



# Tribal Health *Advisor*

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## NATIONAL HEALTH REFORM IN INDIAN COUNTRY

The United States is again focusing on the need for national health reform. The Obama Administration is keeping its campaign pledge to make national health reform a major priority for their first year in office. The need to reform the health care industry is reflected in the statement: "In America we have a non system health care system" but the driving issue is cost. No other industrialized country pays as much for health care as we do and yet the health status of the average American is lower than that of seventeen other industrialized nations. Proof of the Administrations commitment is seen in the just released FY2010 budget request to Congress where the administration has set aside \$670 Billion to fund national health reform. In an effort to avoid the mistakes of the past President Obama has given Congress the responsibility to craft health reform legislation with the dual goals of expanding coverage for the uninsured and to control costs.

What does this mean for Tribes and Tribal Health Programs in California? First and foremost it should mean a new stream of federal funding for Tribal Health Programs. For example Congress is expected to create a new form of government health insurance coverage which will be open to all citizens and will require premiums be paid on a sliding fee scale. They are also expected to increase access to Medicaid by raising the threshold to 150% of poverty. Some of these newly insured will be American Indians and Alaska Natives. But more to the point this is an opportunity to urge Congress to "fix" the Indian Health Service.

The time line is very short as Congress hopes to bring a finished product to the President to sign this fall but the opportunity for real change is huge. Over the next few weeks Tribes and Tribal Health Programs need to meet, analyze and propose their vision of how the IHS should operate in an environment where everyone has health insurance and the IHS approaches "full funding." The NIHB has organized a National Health Reform workgroup, in which CRIHB participates, so send your ideas here so we can share them through that structure, be ready to communicate with Congress on your support for substantive change and hope this time reform will succeed.



# CALIFORNIA TRIBAL BRFSS PROJECT

A BRFSS is a Behavior Risk Factor Surveillance Survey. These health surveys gather data on health conditions and risk behaviors for selected populations. BRFSS has been performed in all 50 states every year since 1984 and is the largest on-going telephone health survey system. For many states, the BRFSS is the only available source for timely, accurate data on health-related behaviors. However, state-sponsored BRFSS's do not oversample the American Indian population and are not representative of tribal populations. Thus, Indians belonging to California tribes were not represented the way they should be in the California BRFSS and make up a very tiny portion of their prevalence data. Furthermore, a telephone survey is not the most culturally appropriate way to collect health data for California Indians – especially for those who live in rural areas with limited or no access to a telephone.

In order to address the deficiencies in state-sponsored BRFSS's, tribes in the Northwest Portland and Southwest/Albuquerque Area, as well as the Navajo Nation, have either started or finished tribal-specific BRFSS's

in their Indian communities to better capture health priorities and focus areas for their community clinics. These Tribal BRFSS's are conducted face-to-face, rather than over the phone, and contain many tribal-specific questions that are not contained in state BRFSS's, such as traditional tobacco use, availability of a medicine man or traditional healer, injury prevention specific to Indian country, and several other topics that are of particular interest to Indian people. To date, almost 3,000 Indians have participated in a Tribal BRFSS.

In 2008, the California EpiCenter was approached by a California tribe who had funded their own tribal-specific BRFSS. This Tribal BRFSS was conducted in their community in a way that could help them determine health priorities, health clinic focus areas, and recognize strengths in their community. The California EpiCenter is willing to assist tribes interested in a Tribal-BRFSS with respect to data entry, analysis, survey construction, and interviewer trainings.

If your Tribal community is interested in assistance from the California EpiCenter for a Tribal-specific BRFSS Contact Virginia Myers (Yurok/Karuk), EpiCenter Program Coordinator, at 916-929-9761 or [virginia.myers@crihb.net](mailto:virginia.myers@crihb.net).

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The California Rural Indian Health Board  
&  
The Northwest Portland Area Indian Health Board  
presents  
The 10th Joint Bi-Annual Board of  
Directors Meeting  
Monday - Thursday  
July 20 - 23, 2009  
Hosted by The Tulalip Tribe

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## UPDATE: CALL FOR INPUT NIHB'S EXPLORING TRIBAL PUBLIC HEALTH ACCREDITATION PROJECT

The Public Health Accreditation Board (PHAB) was established in 2007 to spearhead a national initiative for state, territorial, tribal and local public health departments to undergo voluntary accreditation with the goal to improve and protect the health of the public by advancing the quality and performance of state and local public health departments. The initiative is supported by the CDC and the Robert Wood Johnson Foundation. National Indian Health Board: NIHB has worked extensively with PHAB; its members participating on the Exploring Public Health Accreditation steering committee and workgroups.

In 2008, NIHB was funded by the Robert Wood Johnson Foundation to lead a project assessing the feasibility of the accreditation initiative in Indian country; objectives include establishing a tribal advisory committee, gather information and develop a strategic plan. The NIHB Voluntary Public Health Accreditation Advisory Committee met for the 4th time this April to discuss recent developments of the national initiative and consider the potential of implementing the program in Indian Country.

Questions arose about documentation requirements, accountability of partners, costs, enforcement, etc. Complex and missing elements were also discussed such as the lack of measures related to cultural competence, the role public health workers in the process, "evidence-based" measures for tribes that lack data and the lack of inclusion of certain clinical and health issues such as substance abuse. Public Health in Indian Country: Public health services diverse and varied set of stakeholders and partners intratribal communities.



Brenda Adams, Nelson Pinola and Michelle Hayward

Tribes may deliver public health service through federal, state and other non-profit grants and contracts. Involve-

ment of tribes in health are delivered by a care delivery in their communities often results in more or greater emphasis on public health activities such as prevention and wellness programs. Tribes may also provide public health services through partnership with local, county and state health departments. The extent of tribal partnerships and relationships with other public health entities varies by tribe, state, and type of service. As a result, the definition of public health in Indian Country is a complex set of services and activities with diverse partners and stakeholders varying by tribe and region.



Amos Tripp and David Lent

Public Health Accreditation may result in better quality of and access to culturally appropriate public health services for your community because:

- *It helps define and strengthen the role and identify responsibilities of tribal governments in regulating public health in their community.*

- *It will help define, educate and elevate visibility about public health benefits in your tribal community.*

- *It clarifies that public health includes prevention and wellness which ultimately can reduce health disparities.*

- *It is a way to assess strengths and areas for improvement in public health services.*

- *It helps encourage better partnerships with all entities that do public health for our communities, including internal and external partners such as states, counties, local, tribes, federal, private, non-profit, etc.*

- *It may lead to more resources for public health, such as grant opportunities, and save costs in the long run.*

- *It provides an opportunity for tribal communities to plan for the wellness and strengths of their respective communities.*

*It is imperative that this initiative have input from tribal organizations statewide.*

Please encourage public comment from community members and stakeholders by May 30, 2009 through [www.crihb.org](http://www.crihb.org) or Jackie Kaslow, Director, Family Community Health Services at: [Jackie.kaslow@CRIHB.net](mailto:Jackie.kaslow@CRIHB.net)

# CRIHB TRIBAL FACILITIES ENGINEERING PROGRAM UPDATES

Stimulus Bill: American Recovery & Reinvestment Act of 2009 (ARRA) California lists for facility projects and equipment are progressing from the IHS thru DHHS to OMB by the May 15 deadline. Once OMB approves the lists, the funds should be sent to the Areas for distribution. No date is known.

M&I Projects: It is anticipated that all the projects will be accepted as proposed. The California Area IHS will soon provide a template for submitting the formal project summary document (PSD). The PSD can be prepared and submitted to the Area Office in advance while awaiting the receipt of the funds. The amount of funds to be received by each tribal health program is still unknown but the amount to each Area was provided by IHSHQ. The amount of funds should be in the range of the annual M&I appropriation. The exact amounts will be provided to the health programs as soon as CRIHB is notified.

Clinic Equipment: The equipment requests changed significantly during the last few days before the submission deadline. Unfortunately, the final equipment selection may have been made without notice to the tribal health programs due to time constraints. Specific language in the legislation placed requirements that didn't match well with the needs or priorities of the tribal health programs. In order

to receive any funds, the specific one item ordered had to cost at least \$10,000. Grouping of equipment to make up a "unit" was not allowed. Tribal health programs, depending on size, received multiples of the \$10,000 grant. All programs regardless of size or annual equipment appropriation, received at least one item. Any remaining funds or future funds may be distributed to the tribal health programs with less stringent requirements.

Annual M&I Funding: The Facilities program received its 100% share of the Fiscal Year 2008 Maintenance and Improvement (M&I) funds. The receipt of these funds from the IHS came very late in the fiscal year. We still have not received any of the FY2009 funds as of this date.

Annual Equipment Funding: The Facilities program received its 100% share of the annual replacement clinical equipment funds in FY2008. These funds were likewise received very late in the year. All the funds were transferred to each the health programs as calculated in the IHS M&IE database. No FY2009 funds have been received as of yet.

Energy Funds: A notice of various energy grant opportunities was distributed. There are many annual and stimulus funded grants available for projects ranging from energy studies to conservation projects to power generation.

Please don't hesitate to contact Kerry Gragg at [kerry.gragg@crihb.net](mailto:kerry.gragg@crihb.net) for any Facility related issues.

## CRIHB WEBSITE

The new website was launched on May 8th, 2009. You will find additional enhanced features added from the previous site. Check out the video gallery, which contains numerous videos from our different programs.

Visit [www.crihb.org](http://www.crihb.org) to see the new California Rural Indian Health Board website. If you have any comments or feedback regarding the site please contact Nita Patel at [nita.patel@crihb.net](mailto:nita.patel@crihb.net).



# CALIFORNIA TELEHEALTH NETWORK

During the April CRIHB Board Meeting, representatives from UC Davis Health System met with the Board and made a presentation on the California Telehealth Network (CTN). Following the presentation, there was lively discussion regarding many health care issues that are important to tribes and how CTN may play a role in improving access to needed services not locally available. Close to 80 California Tribal health care sites have expressed interest in joining the CTN in order to take advantage of heavily subsidized telecommunications costs, as well as to benefit from health care services that are planned to become available as the network develops. The accompanying map illustrates the distribution of planned sites, including tribal sites.

The California Telehealth Network will connect hundreds of health care sites to a dedicated statewide telecommunications network. Several key organizations within California, including the Governor's Office, state and local government agencies, not-for-profit health care organizations, and health care providers have joined forces, working together in an unprecedented manner to rally support for the California Telehealth Network. To date, the network has collected Letters of Agency representing over 900 health care facilities in California who are interested in participating in the Network. A special effort has been made to contact tribal representatives and to encourage them to participate. Initially, the information required to assist in the planning of the California Telehealth Network was collected using a publicly available online survey service. Over 450 sites have responded with information concerning their current telecommunications needs, sustainability and resource information, and the specialty care services they need or

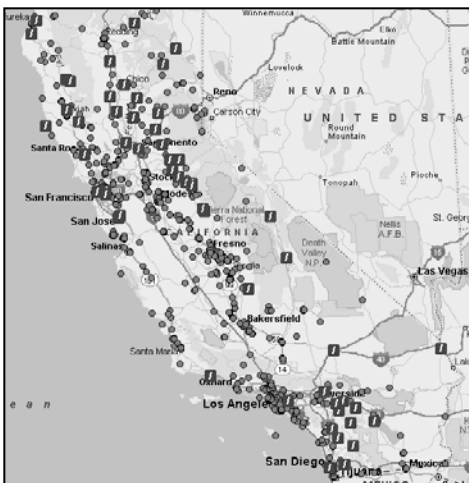
would be willing to provide via telemedicine, among other information. CTN intends to expand the survey effort to include more input from sites that did not have an opportunity to participate initially, including tribal sites. The information from the assessment survey is being used to develop a business model for the Network and for a statewide



effort to expand and implement telemedicine throughout the State. Funding for the program had been obtained from several federal, state and private nonprofit health-care funding organizations. Sources

include: 1) the Federal Communications Commission Rural Health Care Pilot Program (FCC RHCPP, \$22.1 million) that will support 85% of telecommunications expenses; 2) the California Emerging Technology Fund which will provide a 15% match to the FCC RHCPP funds (\$3.6 million); 3) the California Teleconnect Fund that will pay approximately 8% of the monthly telecommunications charges; 4) Proposition 1D funds - a voter-approved, University of California initiative that will provide telemedicine equipment and expand training for rural medical practice. In total, over \$30 million in funding has been garnered to build and maintain the CTN for a period of approximately three years.

The unified efforts and pooled resources will extend the reach of the available funds and promote economies of scale as California continues to develop a collaborative plan for telemedicine in the State. The current timeline for the project is to select a Prime Contractor who will construct the network and to begin construction some time during 2009.



Jim Crouch and Reno Franklin

## SPECIAL DIABETES PROGRAM FOR INDIANS UPDATE

Last year congress extended the Special Diabetes Program for Indians (SDPI) for 2 more years with annual appropriations of \$150 million. With this new funding we will enter the 13th year of the SDPI grant program. On March 30, 2009 Mr. Robert McSwain released his decisions regarding the national distribution of funds for the SDPI for fiscal years 2010-2011.

The annual distribution of the SDPI funding will remain the same for FY 2010 and FY 2011, as it has been for the past 6 years. The TLDC is currently identifying members from the existing committee to form a workgroup to develop formula changes for the distribution of possible SDPI funding for FY 2012. Entities eligible to apply for the new FY 2010 and FY 2011 SDPI funding will remain the same. Indian Health Service is developing a competitive announcement for the new SDPI funding. New SDPI applications that do not meet the minimum score will be provided an opportunity to revise the application based on feedback from the application reviewers.



We have been notified by Indian Health Service that all SDPI programs that currently have grant cycles that start in October will now have a new grant cycle date for FY 2010 which will begin June 1, 2010. This affects all CRIHB member programs who have passed through funding for the SDPI grants. The new grant cycle will cause a funding gap from October 1, 2009 until May 31, 2010. Indian Health Service is working on a plan to support diabetes program staff during the 8 month gap. Programs that still have some carryover funding are encouraged to save those dollars to help pay for program activities during this 8 month time period.

In October 2005, CRIHB, in partnership with UAI, was awarded a 6-year Children's Mental Health Initiative (CMHI) grant federally funded through Substance Abuse and Mental Health Services Administration (SAMHSA) whose goal is to implement a System of Care approach to services to provide comprehensive community mental health services for children, youth and their families in Los Angeles County.

The Seventh Generation System of Care is based on the completed three year UAI Circles of Care project. The Circles of Care was a three-year planning grant funded by SAMHSA to design a System of Care for American Indians in Los Angeles County. The LA community provided input and their voice was important in developing the System of Care model. UAI as a non-profit agency was not eligible to apply for the CMHI grant. CRIHB agreed to partner with UAI in order to apply for the funding.

With the CMHI grant UAI has made some meaningful changes among American Indian children, youth and families in Los Angeles County. The funding allowed for a full array of culturally competent mental health and support services organized into a coordinated network in order to meet the unique clinical and functional needs of each child and family. The services are based on the premise that the mental health needs of children and adolescents can be best met within their home, school, and community. Families and youth are the driving force in the transformation of their own care. An evaluation component will allow for the success of this program and partnership to be measured.

## MEDI-CAL ADULT DENTAL AND OTHER SERVICES CUT FROM STATE BUDGET

On March 27, 2009, the State Treasurer and Finance Director determined that California will not receive enough federal stimulus aid to prevent \$1 billion in program cuts and higher taxes. As a result, taxpayers will see an increase in the personal income tax rate of 0.25 percent. In addition, spending cuts to courts, health care programs (including dental care for adults, psychology, chiropractic, optometry, acupuncture, speech therapy, skin treatments, and podiatry services), higher education, and social services are to be made. The state leaders did indicate that the aid will provide \$8 billion to offset declining general fund revenue through June 30, 2010. However, California needed \$10 billion to avoid cuts and higher taxes under the budget deal lawmakers and the governor reached in February.

“We did this in a very straightforward manner and did not put our thumb on the scales” said H.D. Palmer, a spokesman for the governor’s finance department. Assemblyman Jim Beall said, “based on what I heard and knew about the stimulus package, it seemed clear this would not happen, but it did. I feel like there was manipulation when we approved this. I mean, (cutting) dental coverage for the developmentally disabled? That’s disgusting. It’s shameful.”

Treasurer Lockyer said he is particularly concerned about cutting dental care for poor adults and capping pay for in-home supportive service workers at \$9.50 an hour. “I consider the suffering that would be caused by these particular cuts to be both severe and compelling,” Lockyer wrote in a letter to the governor and legislative leaders. “I strongly urge the governor and Legislature to reconsider these two programmatic cuts before they take effect on July 1,” Lockyer further wrote.

Indian healthcare advocates have been discussing these issues and findings, as well as the related reality facing



## CALIFORNIA’S BUDGET DEFICIT MAY GROW IF VOTERS REJECT PROPOSITIONS

State budget analysts predict that California will face a \$12 billion+ budget deficit in fiscal year 2009-2010 if voters reject measures on the May 19 election ballot. These measures would move funding from mental and child health care and education and permit the state to borrow against future lottery funds. Even if the propositions are approved, the state will face a budget deficit of at least \$6 billion because state revenue is falling about \$8 billion short of expectations.

The measures would complete the budget Governor Schwarzenegger signed recently that uses tax increases, spending cuts, and borrowing to cover California’s budget deficit through fiscal year 2009-2010. Rejection of these propositions could result in another battle between lawmakers and the governor over tax increases and program cuts.

Indian clinics with key representatives of the Legislature and the governor and urging them to find a way to maintain health related services, especially adult dental.

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## CRIHB’S 40TH ANNIVERSARY ANNUAL MEETING

Mark your calendars for the 40th Anniversary Annual Meeting on October 15th - 18th, 2009. Location will be determined in the following month. Hope to see you there !

## DENTAL SUPPORT CENTER UPDATES

We are happy to announce the 2008 GPRA Sealant Challenge winners! CONGRATULATIONS!!!

\$500 Winners - Tribal/Urban Programs that met their Sealant goal for 2008 GPRA year

Central Valley Indian Health  
Chapa De Indian Health  
Feather River Indian Health  
Hoopa Indian Health  
Riverside-San Bernardino Indian Health  
Shingle Springs Tribal Health Program  
Susanville Indian Health Center

\$250 Winners -Tribal/Urban Programs that showed a 30% or more improvement from 2007 GPRA Goal

Chapa De Indian Health  
Feather River Indian Health  
Hoopa Indian Health  
Northern Valley Indian Health  
Riverside-San Bernardino Indian Health  
Santa Ynez Indian Health  
Shingle Springs Tribal Health Program  
Toiyabe Indian Health  
Tule River Indian Health



## UPCOMING DENTAL CONFERENCES AND TRAININGS

Two Registered Dental Assistant (RDA) Sealant Trainings were completed with a total of 22 RDAs receiving certification. Two more trainings are scheduled in June 2009: June 22-23 in Oakland and June 26-27 in Sonora, CA.

For more information, please contact Lalani Ratnayake, Dental Support Center Coordinator at [lalani.ratnayake@crihb.net](mailto:lalani.ratnayake@crihb.net).



## **TRIBAL LEADERS ACHIEVE CONSENSUS ON STATE HEALTHCARE ISSUES**

Tribal leaders achieve consensus on state healthcare issues, send letter to Governor urging no-cuts to Medi-Cal services. On March 23-26, 2009, Tribal leaders representing 50 Tribal Governments gathered at the Annual Indian Health Service Tribal Leaders Consultation Conference in Buellton, CA to discuss issues of importance for their tribes and tribal health programs. As a result of these deliberations the Tribal leaders outlined critical issues affecting their health delivery systems in the state and have brought these issues to Governor Schwarzenegger's attention to assist in seeking remedy. The following is the list of the issues.

### **Protect Medi-Cal Adult Dental**

Native American health clinics in California are part of a health care system that is chronically under funded and highly dependent on the Medi-Cal program to provide vital dental care to adult patients from all backgrounds.

In light of this, if budget reductions must be made to the vast Medi-Cal program, adult dental care must be retained.

It is imperative that the current Medi-Cal Adult Dental Program benefits be retained. Removing these benefits will result in significant and dramatic reductions in the health of Native Americans. In addition, adult dental should be made part of the basic medical benefits package and not maintained as an optional benefit. Federal guidelines establish the core Medicaid services. However, evidence-based medicine demonstrates that oral health must be an integral part of BASIC medical care and NOT an optional benefit. Therefore, the state should work with the Federal Centers for Medicaid and Medicare Services to reclassify adult dental care.

### **Maintain All Medi-Cal "Optional" Services**

The cuts to these services would eliminate dental, optometry, podiatry, psychology, and several other benefits for around three million California parents, seniors and people with disabilities. These cuts will incur new costs to the state health system as these services often provide the preventative care needed to prevent more expensive treatments later. For example, podiatry services often provide early-warning for diabetes and obesity.

### **Tribal Health Program Right to Bill Medi-Cal**

The Tribes are requesting a change in state regulation and or law that would allow out of state licensed providers who are working for Tribal Health Programs, on or off tribal land, which is either state licensed or certified as a primary care clinic. This is necessary in order to allow them to bill Medi-Cal while their application to become a state licensed provider is under review. This "right to bill" would be revoked if they change employers or are found to be unsuitable to be licensed in their profession by the State.

### **Behavioral Health**

Many of the Indian behavioral health programs are struggling financially yet need to expand their services to meet the increased needs of their patient population. The State and counties are grateful that these Indian programs are providing these services, however the Indian programs often go without financial support and compensation much needed by the tribes. The State and counties are legally bound to find a way to provide behavioral healthcare to this diverse and hard to reach population. The counties count the Native residents in their regions and use this information in their proposals to justify receipt of funding, yet few service dollars actually reach the Native communities. It is time to eliminate this obvious oversight.

The State of California should take leadership in developing financial mechanisms to assist Tribal/Indian Health Programs who are helping to carry out the mandates of State and County programs in providing behavioral health services.

### **Native American Liaison**

The tribes are recommending that the Governor appoint a tribal liaison from the American Indian community to serve as a resource to the Governor and as a point person on issues of importance to California Indian tribes. The tribes prefer the candidate to be a California Indian and would like to provide a list of nominees to fill this position.



# MAXIMIZING STIMULUS FUNDING: CALIFORNIA'S OPPORTUNITY

The mission of the California Emerging Technology Fund (CETF) is to close the Digital Divide and ensure that California is a global leader in the development and adoption of broadband. This is a significant challenge considering there are 17 million Californians not connected to broadband. Closing the Digital Divide in the Native American population is a significant part of this overall challenge. Data on Native Americans with computers, Internet connectivity and broadband access or adoption is often outdated or non-existent. The 2000 census found that nationally 26.8% of rural Native American households had access to a computer at home compared to a national average of 42.1%. Only 18.9% had access to the Internet compared to national average of 26.2%. Current data on Native American access to broadband is likely to be much worse.

The recently enacted American Recovery and Reinvestment Act of 2009 (ARRA) includes \$7.2 billion for broadband deployment and adoption nationally. This presents an unprecedented and significant opportunity to address and in some cases eliminate the lack of broadband connectivity

on tribal lands. CETF is committed to assist tribal governments and communities attract ARRA funds in several ways. CETF has committed \$15 million of its \$60 million seed capital to serve as a 10% match as required by the federal funding requirement. CETF has also invested in seven rural demand aggregation projects that are actively involved in making the business case for ARRA and private broadband investment in rural California which include many tribes. In addition, the \$7.2 billion allows for numerous projects tribes may consider important including educating tribal members on the basics of computer use, upgrading existing technology centers, providing technical training and creating telehealth applications to improve health outcomes to those in the most remote areas of the state.

The ARRA broadband public hearings in Las Vegas and Flagstaff held in March 2009 demonstrated the powerful voice Native American leaders have in this country. CETF hopes to see this translate into significant investments in California tribes who have a lot to offer the state, the nation and global community. Either as a partner with a CETF rural consortium or direct applicant for ARRA funds, tribal governments should consider CETF as an ally in closing the Digital Divide anywhere it remains. For more information please visit [www.cetfund.org](http://www.cetfund.org).



## NEW LOCATION FOR THE LYTTON PROGRAMS

Since the inception of the Lytton Rancheria Head Start, it has been a long-term goal for both CRIHB Tribal Head Start and the Lytton Tribe to find “a place to call home”. Currently, the Lytton Rancheria Head Start and Lytton “Fist Steps” programs are housed on elementary school campuses through year-to-year leases. Our partnership with the Wright Elementary School District and its superintendent, Casey D’Angelo, has been historically positive but the Tribal Head Start Department has always been interested in housing the two programs under one roof and in serving more Native children. Under the Memorandum of Agreement with the school district, CRIHB is required to share enrollment slots with the school district.

As a tribal program with both federal Head Start and local tribal funding, it is important that CRIHB reach as many Native children as possible. And, there continues to be many unserved preschool-aged Native children in Sonoma County. We feel very luck to have found the new location, as preschool property in Sonoma County is rare and can be rather costly.

Once CRIHB got word that the local Countryside Preschool was closing its doors, Mike and Andrea

## THE AAIR PROGRAM: UNITED INDIAN HEALTH SERVICES, INC. ACTS AS A VALUABLE ALLY

The Access to American Indian Recovery (AAIR) Advisory Board met at CRIHB in March to discuss the under-utilization of recovery support services. To date, the AAIR program has served over 1900 American Indian/Alaska Native (AI/AN) people, 45 percent of them with meth-related issues. Some provider organizations have delivered over \$250,000 AAIR services since the program’s launch in January 2008, yet many Tribal Organizations don’t participate in AAIR.

The goal was twofold: to increase AAIR program participation by providers and to boost AAIR client enrollment. Alan Schrader, LCSW, Clinical Director of Substance Abuse and Mental Health at UIHS Potawot Health Village, has seen the difference the AAIR program can make and the lives it can help. AAIR provides a major part of the budget for the 7 drug/alcohol treatment staff at UIHS. AAIR helps improve the quality of client care with the use of standard intake procedures, assessments, and measurement

pursued the location as a possible site for the two programs. With the firm support and encouragement of Jim Crouch, CRIHB Executive Director and also Margie Mejia, Lytton Tribal Council Chairperson, CRIHB is currently reviewing the draft lease agreement for the property. It is expected that the lease agreement will be formalized sometime in April. Preschool property in Sonoma County is a rare find and the CRIHB Tribal Head Start department feels fortunate to be supported in this venture and that we will be able to use 100% of enrollment for Native children in the community. Although the center was previously licensed by the state, CRIHB must obtain its own state license. The application process can be lengthy but if all goes as planned, the new center will open its doors to children and families in September 2009.



tools (GPRA) for all clients. Alan says that AAIR voucher definitions show “AAIR values Native American Spiritual providers.” That’s important because UIHS programs include access to purification sweats, Native American healers and traditional foods and herbs for total mind/body/spirit balance. He points out that AAIR also supports providers as they face deep cuts in treatment and healthcare funding, by: Gathering providers together to problem-solve ways to ease residential/outpatient transfers; discussing how to advocate Federally and begin long-term plans for sustainable funding for drug/alcohol addictions and ongoing support of our local partnerships with training support.

After a recent Methamphetamine Awareness Conference, local tribal governments requested that Alan assist them to become AAIR providers and run sober living homes. Clients in early recovery have a hard time finding safe, drug-free places to live, yet sober living homes are affordable and effective. They could be run using Tribal social service and AAIR funds. This would make a big difference for the communities and people UIHS serves. He urges reaching out to other Tribal governments through teleconferences, for “focused discussions and planning sessions that lead to more AAIR providers in the Tribal areas. More AAIR services means more clients served.”



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Sacramento, CA 95841  
1.916-929-9761, voice  
1.916.929.7246, fax  
www.crihb.org

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*Quarterly Board of Directors and Program Directors Meeting*  
Joint Bi-Annual Meeting with NorthWest Portland Area Indian Health Board  
July 20th - 23rd, 2009  
Tulalip Resort Casino, 10200 Quil Ceda Boulevard, Tulalip WA 98271

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CRIHB MEMBER TRIBAL HEALTH PROGRAMS

Greenville Rancheria  
Tribal Health  
P.O. Box 279  
Greenville, CA 95947  
530.284.7990

Redding Rancheria  
Indian Health Services  
3184 Churn Creek Road  
Redding, CA 96002  
530.224.2700

Tule River  
Indian Health Center, Inc.  
P.O. Box 768  
Porterville, CA 93258  
559.784.2316

Karuk Tribal  
Health Program  
P.O. Box 1016  
Happy Camp, CA 96039  
530.493.5305

Shingle Springs  
Tribal Health Program  
4140 Mother Lode Drive, Suite 112  
Shingle Springs, CA 95682  
530.672.8059

United Indian Health  
Services, Inc.  
1600 Weeot Way  
Arcata, CA 95521  
707.825.5000

M.A.C.T. Health Board, Inc.  
P.O. Box 939  
Angels Camp  
209.754.6272

Sonoma County Indian  
Health Project  
144 Stony Point Rd  
Santa Rosa, CA 95401-4122  
707.544.4056

Warner Mountain Indian  
Health Project  
P.O. Box 247  
Fort Bidwell, CA 96112  
530.279.6194

Mathiesen Memorial Clinic  
P.O. Box 535  
18144 Seco Street  
Jamestown, CA 95327

Toiyabe Indian  
Health Project  
52 TuSu Lane  
Bishop, CA 93514  
760.873.8464