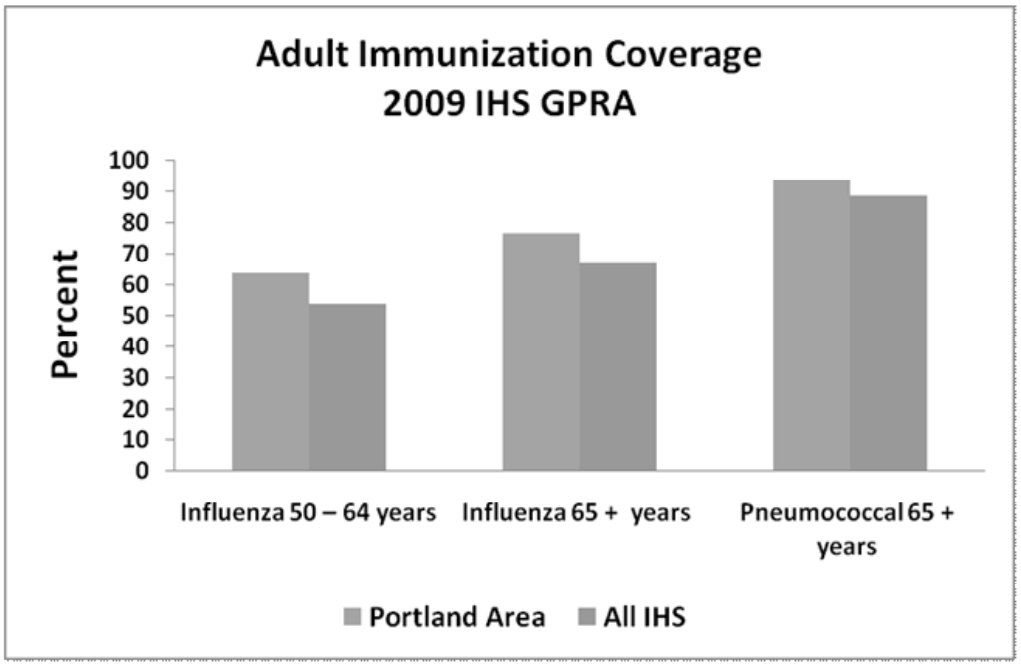
continued from page 5

We know that the best immunization protection happens when the vaccine is a good match for the virus. The vaccine developed against the Novel H1N1 influenza virus is one of the best matches ever for an influenza vaccine. Many are concerned that this vaccine is too new to be trusted. But this vaccine was produced using:

- Same egg-based manufacturing process as licensed seasonal influenza vaccines
- Same in-process controls as seasonal influenza vaccines
- Same lot release requirements as seasonal influenza vaccines
- Same clinical data requirements as seasonal influenza vaccines

The first doses of novel H1N1 influenza vaccine were distributed the week of October 5. Orders for the new vaccine are placed each week by local health departments and others registered to administer the vaccine. Currently, it is estimated there will be 45 million doses available by mid October with an additional 20 million more doses expected to be available weekly. The vaccine will be available as a live, attenuated intranasal vaccine for the first two weeks but the majority thereafter will be in multi-dose vials. Thimerosol-free, single-dose syringes will also be available for pregnant women and young children.

Who should receive the Novel H1N1 influenza vaccine? Pregnant women, household or close contacts



of children under 6 months, children and young adults from 6 months up to 25 years, adults with: chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, cognitive, neurologic/neuromuscular, hematologic, or metabolic disorders (including diabetes mellitus) or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus) and healthcare workers with direct patient contact (see: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e0821a1.htm)

How many doses of vaccine does a person need? It depends on the age of the person. Children and adults aged 10 years and over require only a single dose of the vaccine. Infants and children aged 6 months to 9 years will need two doses given 3-4 weeks apart in order to be fully protected. The H1N1 vaccine can be given any time before, after or at the same time as the seasonal flu vaccine except when both vaccines are the live, attenuated intranasal vaccine (LAIV). If both vaccines are the LAIV type, there must be at least 4 weeks between the vaccines.
Figure 3.

Many people have asked about vaccine safety and what is being done to make sure that this vaccine is not harmful. The CDC, the Food and Drug Administration (FDA) and the National Institutes of Health (NIH) are working together to ensure vaccine safety. Three new active surveillance systems have been developed to supplement the passive Vaccine Adverse

Pandemic Influenza Response

Events reporting System (VAERS). VAERS relies on voluntary reports by hospital, doctors, and patients. To make adverse event detection more timely, the Post-licensure Rapid Influenza Safety Monitoring (PRISM) system will actively collect data from several large health plans and 8 State immunization registries covering approximately 15% of US population. The Vaccine Safety Datalink (VSD) is another active surveillance system that is a partnership with 8 health plans. Adverse events detected through this system can be quickly investigated as this system allows for in-depth review of data and medical records. The Clinical Immunization Safety Assessment (CISA) Network is another partnership between CDC and 6 academic centers that will also be able to detect and investigate suspected adverse events associated with vaccination.

Because the novel H1N1 vaccine was manufactured using the same methods as the seasonal influenza vaccines, we expect a low number of adverse events. In a review of serious adverse events from 1990 – 2005, covering approximately 750 million doses, the overall adverse events rate was 24/million doses. The serious adverse events rate was much lower at 3.4/ million doses. During the period covered by the review, reporting was constant over time and no new safety concerns emerged.

Communication

IHS, CDC, National Indian Health Board (NIHB), PAO HIS, and the NPAIHB have worked together to improve communications between Tribes and State and Federal agencies to ensure tribal populations were included in State plans. At the request of IHS, we assisted in determining how many in our tribal populations were at increased risk for either becoming ill with the novel H1N1 influenza virus or were at risk for serious complications from the virus. This information was shared with IHS and each of the States in our region to assist with plans to provide vaccine, antiviral medications and personal protective equipment. We further assisted tribes in all three states to obtain a share of federal (CDC) funding allocated to states for Pandemic Influenza prevention and preparedness activities and supplies. Through the NPAIHB website and periodic email blasts to Tribal Health Directors (THDs), Service Unit Chief Executive Officers (CEOs), Clinic Directors (CDs), and Immunizations Coordinators we have worked to provide the most current guidance on the use of antiviral medications, vaccine strategies, community mitigation strategies, and education materials. Each week there are conference calls with IHS headquarters and with States to discuss the most current information and recommendations and to maintain situational awareness.

Bi-weekly, the NPAIHB hosts a conference call for THDs, CEOs and CDs to discuss current needs and identify gaps in either the Federal or State response to the H1N1 pandemic. To join this call, contact Elaine Dado edado@npaihb.org or call 503-3268. We are also available to meet with tribal health staff, on request, to discuss tribe-specific issues that come up with regard to the ongoing pandemic.

The PAOIHS/NPAIHB 2009 H1N1 Pandemic Influenza Response Team Members include:
PAOIHS: Clark Marquart, CMO; Celeste Davis, Director, Office of Environmental Health and Engineering and Emergency Management Coordinator; Thomas Weiser, Medical Epidemiologist; Mary Brickell, IT Specialist.
NPAIHB: Joe Finkbonner, Executive Director; Victoria Warren-Mears, EpiCenter Director; Clarice Charging, Immunizations Coordinator.

State Law Helps Smokers and Chewers Quit!

by Terresa White, Western Tribal Prevention Project Coordinator

A new Oregon law, Senate Bill 734, mandates health insurance coverage for tobacco cessation. The law gives insurance plan members, ages fifteen and older, access to and coverage of tobacco cessation therapy, medicines, and programs through a benefit of up to $500 per enrollee.

This is good news for insured American Indian and Alaska Natives (AI/AN) in the State of Oregon where smoking among AI/AN women is 36% and among AI/AN men is 40% (compared to the overall prevalence of 18% for Oregon women and 21% for Oregon men.) We lose 64 AI/ANs in Oregon each year who pass on from disease and complications related to tobacco use. We know that chronic diseases, such as cancer, heart disease, and diabetes problems, disproportionately affect AI/ANs and are directly linked to tobacco use and that at least 1,250 American Indian/Alaska Natives in the state suffer from a serious illness caused by tobacco use.

Senate Bill 734 is the result of new U.S. Public Health Service guideline recommendations recognizing that tobacco dependence treatments are both cost-effective and clinically-effective. These treatments can include, but are not limited to behavior modification assistance such as support groups, counseling, education, and over-the-counter treatments such as the patch and other first-line prescription medications.

Tobacco dependence is a chronic condition that often requires repeated intervention. Effective treatment can produce long-term and permanent abstinence. Clinicians are encouraged to screen for tobacco use at every visit and follow the 5-A's model of intervention: 1. Ask—systematically identify all tobacco users at every visit; 2. Advise—strongly urge all tobacco users to quit; 3. Assess—determine a tobacco user's willingness to make a quit attempt; 4. Assist—aid the patient in quitting; 5. Arrange—schedule follow-up contact.

With Oregon's new law in effect, insured AI/AN smokers and chewers have new resources available to help them succeed!

THE NATIVE TRUTH FILM PROJECT

by Terresa White, WTPP Project Coordinator

Now available on DVD!
THE NATIVE TRUTH FILM PROJECT
a production of The Northwest Portland Area Indian Health Board and the Northwest Film Center's Young Filmmakers Program

Based on the data available, among seniors in high school, American Indians and Alaska Natives had higher rates of tobacco use than all other youth. –American Legacy Foundation®, Fact Sheet on American Indian, Alaska Natives and Tobacco

A new DVD containing three short films and seven public service announcements about the dangers of smoking in American Indian communities is now available free of charge to tribes, schools, prevention programs, health educators, libraries, and other interested parties. Produced by fifteen American Indian youth from Yakama Nation, Spokane Tribes, and Shoshone-Bannock Tribes, the topics include: the harmful chemicals used in manufacturing cigarettes, secondhand smoke in the workplace, differing generational views on smoking, and the difference between sacred tobacco use and commercial tobacco use.

The films were produced through the Native Truth Film Project, a year-long project of the Northwest Portland Area Indian Health Board, in partnership with the Northwest Film Center. Made on location in the youth's local communities, with guidance from filmmakers-in-residence Brian Lindstrom and Sue Arbuthnot, the films include interviews with parents, community leaders, and positive American Indian role models.

The video program is suitable for grades six and up. Total running time of the DVD is thirty-five minutes.

The videos originally debuted on May 16, 2009 at the Northwest Film Center's Whitsell Auditorium in the Portland Art Museum, with youth filmmakers, adult mentors, and tribal leaders in attendance. **The films will be shown to NPAIHB Delegates and attendees of the NPAIHB Quarterly Board Meeting, hosted by the Quileute Tribe, on Tuesday October 20, 2009 at 1:45pm.**

Health organizations that will receive the DVD include Teens Against Tobacco Use, Indian Health Service Clinics, and Tribal Health Education Programs. Additional regional health organizations that are slated to receive

continued on page 15

FY 2010 IHS Appropriations

by Jim Roberts, Policy Analyst

Both the Senate and House have moved to approve the FY 2010 Interior, Environment, and Related Agencies appropriations bill. The House bill provides $17.8 million more funding than the Senate approved bill. The Senate approved the same level of funding as the President requested in his May budget submission to Congress. The Interior bill will go to conference to reconcile the $17.8 million difference. It's expected that the appropriations bills will be wrapped into a larger omnibus appropriation bill later this year or sometime in January 2010. This means that the federal government will operate under a continuing resolution at least through December 2009. For now, a continuing resolution is in place until October 31, 2009.

Completing an omnibus appropriations bill could also become complicated by health reform. The Congressional budget resolution includes budget reconciliation instructions that Congress could use to help enact health reform legislation. Reconciliation is a process set forth in the Congressional Budget Act that allows for special consideration of legislation affecting mandatory programs or taxes. The reconciliation instructions direct the House Energy and Commerce, Ways and Means, and Education and Labor committees and the Senate Finance and Health, Education, Labor, and Pensions (HELP) committees to report reconciliation legislation no later than October 15, 2009. While Congress is not obligated to follow the reconciliation instructions, reconciliation is available if a minority of Congressional members attempt to block health reform legislation.

The Senate approved H.R. 2996, the Fiscal Year 2010 Interior, Environment, and Related Agencies Appropriations bill (S. Rpt. 111-38) by a vote of 77 to 21. The bill provides $4.035 billion for the Indian Health Service (IHS), which mirrors the same levels of funding that the President included in his request to Congress. Earlier this year, the full House moved to provide $17.8 million more than the President's request by including increases for the following:

- $2.5 million increase in H&C line item for Domestic Violence Initiative.
- $1.25 million increase for Dental Services
- $5 million increase for Urban Health
- $9 million increase for Contract Support Costs
- The House increase over the Senate and President's Request is $17.75 million

The spreadsheet provides details of the House and Senate approved bills and compares the marks to the President's Request. A key highlight of the Senate and House approved bills is that they provide approximately a 13% increase for the IHS budget. The Hospital and Clinics budget line items received an addition $327 million increase (12%) over last year's budget amounts. The Contract Health Service (CHS) budget increase is $145 million, which represents a 23% increase over last year's amount. The House bill provides a $5 million increase (19%) for the Urban Indian Programs. The rest of the budget also includes sizable increases and is the best budget that the IHS has received in at least 25 years.

Hopefully this year's IHS budget will not get caught up in an appropriations debate that will tie up funding. Two years ago, Congress passed a year-long continuing resolution that held spending to the previous fiscal year's levels. It would be unfortunate if something like this happened again to the best budget marks that the Agency has received in some time.

President's FY 2010 Request for the IHS Budget

Compares FY 2009 to President's FY 2010

(Dollars in Thousands)

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

A Family's

by Tam Lutz, PTOTs and Native CARS Director

July 2009 marked the 20th anniversary of the tribal canoe journey for northwest coastal tribes. This year 87 canoes completed their journey arriving at the Suquamish Tribe on August 3rd. For our family, the Oliver family of Quinault, Chinook and Cowlitz heritage, it meant a special journey to honor our Uncle Emmett Oliver who among others helped begin the historical 1989 Paddle to Seattle journey that helped revive a significant piece of our coastal culture. It also meant an opportunity for us to honor Emmett's brother Charles (Toad) and my grandfather James (Jim) Oliver.

While I have pulled a war canoe in my younger days, for most of the crew this was the first travel canoe experience. Our canoe is named"Willapa Spirit" and it took us from Potlatch state Park to the shores of the Suquamish. But the journey started long before our canoe hit the water. For a family inter-married into several different tribes throughout the northwest, it meant reconnecting with relatives, building a canoe, learning about our shared heritage, and learning there were still many things we needed to learn. My cousin Marilyn stood next her father Emmett and stated in one of the early journey meetings, "We are the Oliver family, we don't have a song, we don't have a dance, and we have one drum." So began our journey with our elders, including Marilyn, Marlene (my mother) and Jim. Together and with the help of their siblings, childrens and grandchildren we formed the "Oliver Canoe Club" to help "pull" us together for this journey and future journies. John Smith (Skokomish) worked on building our canoe, "the Willapa Spirit" named after the area of the Northwest where Jim, Charles, and Emmett grew up. Marvin (Emmett's son) began creating the beautiful artwork that would be painted on the canoe. Meanwhile, we conceived every method possible of raising money to pay for it... raffles, car washes, garage sales, canoe rides, t-shirt sales, small grants, and so on. Members of our extended family began to teach younger members of the family what was expected in terms of canoe pulling protocol, the respectful way to introduce yourself, how to make and play a drum, while others worked on getting button blankets, vests, give-aways, and paddles made. Our family elders prepared to become what we later found to be the most amazing support crew ever. Our fellow Quinault tribal members graciously taught us to dance so that we were prepared for our protocol night in the Suquamish longhouse. Our fellow Cowlitz tribal members joined us for practice pulls, prayers, and moral support.

Canoe Journey

By the last week of July we weren't entirely ready, but we were there that first morning at 3:30 am, along with support boat captain, Rick Finkbonner, anxious to get on the water and begin. We made mistakes along the way, had short words with one another at times, but nothing significant enough to overshadow the amazing journey. It was strenuous but highly spiritual... we saw a seal that had just given birth, porpoises that followed our canoe's path, an eagle that swooped down alongside the canoes; we saw our children, grandchildren, and great grandchildren learn to pull stronger and stronger; we watched a new generation of little children call each other cousin as they helped out in the camp and danced in the longhouse; we made crafts in the evening laughing loud while we retold stories from our childhood; and we slept on the hard ground in our tent and had dreams of relatives we had lost. For some family members it meant a return to a commitment to become more physically active, for others it helped them prioritize spending more time with family, for others a way to celebrate their commitment to sobriety, and others a way to remember a family member lost. I know I can't capture the experience of a journey in one small paragraph and some things just need to be experienced, and this is one of them. It was a great time to be a coastal Indian. Physically, spiritually, socially, mentally I can't imagine anything more worthwhile. I hope the journey will continue to grow with more folks returning to the canoe and joining the Makah Journey Canoe Journey 2010.

Our family would like to hold our hands up in thanks to Suquamish Tribe for the amazing job they did hosting this year's journey. They thought of every last detail to make the event memorable and comfortable. We would also like to hold our hands up to in thanks to all of the tribes and communities that welcomed, encouraged, and feed us all along the way.

Tam Dixon Lutz (enrolled member of the Lummi Nation, with ancestral ties to the Quinault, Chinook, Cowlitz, Nooksack and Duwamish Tribes)

Preventing Injuries in Native Communities

by Bridget Canniff, Tribal EpiCenter Consortium and Data into Action Project Director

In late September, over twenty tribal and urban health program staff members met in Portland to learn about the impact of unintentional injuries on Native communities, and find out how these injuries can be prevented.

The one-day Injury Prevention Summit, hosted by the Northwest Portland Area Indian Health Board (NPAIHB) and co-hosted by the Californian Rural Indian Health Board (CRIHB) and Oklahoma City Area Inter-Tribal Health Board (OCAITHB), was held on September 24, 2009 at NPAIHB's Portland office. Northwest Tribes represented at this training included: Burns Paiute; Coeur d'Alene; Colville; Coos, Lower Umpqua and Siuslaw; Shoalwater Bay; Shoshone-Bannock; Siletz; and Squaxin Island. Also in attendance were participants from NARA Northwest, Portland Area IHS Division of Environmental Health Services, and NPAIHB. Invited speakers were Barbara Hart and Karen Santana from the CRIHB; Bridget Canniff from NPAIHB and Courtney Carrier from the OCAITHB; Mary Robertson-Begay from Hardrock Council on Substance Abuse (Arizona); Joanne Fairchild from Legacy Health's Trauma Nurses Talk Tough program; and Tam Lutz of NPAIHB's Native Children Always Ride Safe (CARS) project.

Unintentional injuries – such as motor vehicle crashes, poisonings, and falls – are the leading cause of death for American Indians/Alaska Natives ages 1-44, according to the Centers for Disease Control and Prevention (CDC). During our summit, we explored the impact of these injuries on Native communities, and discussed proven strategies for preventing injury and death, such as proper use of child safety seats and seatbelts; reducing motor vehicle crashes; working with elders to prevent falls; promotion of home fire safety; and use of helmets when riding bikes, skateboards, ATVs, etc.

This training was organized by the Tribal Epidemiology Center Consortium (TECC), a joint project of NPAIHB, CRIHB, and OCAITHB funded by the CDC. Previous TECC injury prevention trainings were held in May 2008 in Oklahoma City and in February 2009 in Sacramento. The TECC project has also created an Injury Prevention in Indian Country toolkit to help health program staff learn about injury prevention topics and provide them with culturally-appropriate tools and publications like presentations, brochures, and fact sheets that they can use to educate Native communities about how to reduce injury and death from preventable causes. The toolkit is available online at http://crihb.org/health-resources/injury-prevention/injury-prevention-toolkit.html, or by contacting Jaci McCormack at 503-416-3304 or jmccormack@npaihb.org.

Thanks to all those who helped make this event a success, especially our speakers and participants! We look forward to collaborating more closely with Northwest Native communities to increase awareness of injury prevention, while working to save and improve lives. If you would like more information about TECC or injury prevention efforts in the Northwest, please contact us:

Bridget Canniff, TECC Project Director
503-416-3302
bcanniff@npaihb.org

Jaci McCormack, TECC Project Specialist
503-416-3304
jmccormack@npaihb.org

New NPAIHB Employee

My name is Carol Grimes and I am pleased to join the NPAIHB as the new Research Project Coordinator for the Prevention of Toddler Overweight and Tooth Decay Study (PTOTS). I began at the NPAIHB as an intern in Summer 2008, analyzing qualitative data from PTOTS focus groups. I am very excited to now be working for the Northwest Tribes, as I am dedicated to eliminating health inequalities and disparities, and working to improve health outcomes for minority women and children in particular. I recently graduated from Portland State University with a Masters of Public Health in health promotion/women's health. In the past I have worked for a women's shelter, a mental health and addiction organization, and in publishing (undergraduate = English). I also lived in Niger, West Africa for 2 ½ years as a Community Health Agent in an extremely poor, rural community with the Hausa and Fulani ethnic groups. I am very excited to be returning to Africa again this Fall with the Americans for UNFPA to meet the Directors and tour the facilities of UN funded maternal and child health programs in Ethiopia!

My grandparents and parents are from Bellingham, WA but I was born and raised in Gaithersburg, MD with three older brothers. We are all back out in the NW now, along with the extended family. This is the beginning of my fifth year living in Portland. I live in NE with two cute cats – a stray mama and her baby. Hobbies include hiking, yoga, printmaking, reading, language, music, and seeing the world as much as possible. I recently underwent a major surgery related to my thyroid and as I recover, I have dedicated myself to living a healthier lifestyle – cooking/eating organic veggies from my CSA, doing lots of yoga and biking, and of course reducing/preventing stress in my life as much as possible. The NPAIHB is the perfect place for me to work in supporting this new lifestyle with its family-like atmosphere and excellent wellness policies. Thank you for accepting and welcoming me here.

Native Truth Continued

continued from page 9

the DVD include local American Lung Associations, American Cancer Society programs, Washington State Department of Health, Oregon Department of Health and Human Services, and the Idaho Department of Health and Welfare.

High Schools that have received the videos include Shoshone-Bannock High School (Shoshone-Bannock Tribes), Wellpinit High School (Spokane Tribe), Springdale High School (Spokane Tribe), Toppenish High School (Yakama Nation), Granger High School (Yakama Nation), and Lincoln Elementary (Yakama Nation).

For more information about the Native Truth Film Project or to obtain a copy of the DVD, contact:
Terresa White, Program Coordinator
Western Tobacco Prevention Project
Northwest Portland Area Indian Health Board
Phone: 503-228-4185
www.npaihb.org

Health News and Notes is published by the Northwest Portland Area Indian Health Board (NPAIHB). NPAIHB is a nonprofit advisory board established in 1972 to advocate for tribes of Washington, Oregon, and Idaho to address health issues. Previous issues of *Health News and Notes* can be found on the NPAIHB webpage www.npaihb.org.

Contact Sonciray Bonnell (503) 228-4185 or sbonnell@npaihb.org., *Health News and Notes* Editor, to submit articles, comments, letters, and requests to receive our newsletter via mail.

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

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

Return Service Requested

Northwest Portland Area Indian Health Board and California Rural Indian Health Board July 2009 Joint Resolutions

Joint Resolution # 09-04-01
Support and Urging Congress to Include AI/AN Provisions and the Indian Health Care Improvement Act in Health Reform Legislation

Joint Resolution # 09-04-02
Support of the Colville Tribe as they confront destructive impacts on ongoing underfunding of their Health Care system by the Indian Health Service

Joint Resolution # 09-04-03
Support for the Reauthorization of the Indian Health Care Improvement Act

Joint Resolution # 09-04-04
Support for an Area Distribution Fund in the new HFCPS and Recommend the IHS Director to Implement the new Priority System

Joint Resolution # 09-04-05
In Support of Appropriate Access to IHS Held Data for IHS Funded Epidemiology Centers, Tribes and Tribal Organizations